Minnesota Prepaid Medical Assistance Project Plus
(PMAP+) §1115 Waiver
No. 11-W-00039/5

Waiver Extension Request
June 2010

Minnesota Department of Human Services

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Section One Introduction

Minnesota was one of the early states to use health care reform waivers to cover its uninsured population. We received one of the first health care reform waivers (at the time called the MinnesotaCare Health Care Reform Waiver; currently known as the PMAP+ Waiver), which allowed Minnesota to first cover pregnant women and children in our MinnesotaCare program, and later caretaker adults. The goal of Minnesota's health care reform effort is to provide organized and coordinated health care that includes pre-established providers networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services.

1.1 Background

For over twenty years, Minnesota's Medicaid Program (Medical Assistance or MA) has administered a § 1115 waiver, allowing for the purchase of coverage from managed care organizations (MCOs) on a prepaid capitated basis. This purchasing project, known as the Prepaid Medical Assistance Program (PMAP), was originally limited to a few Minnesota counties. The project required that MA recipients who are not disabled be enrolled with an MCO, and remain enrolled with that MCO for 12 months.

In April 1995, the Centers for Medicare & Medicaid Services (CMS, then called HCFA) approved a statewide health care reform amendment to the PMAP waiver. This amendment, known as Phase I, allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the federal poverty guidelines (FPG) into the Medicaid Program.

In March 1997, the State proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that CMS authorize a second phase of provisions that had been enacted by the Minnesota Legislature. An amendment approved in February 1999 expanded coverage to include caretaker adults enrolled in MinnesotaCare. Some of these caretaker adults, with income from 100 to 200 percent of poverty, were partially funded through SCHIP. In August 2000, CMS approved most aspects of Minnesota's Phase 2 amendment request. The waiver was titled the Prepaid Medical Assistance Project Plus (PMAP+) waiver.

In June 2001, Minnesota requested an extension of its PMAP+ waiver. CMS approved the extension in October 2001. Minnesota also requested and received an amendment to the budget neutrality terms and conditions of the waiver, which was effective July 1, 2003. With passage of the Balanced Budget Act of 1997, and subsequent promulgation of related regulations in 2002, most aspects of Minnesota's pre-paid managed health care programs could be operated under the

State Plan. The majority of MA recipients receiving managed care under the authority of the §1115 PMAP+ waiver moved to state plan authority for managed care effective July 2005. And in June 2005, Minnesota moved all PMAP+ seniors to Minnesota Senior Care (MSC) under the authority of a §1915(b) waiver. This waiver option continued to allow mandatory enrollment of seniors, including those dually eligible for both Medicaid and Medicare, in managed care. Nevertheless, several important components of the State's programs continue to require waivers under §1115 of the Social Security Act in order to remain in operation, including but not limited to providing Medicaid coverage for expansion populations and mandatory enrollment of certain populations in managed care.

In December 2007, the State submitted a request to extend the §1115 waiver authority necessary to continue PMAP+ through June 30, 2011. The extension request was approved by CMS in October 2008. The current waiver expires on June 30, 2011.

In February 2009, the SCHIP §1115 MinnesotaCare Demonstration was terminated and caretaker adults from 100 to 200 percent of FPG were permanently transitioned into the PMAP+ §1115 waiver.

1.2 Medical Assistance Program

Minnesota, through its Department of Human Services (DHS), administers the Medical Assistance (MA) Program under Title XIX of the Social Security Act. The program covers health care services that address acute, chronic and long-term care needs for over 600,000 residents. Eligibility requirements for the program are set forth in the State's Medicaid plan, five 1915(c) home and community-based waivers, this §1115 PMAP+ waiver, the Minnesota SeniorCare §1915(b) waiver and other federal waivers under §1115, §1915(a), and §1915(b).

1.3 MinnesotaCare Program

MinnesotaCare is a state and federally-funded program that primarily covers acute care services for approximately 140,000 uninsured Minnesotans. Minnesota receives federal financial participation for infants, children, and pregnant women enrolled in the MinnesotaCare Program as part of the PMAP+ §1115 Waiver. Coverage for this population is equivalent to MA coverage under Minnesota's Medicaid state plan. Minnesota also receives FFP for parents and caretaker adults enrolled in MinnesotaCare. Coverage for this group differs from state plan coverage. Minnesota covers adults without children in MinnesotaCare, but receives no FFP for these individuals. Coverage for this group differs from state plan coverage.

To be eligible for MinnesotaCare, individuals must not otherwise be insured for four months prior to application and must not have had access to employer-subsidized insurance coverage from a current employer for 18 months prior to application. Enrollees pay a premium for MinnesotaCare

coverage based on a sliding scale related to family income and family size. MinnesotaCare enrollees receive coverage through prepaid managed care organizations (MCOs).

1.4 MA and MinnesotaCare Purchasing

Minnesota purchases services for MA and MinnesotaCare recipients in accordance with the state plan, this §1115 waiver, and §1915(b) and §1915(c) waivers. Currently, this includes:

- PMAP+ §1115 Waiver
- State Plan managed care option under §1932(a).
- Fee-for-service purchase of services under the state plan.
- Mandatory managed care under §1915(b) waiver for most seniors enrolled in Medicaid.
- Comprehensive, risk-based managed care, authorized under §1915(a) of the Social Security Act, for dually eligible Medicare and Medicaid recipients who voluntarily enroll with an MCO for Medicare and Medicaid coverage. This purchasing model includes both acute and certain long term care services.
- Consolidated Chemical Dependency Treatment Fund §1915(b) waiver for non-PMAP enrollees.
- §1915(c) waivers for people at risk of requiring institutional care.

1.41 PMAP Purchasing

PMAP is a prepaid, capitated managed care service delivery mechanism that is currently operating statewide. For most individuals managed care is authorized under a §1932 state plan managed care option. Participating MA recipients are required to choose a participating health plan and then receive all health care services, including Medicare copays and deductibles, through the MCO (except home and community-based waiver services; nursing facility services (NF) beyond 90 days; intermediate care facility services for people with mental retardation (ICF/MR); abortion services; targeted case management services; and residential rehabilitative services for children with severe emotional disturbance).

Managed care is an organized and coordinated health care system that includes preestablished provider networks and payment arrangements; administrative and clinical systems for utilization review, quality improvement, patient and provider services; and comprehensive or targeted management of health services.

1.42 MinnesotaCare Purchasing

Most services for MinnesotaCare recipients are purchased through comprehensive managed care organizations on a prepaid, capitated basis. Services for a period of retroactive coverage are purchased on a fee-for-service basis.

Section Two Demonstration Design and Overview

This section outlines those provisions of the Act the State is requesting to be waived, and describes how these waivers affect operation of the programs and how they are implemented. Section Seven summarizes the previously approved waiver and expenditure authorities currently in place that the State wishes to continue, along with additional authority the State is requesting for the period of this extension.

2.1 Managed Care Provisions

2.11 Mandatory Enrollment of Exempt Groups

The State mandates enrollment of several MA eligible groups who are exempt from mandatory enrollment under the managed care regulations at 42 CFR 438.50(d), namely, Medicare and Medicaid dual eligibles under 65 years who are not using a disabled basis of eligibility, American Indians who are members of federally recognized tribes; children in foster care or other out-of-home placements, children receiving Title IV-E adoption assistance, and children under age19 receiving Title V services.

2.12 American Indians

Out-of-network services. DHS has consulted with tribal governments to develop an approach to MA purchasing for American Indian recipients that is different from the remainder of the MA program, in order to address issues related to tribal sovereignty, the application of federal provisions that prevent Indian Health Services (IHS) facilities from entering into contracts with MCOs, and other issues that have posed obstacles to enrolling American Indian/Alaska Native MA recipients into PMAP.

American Indian MA recipients, whether residing on or off a reservation, have direct access to out-of-network services at IHS or 93-638 (IHS/638) facilities. DHS purchases these out-of-network services on a FFS basis using payment rates negotiated between IHS and CMS, except when a 93-638 facility elects to receive the standard MA rate.

Physicians at IHS and 93-638 facilities may to refer recipients to specialists within the MCO's network. Enrollees may not be required to see their MCO primary care provider prior to accessing the referral specialist.

Marketing, education, and enrollment. The State consults with tribal governments before approving marketing materials that target American Indian recipients. Certificates of coverage (COC) include a description of how American Indian enrollees may directly access IHS/638

providers, and how they may obtain referral services. The State consults with tribal governments prior to approving the COC.

MCOs will provide training and orientation materials to tribal governments upon request, and will make training and orientation available to interested tribal governments. Tribal governments may assist the State in presenting or developing materials describing various MCO options to their members. If a tribal government revises any MCO materials, the MCO may review them. No MCO materials will be distributed until there is agreement between the MCO and Tribal government on any revisions.

Access. The MCO may not require any prior approval or impose any condition for an American Indian to access services at IHS/638 facilities. A physician in an IHS/ 638 facility may refer an American Indian recipient to an MCO participating provider for services covered by MA, and the MCO may not require the recipient to see a primary care provider within the MCO's network prior to the referral. The participating provider may determine that services are not medically necessary.

2.13 Medical Education and Research Costs (MERC)

MA payments for the costs of medical education related to managed care enrollment are removed from the capitation payments to the MCOs under PMAP and directed to a medical education trust fund for direct distribution to teaching entities. The State has established this medical education and research trust fund through the Minnesota Department of Health.

2.14 Higher Premium Structure

The PMAP+ waiver permits premiums that are higher than would be permissible under Medicaid to be charged to MinnesotaCare applicants and enrollees. The premium structure is described in Section 3.3.

2.2 Eligibility and Coverage Provisions

2.21 MinnesotaCare Expansion Populations

Effective July 1, 1995, expenditures for pregnant women and children under the age of 21 with income up to 275 percent FPG enrolled in MinnesotaCare became eligible for federal financial participation (FFP) as a part of Minnesota's expanded Medicaid Program.

Effective February 27, 1999, expenditures for parents and caretaker adults enrolled in

MinnesotaCare became eligible for FFP. Minnesota began claiming FFP for parents and caretaker adults with income at or below 175 percent of FPG for services provided on or after March 1, 1999. For parents and caretaker adults with income above 175 percent of FPG and at or below 275 percent of FPG, Minnesota began claiming FFP for services provided on or after January 1, 2001. Effective July 1, 2003 the gross income standard for parents and caretaker adults was amended to the lesser of 275 percent of FPG or $50,000. In 2008 the Minnesota Legislature increased the gross income standard for parents and caretaker adults to the lesser of 275 percent of FPG or $57,500.[1]

2.22 Coverage for Pregnant Women

Rather than requiring multiple eligibility determinations for qualified pregnant women, medically needy pregnant women, and categorically needy pregnant women, MA eligibility for all pregnant women is determined using an income standard of 275 percent of the FPG, with no asset test. Eligibility continues until the end of the month in which 60 days post-partum occurs. A woman must provide medical verification of her pregnancy within 30 days of enrollment as a pregnant woman.

Coverage for all pregnant women consists of the full MA benefit set for a qualified pregnant woman in accordance with §1902(a)(10)(A)(i)(III).

2.23 Children Under Age Two

MA eligibility for children age one and under age two is determined using an income standard of 275 percent of FPG with no asset test. This waiver extends the income standard of 275 percent of FPG that is applied to children under age one under the state plan, to include children under age two. This is an expansion of coverage under the state plan for children up to age one who would otherwise be eligible at 133 percent of FPG. This provision improves access to postnatal and early childhood health care.

2.3 Administrative Simplification

2.31 Elimination of Certain Six-Month Income Reviews

Six-month income reviews for medically needy MA recipients with only unvarying, unearned income or excluded income were discontinued in July 2001. This provision applies to medically needy recipient households who have only unvarying, unearned

[1] MINNESOTA LAWS 2008, Chapter 358, Article 3, Section 6. Effective July 1, 2010 or upon Federal approval, whichever is later.

income is defined as income from a source other than employment or self-employment that can reasonably be anticipated to be the same amount every month and for which changes, such as periodic cost-of-living increases, can be anticipated. Examples of this type of income include SSDI, Reemployment Insurance (Unemployment Compensation), veterans' disability payments, and private pensions. Data matches currently exist to allow direct verification of SSDI, SSI, and Reemployment Insurance. The State hopes to develop additional matches with other sources such as the Veterans Administration.

This provision also applies to medically needy recipient households whose sole income is from a source excluded from consideration by law. Examples include federally excluded payments such as certain tribal payments, German war reparations, WIC benefits, and earnings of a minor household member who is a full-time student.

For these two groups, income reported at the time of application or annual review is projected for 12 months. The amount of income reported is assumed to be the same unless the recipient notifies the local agency of a change. The State uses data matches where available to monitor and verify changes. Although income reports are not required, cases with spenddowns are reviewed every six months to insure that the recipient continues to have sufficient medical expenses to meet the spenddown.

2.32 Different Definition of "Family"

Under this waiver, the term family is defined differently between MinnesotaCare and MA. For MinnesotaCare eligibility, "family" means a parent or parents and their children; or guardians and their wards who are children; and grandparents, foster parents and relative caretakers residing in the same household; and includes children temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. "Family" also means an emancipated minor and an emancipated minor's spouse.

In general, families cannot choose to enroll only certain uninsured members in MinnesotaCare. Parents who enroll in MinnesotaCare must enroll all eligible children in MinnesotaCare or Medical Assistance, unless other insurance is available. If one child in a family is enrolled, all children must be enrolled unless other insurance is available. Children may be enrolled in MinnesotaCare even if their parents do not enroll. In families that include a grandparent, relative caretaker, foster parent or legal guardian, the grandparent, relative caretaker, foster parent or legal guardian may apply as a family or may apply separately for the children.

2.33 Different Income Methodology and Deeming Requirements

Under this waiver, income for MinnesotaCare is determined using a different methodology than that used for MA eligibility. The MinnesotaCare income methodology is summarized at Section 3.11.

2.34 Four-Month Penalty for Voluntary Terminations

A MinnesotaCare enrollee who voluntarily disenrolls or who is disenrolled for failure to pay the required premium is not eligible to reenroll until four calendar months after the date coverage terminates unless the person demonstrates good cause for voluntary termination or nonpayment and pays the unpaid premium for any month in which coverage was provided. The four-month penalty is not applicable to children under age two or pregnant women.

Section Three MinnesotaCare Eligibility and Coverage

3.1 General Eligibility Requirements

An applicant or enrollee must meet the MinnesotaCare eligibility requirements in items A to J:

A. Be a resident of Minnesota in accordance with 42 CFR §435.403 for children, pregnant women, and parents and caretaker adults.

B. Not currently have other health coverage nor have had other health coverage during the four months immediately preceding the date coverage begins. Medical Assistance and the Civilian Health and Medical Program of the Uniformed Service, TriCare, formerly known as CHAMPUS, are not considered insurance or health coverage for the purposes of this item.

C. Not have current access to employer-subsidized health coverage, and employer-subsidized health coverage has not been lost due to:

(1) the employer terminating coverage during the 18 months immediately preceding the date coverage begins, except that this provision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit during the period prior to reapplication, or

(2) the employee failing to take up coverage offered by the employer during an open enrollment period within the preceding 18 months.

D. Identify potentially liable third-party payers and assist DHS in obtaining third party payments.

E. Have gross annual family income that does not exceed 275 percent of FPG or, for parents and caretaker adults, that does not exceed the lesser of 275 percent of FPG or $57,500.[2]

F. For those adults subject to an asset test, not have assets that exceed the requirements in Section 3.12.

G. Comply with the family enrollment requirements in Section 3.13.

[2] Ibid.

H. Cooperate with the child and medical support requirements of the state Medicaid plan.

I. Not be a resident of a correctional or detention facility.

J. Be a United States citizen or an immigrant who can obtain a social security number and who has permission to remain in the United States permanently.

3.11 Gross Annual Family Income

"Gross annual family income" means the total non-excluded income of all family members determined in accordance with items A to E:

A. The income of self-employed people is calculated in accordance with subitems (1) and (2).

(1) The net profit or loss reported on the applicant or enrollee's federal income tax form for the previous year is summed with the depreciation, carryover loss, and net operating loss amounts.

In the case of self-employed farmers, adjusted gross income from the applicant or enrollee's federal income tax form for the previous year is used.[3]

(2) If the applicant or enrollee reports that income has changed since the period of their last tax return, income is calculated using documentation such as business records or quarterly tax reports.

B. Earned income is calculated in accordance with subitems (1) and (2).

(1) The income of wage earners, including all wages, salaries, commissions, and other benefits received as monetary compensation from employers before any deduction, disregard, or exclusion, is calculated by determining:

(a) Income from the last 30 days.

(b) If the wage earner is employed on a seasonal basis or receives income too infrequently or irregularly to be calculated under subitem (1), total income for the past twelve months.

(c) The earned income of full-time and part-time students under age 19 is not

[3] MINNESOTA LAWS 2009, Chapter 79, Article 5, Section 79. Effective July 1, 2009 or upon federal approval, whichever is later.

counted as income.

(d) Effective July 1, 1999 federal or state tax rebates are not counted as income or assets.

(2) When an applicant or enrollee reports that earned income has changed from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

C. Unearned income is calculated in accordance with subitems (1) and (2).

(1) The following unearned income received in the preceding tax year, with any reported changes, is projected to reflect a 12-month period:

(a) supplemental security income under title XVI of the Social Security Act;

(b) social security benefits;

(c) veterans' administration benefits;

(d) railroad retirement benefits;

(e) unemployment benefits;

(f) workers' compensation benefits;

(g) child support;

(h) spousal maintenance or support payments; and

(i) income from any other source, including interest, dividends, and rent.

(2) When an applicant or enrollee reports that unearned income has changed from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

(3) Lump sums are only counted as income for people who are self-employed if claimed as income on the tax return.

D. For applicants and enrollees who are not citizens and whose sponsor signed an affidavit of support as defined under United States Code, Title 8, Section 1183a, their sponsor's income as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Title IV, Public Law Number 104-193 will be included as gross family

income to the same extent sponsor deeming applies in the Medical Assistance program.[4]

E. If the grandparent, relative caretaker, foster parent or legal guardian applies separately for the children, only the children's income is counted. If the grandparent, relative caretaker, foster parent or legal guardian applies with the children, the adult's income is counted in determining gross family income.

F. Payments made to victims under the Catastrophic Survivor Compensation Fund are not counted as income in determining gross family income.[5]

3.12 Assets

"Assets" means cash and other personal property, as well as any real property, that a family owns that has monetary value. "Net asset" means the asset's fair market value minus any encumbrances including but not limited to, liens and mortgages. Adult applicants and enrollees, except pregnant women, must meet the following asset limits:

A. A household of one person must not own more than $10,000 in total net assets.

B. A household of two or more persons must not own more than $20,000 in total net assets.

C. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination.

D. Adult applicants and enrollees who are not citizens and whose sponsor signed an affidavit of support must count their sponsor's assets when determining eligibility. This request does not apply to pregnant women.

E. The value of assets that are not considered in determining eligibility for MinnesotaCare for families and children is the same as the value of assets that are not considered in determining eligibility for Medical Assistance, with the following exception: the value of workers compensation settlements are not considered in determining assets for MinnesotaCare.[6]

F. Business assets must be disclosed to the local agency at the time of application and renewal and verified upon request of the local agency.[7]

[4] MINNESOTA LAWS 2009, Chapter 79, Article 5, Sections 24 and 58. Effective July 1, 2010 or upon Federal approval, whichever is later.

[5] MINNESOTA LAWS 2008, Chapter 370, Section 10 and Chapter 338, Section 1. Retroactive from May 9, 2008.

[6] MINNESOTA LAWS, 2009, Chapter 79, Article 5 Section 17.

[7] Ibid.

G. MA and MinnesotaCare applicants and enrollees who are self-employed must segregate liquid assets excluded under the $200,000 exclusion for capital or operating assets of a trade or business.[8]

3.13 Family Enrollment

A. Parents who enroll in MinnesotaCare must enroll any eligible children in MinnesotaCare or Medical Assistance.

B. Unless other insurance is available, children may be enrolled in MinnesotaCare even if their parents do not enroll.

C. If one parent in a household enrolls in MinnesotaCare, both parents in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

D. If one child in a family is enrolled in MinnesotaCare, all children in the family must be enrolled in MinnesotaCare or Medical Assistance unless other insurance is available.

E. If one spouse in a household is enrolled in MinnesotaCare, the other spouse in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

F. Except as provided in item B, families cannot enroll only some uninsured members in MinnesotaCare.

G. In families that include a grandparent, relative caretaker, foster parent or legal guardian, the grandparent, relative caretaker, foster parent or legal guardian may apply as a family or may apply separately for the children.

3.14 Annual Redetermination

DHS redetermines eligibility annually for each MinnesotaCare enrollee. Enrollees must provide the information needed to redetermine eligibility annually, before the anniversary date of initial eligibility. The 12-month period begins the month after the application is approved.

[8] Ibid.

3.15 Annual Redeterminations for MinnesotaCare Children[9]

MinnesotaCare children in families with income equal to or below 275 percent of FPG who fail to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible. DHS will use any means available to verify family income. If it is determined that there has been a change in income and that a premium payment is required to remain enrolled DHS will notify the family of the new premium payment and that the children will be disenrolled if the premium payment is not received timely. If the new premium payment is not received, the children will be disenrolled effective the first day of the calendar month following the calendar month for which the premium is due.

3.16 Reporting Changes

Enrollees must report to DHS any changes that affect eligibility such as changes in income, access to employer sponsored insurance, changes in household composition, and changes in assets.

3.17 Continuous Eligibility

An enrollee remains eligible for MinnesotaCare as long as the enrollee:

A. Maintains residency in Minnesota;

B. Has annual income that is equal to or less than 275 percent of FPG and, for non-pregnant adults, is less than $57,500.[10]

D. Meets all other eligibility criteria; and

E. Is continuously enrolled in MinnesotaCare or Medical Assistance. To be continuously enrolled, an enrollee's re-application must be received by DHS before the last day of the first calendar month following the date of notice of termination of coverage from MinnesotaCare or Medical Assistance.

[9] MINNESOTA LAWS 2009, Chapter 79, Article 5, Section 62. Effective July 1, 2009 or upon Federal approval, whichever is later.

[10] MINNESOTA LAWS 2008, Chapter 358, Article 3, Section 6. Effective July 1, 2010 or upon Federal approval, whichever is later.

3.2 Exceptions to General Eligibility Requirements

3.21 MinnesotaCare Rolling Month Eligibility

Except for children identified in paragraph Section 3.15, MinnesotaCare enrollees who fail to submit renewal forms remain eligible for an additional month before being disenrolled. The enrollee remains responsible for the MinnesotaCare premium for the rolling month.[11]

3.22 Individuals who Receive a COBRA Premium Subsidy from the State[12]

Individuals and their qualified family members who are eligible for the 65 percent COBRA continuation premium subsidy for health care coverage under the American Recovery and Reinvestment Act of 2009 may also be eligible for a state premium subsidy. Any individual who receives a state premium subsidy under this provision is exempt from the insurance barrier described at Section 3.1, item B if the individual or the individual's qualified beneficiaries apply for MinnesotaCare after the individual no longer receives COBRA continuation coverage.

3.23 Children in Families with Income At or Below 200 Percent of Federal Poverty Guidelines

A child who has been continuously enrolled in the Children's Health Plan (and subsequently in MinnesotaCare) or a child in a family with gross annual family income at or below 200 percent[13] of the federal poverty guideline is eligible for MinnesotaCare without regard to the insurance barriers at Section 3.1, items B and C as long as continuous enrollment is maintained from initial eligibility if the child:

A. meets the requirements under Section 3.1, items A and G; and

B. is not otherwise insured for the covered health services. A child is not otherwise insured for covered health services when subitems (1) or (2) or (3) apply:

   (1) the child lacks coverage in two or more of the areas listed in subitems (a) to (e):

[11] MINNESOTALAWS 2008, Chapter 358, Article 3, Section 9. Effective July 1, 2009 or upon Federal approval, whichever is later.

[12] MINNESOTA LAWS 2009, Chapter 79, Article 5, Section 78. Effective July 1, 2009 or upon Federal approval, whichever is later.

[13] MINNESOTA LAWS 2009, Chapter 79, Article 5, Sections 63, 64, 65, 68, 69. Effective July 1, 2009 or upon Federal approval, whichever is later.

(a) basic hospital coverage;

(b) medical-surgical coverage;

(c) major medical coverage;

(d) dental coverage;

(e) vision coverage; or

(2) coverage requires a deductible of $100 or more per person per year; or

(3) a child with a particular diagnosis lacks coverage because the child has exceeded the maximum coverage for that diagnosis or the policy of coverage excludes that diagnosis.

3.24 Children Residing in Foster Care or Juvenile Residential Correctional Facilities[14]

Any child who was residing in foster care or a juvenile residential correctional facility on the child's 18th birthday is, upon completion of an initial application for MinnesotaCare, automatically eligible for MinnesotaCare without regard to the income limits, insurance barriers, family enrollment requirements, and premium payments described in Sections 3.1 and 3.3. MinnesotaCare coverage begins the first day of the month following the date of termination from foster care or release from a juvenile residential correctional facility. Individuals must be contacted annually to ensure that they continue to reside in the state and are interested in continuing MinnesotaCare coverage. The first period of renewal begins the month the enrollee turns 21 years of age.

3.25 Transition from MA to MinnesotaCare for Children[15]

Additional Medical Assistance for Children Children age two through 18 years of age who are enrolled in Medical Assistance under the state plan and who become ineligible due to excess income will remain enrolled in Medical Assistance for two additional months in order to establish the MinnesotaCare premium, issue a premium notice, and complete the MinnesotaCare enrollment process.

Automatic Eligibility for MinnesotaCare Children who receive two additional months of Medical Assistance eligibility, as described above, who pay their MinnesotaCare premium, will be

[14] MINNESOTA LAWS 2009, Chapter 79, Article 5, Sections 55, 61, 62, 66. Effective July 1, 2009 or upon Federal approval, whichever is later.

[15] MINNESOTA LAWS 2007, Chapter 147, Article 13, Section 1, 2 , 3. Effective October 1, 2008 or upon Federal approval, whichever is later.

enrolled in MinnesotaCare and will remain eligible without regard to the eligibility criteria described in Section 3.1 (B), (C), (E) and (G) until the MinnesotaCare renewal.

These children will remain automatically eligible for the MinnesotaCare program for a period of up to 12 months. Children with other family members enrolled in MinnesotaCare will remain automatically eligible until the family's next scheduled renewal. Children with no other family members enrolled in MinnesotaCare will remain automatically eligible for 12 months, until the first MinnesotaCare renewal.

These children must continue to pay the MinnesotaCare premium to remain enrolled during the period of automatic eligibility.

To continue MinnesotaCare eligibility beyond renewal, these children must meet all MinnesotaCare eligibility criteria.

3.3 Premium Payments

Applicants and enrollees must pay a premium to enroll and to continue enrollment in MinnesotaCare. The amount of premium is based on the family's gross income. If a family reports income changes after enrollment, premiums are adjusted at the time the change is reported.

A. MinnesotaCare children with MinnesotaCare gross family income at or below 200 percent FPL may be charged no premiums.[16]

B. Applicants who demonstrate American Indian status may be charged no premiums.[17]

C. Enrollees pay a premium for MinnesotaCare coverage based on a sliding scale related to family size and income. For any family member not included under Item A, the amount is determined in accordance with premium tables that are updated annually in response to changes in federal poverty guidelines. Attachment A includes the table of MinnesotaCare premiums for SFY 2011 by income and family size.

D. Members of the military and their families who meet the eligibility requirements for MinnesotaCare upon eligibility determination made within 24 months following the end of the member's active tour of duty will have their premiums paid by DHS. The exemption lasts for 12 months. The effective date of coverage is the first day of the month following the month in which eligibility is approved.[18]

[16] MINNESOTA LAWS 2009, Chapter 79, Article 5, Sections 63, 64, 65, 68, 69. Effective July 1, 2009 or upon Federal approval, whichever is later.

[17] American Recovery and Reinvestment Act of 2009, Public Law 111-5, Section 5006.

[18] MINNESOTA LAWS 2007, Chapter 147, Article 5, Section 32, as amended by Minnesota Laws, 2010

3.31 Premium Payment Schedule

Applicants and enrollees must pay premiums on a monthly basis, unless they choose to make advance payments on a quarterly or semiannual basis.

3.32 Billing Notices

DHS mails monthly premium payment billing notices by the first day of the month preceding the month for which coverage will be provided. Enrollees who have made advance payments will receive monthly premium notices with no payment due.

3.33 Premium Payment Dates

A. An initial premium must be received by DHS within four months after the date on the applicant's first premium notice.

B. Subsequent monthly premiums must be received by DHS by the 15th of the month preceding the month for which the premium is paid.

3.34 Premium Payments Options

DHS may permit enrollees to pay premiums by check, credit card, recurring automatic checking withdrawal, one-time electronic transfer of funds, wage withholding (with the consent of the employer and the employee), or using state tax refund payments.

At application or re-application an applicant or enrollee may authorize DHS to collect funds from the applicant’s or enrollee’s state income tax refund for premium obligations. The applicant or enrollee may also authorize the commissioner to apply for the working family tax credit on behalf of the applicant or enrollee for payment of premium obligations.

Special Session, Chapter. 1, Article 24, Section 7. This provision expires June 30, 2010 unless expiration violates Federal law.

3.4 Application and Enrollment

3.41 Application Sources

Applicants may apply directly to DHS or through appropriate referral sources.

A. Appropriate referral sources include but are not limited to: eligible provider offices; local social service agencies; school district offices; public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches; community health offices; and WIC program sites.

B. Referral sources that accept applications must send applications to DHS within five working days after receipt.

C. A family member who is age 18 or over or an authorized representative may apply on an applicant's behalf.

3.42 Necessary Information for Eligibility Determination

Applicants must provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for Medical Assistance, including subitems A to G.

A. Social security number.

B. Household composition.

C. Availability of other health coverage, including access to employer-subsidized health coverage.

D. Gross annual family income.

E. Documentation of immigration status for applicants and enrollees who are not United States citizens.

F. Assets of parents and caretakers.

G. Any additional information needed by DHS to determine or verify eligibility.

3.43 Eligibility Determination Deadline

DHS determines an applicant's eligibility within 30 days after a complete application is received

by DHS.

3.44 Enrollment and Beginning of Coverage

A. An applicant is enrolled in MinnesotaCare on the date the following are completed:

(1) A complete application is received by DHS and the applicant is determined eligible.

(2) The initial premium payment is received by DHS.

B. Coverage begins the first day of the calendar month following the date of enrollment, except:

(1) Coverage for newborns is automatic and begins immediately from the moment of birth if the mother is enrolled.

(2) Coverage for eligible adoptive children of a family enrolled in MinnesotaCare begins on the first day of the month[19] of placement for the purpose of adoption.

(3) Coverage for other new members of an enrolled family begins the first day of the month following the month in which the change is reported.

(4) Coverage of enrollees who are hospitalized on the first day of the month following enrollment begins the day following the date of discharge from the hospital.

C. Coverage begins the first day of the calendar month for which the enrollee requests and pays for retroactive coverage, after meeting the following requirements:

(1) Must be a former MA enrollee.

(2) Must apply for MinnesotaCare within 30 days following termination of MA.

(3) Must return all requested MinnesotaCare verifications within 30 days of written request for verifications.

(4) Must be eligible for ongoing MinnesotaCare.

(5) Must pay the initial MinnesotaCare premium within 30 days of the initial premium billing.

[19] Technical amendment

(6) Must pay the optional premium for the retroactive months within 30 days of the optional premium billing.

3.45 Disenrollment

A. DHS will disenroll enrollees who fail to pay the required premium when due, unless the enrollee is pregnant or is a child under age two. A dishonored check is considered failure to pay the premium and the agency may demand a guaranteed form of payment to replace a dishonored check. Nonpayment of the premium results in disenrollment from the plan effective for the first day of the calendar month following the month for which the premium was due.[20]

B. If an enrollee who is pregnant fails to pay the premium, MinnesotaCare coverage continues to the last day of the month following the month of the 60th day post-partum.

C. If the premium is not paid for an enrollee who is a child under age two, MinnesotaCare coverage continues to the last day of the month following the month in which the child becomes two years of age.

D. MinnesotaCare enrollees who are members of the military and their families, may disenroll for good cause when one or more family members are called to active duty. The 4-month waiting period is eliminated.

3.46 Reenrollment

A. An enrollee who voluntarily terminates coverage from the program or who is disenrolled for failure to pay the required premium is not eligible to reenroll until four calendar months after the date coverage terminates unless the person demonstrates good cause for voluntary termination or nonpayment and complies with Sections 3.1 through 3.46.

B. The four-month penalty under Item A is not applicable to individuals under Section 3.35, items B, C and D.

C. Good cause for nonpayment does not exist if a person chooses to pay other family expenses instead of the MinnesotaCare premium.

D. Good cause for nonpayment and voluntary termination means, generally, circumstances that excuse an enrollee's failure to pay the required premium when due or voluntarily

[20] MINNESOTA LAWS 2008, Chapter 358, Article 3, Section 9. Effective July 1, 2009 or upon Federal approval, whichever is later.

terminating coverage, including circumstances such as:

(1) because of serious physical or mental incapacity or illness, the enrollee fails to pay the premium;

(2) the enrollee voluntarily disenrolls under the mistaken belief that other health coverage is available;

(3) the enrollee does not receive a regular source of income on which the enrollee has relied to pay the required premium.

E. DHS determines whether good cause exists based on the weight of the corroborative evidence submitted by the person to demonstrate good cause.

F. MinnesotaCare enrollees who are members of the military and their families, who voluntarily disenroll when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Income and asset increases reported at the time of reenrollment are disregarded until the renewal date.

G. For MinnesotaCare enrollees who are disenrolled under Section 3.45, item A and who reapply for MinnesotaCare, the unpaid premium will be waived.[21]

3.5 Coordination of MinnesotaCare and Medical Assistance

3.51 Medical Assistance Information

Information regarding Medical Assistance eligibility is provided to all applicants and enrollees.

3.52 Enrollee Eligibility for Medical Assistance

A. Enrollees may apply for and become eligible for Medical Assistance if they choose and if they meet the eligibility requirements for Medical Assistance.

B. MinnesotaCare premiums paid by an enrollee may be used as medical expenses to meet an income spenddown for Medical Assistance.

[21] MINNESOTA LAWS 2008, Chapter 358, Article 3, Section 9. Effective July 1, 2009 or upon Federal approval, whichever is later.

C. An enrollee who is determined eligible for Medical Assistance without a spend down and chooses to receive Medical Assistance instead of MinnesotaCare will be disenrolled from MinnesotaCare. MinnesotaCare coverage terminates the last day of the calendar month in which DHS receives notice of the enrollee's Medical Assistance eligibility.

3.6 Quality Control

3.61 Random Audits

Audits of MinnesotaCare eligibility are conducted annually as part of activities authorized under the MEQC pilot project. The State may also engage in additional random auditing activity to target and inform on more specific quality improvement measures.

3.62 Disenrollment

DHS disenrolls enrollees who fail to provide information required under Section 3.61. MinnesotaCare coverage terminates the last day of the calendar month following the month in which notice of cancellation is sent. People may reenroll after complying with this section and being determined eligible for MinnesotaCare.

3.7 MinnesotaCare Coverage

3.71 Covered Health Care Services for Pregnant Women and Children

For pregnant women and children under age 21, MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients. Chiropractic services covered under MinnesotaCare include medically necessary exams.[22]

3.72 Covered Health Care Services for Parent and Caretaker Adults

For parent and caretaker adults (except pregnant women), MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients, except that the services listed in (1) through (8) below are excluded, inpatient hospital services are limited for certain participants as described in (9) below, and chiropractic services are covered as described in (10)

[22] MINNESOTA LAWS 2009, Chapter 79, Article 5, Section 54. Effective January 1, 2010 or upon Federal approval, whichever is later.

below.[23]

(1) Services included in an individualized education plan.

(2) Private duty nursing services.

(3) Orthodontic services.

(4) Nonemergency medical transportation services.

(5) Personal care services.

(6) Targeted case management services.

(7) Nursing facility services.

(8) ICF/MR services.

(9) Inpatient Hospital Limit: MinnesotaCare Caretaker Adults (except pregnant women) with income above 215 percent of the FPL are subject to a $10,000 annual limit on inpatient hospitalization.

(10) Chiropractic services covered under MinnesotaCare include medically necessary exams.[24]

3.73 Covered Access Services

MinnesotaCare covers sign and spoken language interpreters who assist an enrollee in obtaining MinnesotaCare eligibility and covered services.

3.8 Cost-Sharing

3.81 Copayments

Children under age 21 and American Indians served by Indian health providers or receiving contract health services under a referral from an Indian health provider[25] who are enrolled in MinnesotaCare are exempt from copayments. For all other MinnesotaCare caretaker adults the following copayments apply:

[23] Ibid.
[24] Ibid.
[25] American Recovery and Reinvestment Act of 2009, Public Law 111-5, Section 5006.

- $3 Copayment Prescription Drugs
- $25 Copayment Eyeglasses
- $3 Copayment Nonpreventive Physician or Clinic visit, except mental health services
- $3.50 Copayment Non-emergency visits to a hospital-based emergency room

The copayments described above do not apply to chemical dependency treatment services per Minnesota Statutes, section 254B.02 or to copayments that exceed one day per provider for non-preventive visits, eyeglasses and non-emergency visits to a hospital-based emergency room.

3.82 Copayment Refund

Copayments totaling $30 or more, paid by a pregnant woman after the date the pregnancy is diagnosed, are refunded.

3.83 Premiums

The PMAP+ waiver permits premiums that are higher than would be permissible under Medicaid to be charged to MinnesotaCare applicants and enrollees. The premium structure is described in Section 3.3.

3.84 Third Party Liability

The third-party liability requirements of 42 CFR, Part 433, Subpart D apply in accordance with Minnesota's Medicaid state plan. Cost-effective group health insurance will not be purchased by MinnesotaCare, in accordance with the option afforded the State at §1906(a) of the Social Security Act. When the State provides, pays for, or becomes liable for covered health services, the State will have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollees, or to the enrollees' legal representatives, as a result of the occurrence that necessitated the payment for the covered health services.

Section Four Administrative Structure

Three state agencies have oversight responsibilities for some aspects of Minnesota's Medicaid program:

- Minnesota Department of Human Services (DHS)
- Minnesota Department of Health (MDH)
- Minnesota Department of Commerce (DOC)

In addition, counties play a significant role in administering some aspects of PMAP.

4.1 Department of Human Services' Role

DHS is the single state Medicaid agency responsible for purchasing health services for Medical Assistance (MA) and MinnesotaCare enrollees. DHS supervises administration of MA eligibility at the county level, administers the MinnesotaCare Program at the state level, purchases covered services, and provides for performance measurements and quality improvement of health care administration and service delivery for program enrollees.

Medical Assistance Eligibility. MA eligibility is supervised by DHS and is administered by local county agencies.

MinnesotaCare Eligibility. MinnesotaCare eligibility is primarily administered by DHS. Counties have the ability to choose to administer MinnesotaCare eligibility. Enrollees in those counties may choose between state or county administration for their application.

PMAP Purchasing. PMAP is administered by DHS. State PMAP administration includes the following functions:

- Contract negotiation and management
- Rate setting and financial management.
- Quality improvement, utilization review, and consumer satisfaction analysis.
- Program evaluation.
- Management of the appeals process.
- Oversight of the consumer education process.
- Health plan payment.
- Reporting to health plans (e.g., enrollment reports).
- Education of providers, health plans, advocates, and other interested groups.
- Coordination of the Office of Ombudsman and coordination of advocate activities.
- Coordination of the advocate network.
- Coordination with county project officers.

- Policy setting and dissemination.
- Promulgation of rules.

MinnesotaCare Purchasing. MinnesotaCare is administered by DHS.

Grievances and Appeals. The grievances and appeals process is available to PMAP and MinnesotaCare enrollees to resolve concerns about billing or access to medically necessary care. Enrollees may file a grievance or appeal with the MCO and may file a state fair hearing request through DHS. Enrollees may file a state fair hearing request at any time and are not required to exhaust remedies with the MCO prior to filing at the state. County advocates assist PMAP enrollees with these issues. The Office of Ombudsman for State Managed Health Care Programs assists PMAP and MinnesotaCare enrollees to resolve MCO service access and delivery issues.

4.2 Department of Commerce Role

The Department of Commerce is the state agency responsible for financial and solvency monitoring, regulation, rehabilitation, and liquidation of all health plans licensed or applying for licensure in Minnesota. The Insurance Division of the Department of Commerce is responsible for assuring policyholders are protected against financially unsound insurance companies, and from unfair and discriminatory business practices. Field examiners visit insurance companies to conduct on-site reviews of financial and operations records. Analysts study the data to evaluate the financial status of the companies. The commissioner may authorize additional investigations or take administrative actions when appropriate.

4.3 Department of Health Role

The Minnesota Department of Health provides consultation to the Department of Commerce on issues of health care, including medical necessity, quality of care, and access to care. The department operates programs in disease prevention and control, health promotion, community public health, environmental health, health care policy, and regulation of health care providers. The Minnesota Department of Health conducts triennial audits of HMO licensing requirements.

4.4 County Role

Counties are responsible for administering eligibility for MA. In some cases, counties also administer MinnesotaCare eligibility. County agencies are also responsible for the following PMAP administrative functions:

- Consumer education and recipient enrollment.
- Coordination of the program at the county level including training of county workers.

- Monitoring and evaluation of the program from the county's perspective.
- Program reporting to the county board and county advisory groups.
- Information and technical assistance on the program to county staff, community and provider organizations, and the general public.
- Identifying and responding to problem areas and problem cases.
- Providing input to DHS in the development of PMAP policy.
- Advocating for recipients who need assistance with accessing health care or with the appeal process.

In addition, counties have other health and human services responsibilities related to their role as the local public health, mental health, chemical dependency, and developmental disability authority.

4.5 Public and Stakeholder Involvement

On April 1, 2010 a letter was sent to all tribal chairs and tribal health directors requesting their comment on the Department's intent to submit a request to the Centers for Medicare & Medicaid Services for a renewal of the PMAP+ 1115 waiver. Opportunity for discussion and comment was also provided at the quarterly tribal health director's meeting on May 12, 2010. A request for public comment on the continuation of Minnesota's PMAP+ waiver was published in the *Minnesota State Register* on May 24, 2010. This comment period provided an opportunity for public and stakeholder input on the current program and plans for the PMAP+ waiver extension. Copies of the public notices are provided in Attachment B.

4.6 Managed Care Contract Development and Management

The Families and Children contract covers persons eligible for Medical Assistance (MA) under the age of 65 and all eligible persons in MinnesotaCare. Negotiations for a 12-month contract (January 1, 2010 – December 31, 2010) for Families and Children began in September 2009 and resulted in eight agreements with eight Managed Care Organizations (MCOs): Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health Systems, South Country Health Alliance and UCare Minnesota. Final contracts, rate setting methodologies and actuarial certifications were submitted to the CMS Regional office in December 2009 for approval.

4.61 MCO Service Areas.

For a graphic representation of the location of MCO service areas and for information about the number of plans under contract in each county for PMAP and MinnesotaCare, please refer to the

maps on the county link website at www.dhs.state.mn.us/Maps.

4.62 Contract Development

DHS managed care development staff are responsible for initiatives and ongoing tasks associated with managed care expansion and implementation activities. They meet with county boards and tribal and county health and human services directors to introduce the concept and details of Minnesota health care programs provided under managed care models, answer related questions, obtain input, and develop planning and implementation processes and time lines. Development staff conduct informational meetings to discuss managed care issues with health care providers, and post-implementation meetings for county and tribal staff and MCOs after new areas are enrolled in managed care to ensure a smooth transition for new counties.

Development staff are also responsible for working with counties engaged in planning for county-based purchasing and tribes planning to implement tribal-based purchasing. Staff provide information about parameters and requirements for these initiatives, as well as some technical assistance.

4.63 Contract Management

To assure continuation of effective and efficient contract monitoring while enhancing communications between DHS and the MCOs, designated staff are assigned to monitor individual MCOs for contract compliance, to initiate corrective action or breach of contract notices when necessary, and to act as primary contact persons for issues relating to the contract. Contract management staff also have responsibility for managing the integration of specific policy areas into managed care.

Service delivery issues identified through enrollee complaints and appeals, enrollee phone calls, providers, county staff, and state staff continue to be addressed as part of the contract monitoring plan. Staff meet regularly to discuss, revise, and update managed care issues and policies.

4.64 MCO Meetings

DHS staff meet bi-monthly with MCOs under contract. Discussion topics include issues raised by or about specific plans. In addition, staff use these meetings to keep MCOs informed about changes to federal or state laws and policies that will affect the plans' operations.

4.7 Managed Care Quality Improvement

4.71 Quality Improvement

To ensure that the level of care provided by each MCO meets acceptable standards, the State monitors the quality of care provided through an ongoing review of each MCO's quality improvement system, grievance procedure, service delivery plan, and summary of health utilization information.

4.72 Quality Strategy

The DHS quality strategy is developed in accordance with 42 CFR §438.202(a) and requires the State Medicaid agency to have a written strategy for assessing and improving the quality of health care services offered by MCOs. The quality strategy was developed to monitor and oversee the following publicly funded managed care Minnesota Health Care Programs:

- PMAP/PGAMC (Prepaid Medical Assistance Program/Prepaid General Assistance Medical Care Program)
- MinnesotaCare
- MSHO (Minnesota Senior Health Option)
- MnDHO (Minnesota Disability Health Option)
- Minnesota Senior Care and Minnesota Senior Care Plus

The quality strategy assesses the quality and appropriateness of care and service provided by MCOs for all managed care program enrollees.

It incorporates elements of current DHS/MCO contract requirements, Minnesota HMO licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care rules and regulations (42 CFR, Part 438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) is the core of DHS' responsibility to ensure the delivery of quality care and services in publicly funded managed health care programs. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCOs' compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the Annual Technical Report (ATR).

The quality strategy will evolve over time as the external quality review activities continue. DHS intends to review the effectiveness of the quality strategy. Significant future modifications will be published in the State Register to obtain public comment, presented to the Medicaid Citizen's Advisory Committee and reported to CMS. The current version of the quality strategy can be accessed on the DHS website at: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4538-ENG.

4.73 MCO Internal Quality Improvement System

MCOs are required to have an internal quality improvement system that meets state and federal standards set forth in the contract between the MCO and DHS. These standards are consistent with those required under state health maintenance organization (HMO) licensure requirements. The Minnesota Department of Health conducts triennial audits of the HMO licensing requirements.

4.74 External Review Process

Each year the state Medicaid agency must conduct an external quality review of the managed care services. The purpose of the external quality review is to produce the Annual Technical Report (ATR) that includes:

A. Determination of compliance with federal and state requirements,

B. Validation of performance measures, and performance improvement projects, and

C. An assessment of the quality, access, and timeliness of health care services provided under managed care.

Where there is a finding that a requirement is not met or only partially met, the MCO is expected to take corrective action to come into compliance with the requirement.

The external quality review organization (EQRO) conducts an overall review of Minnesota's managed care system. The EQRO's charge is to identify areas of strength and weakness and to make recommendations for change. Where the ATR describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The EQRO will follow up on the MCO's response to the areas identified in the past year's ATR. The Annual Technical Report is shared with all contracted MCOs and other interested parties. Completed EQR studies are published on DHS's web page for health care administration at www.dhs.state.mn.us and the ATR is available upon request.

The 2008 Medicaid and MinnesotaCare Satisfaction Survey was conducted and data collection was completed in June 2008. The public report is available on the DHS public web page.

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The annual survey results and report is published in May of each year, and

is available on DHS' public web page (www.dhs.state.mn.us) annually.

4.75 Consumer Satisfaction

DHS sponsors an annual satisfaction survey of public program managed care enrollees using the Consumer Assessment of Health Plan Survey (CAHPS©) instrument and methodology to assess and compare the satisfaction of enrollees with services and care provided by MCOs. DHS contracts with a certified CAHPS vendor to administer and analyze the survey. Survey results are published on the DHS web page at www.dhs.state.mn.us.

4.76 Data Warehouse and Executive Information System (EIS)

The EIS/Data Warehouse consists of all health care claim, provider and recipient data collected by DHS during the most recent seven years. The system is a powerful tool for accessing data and defining the inter-relationships of data elements. The system allows DHS staff and managers to review program efficiency and effectiveness in a more flexible and timely manner and allows program staff access to data during program development as well as program evaluation.

DHS continues to add and refine data coming from the MMIS and MAXIS computer eligibility systems, as well as to add other data that expands the scope of analytical parameters. DHS continues to make specialized models for specialized studies or interest areas, including the development of a specialized model to facilitate analysis and ensure completeness of encounter data from pre-paid health care organizations. DHS also continues to research availability of analytical tools and methodology to assist in health care analysis. Staff are evaluating report distribution mechanisms and are researching availability of software and methodology that would assist us in matching data between systems.

4.8 Advocacy and Ombudsman Activities

The grievances and appeals process is available to PMAP and MinnesotaCare enrollees who have problems accessing medically necessary care or have billing issues. Enrollees may file a grievance or appeal with the MCO and may file a state fair hearing through DHS. County advocates assist PMAP enrollees with these issues. The Office of Ombudsman for State Managed Health Care Programs assist PMAP and MinnesotaCare enrollees to resolve MCO service access and delivery issues.

4.81 MCO Grievance and Appeal Procedures

A PMAP or MinnesotaCare enrollee, or a provider acting on behalf of the enrollee, may file a grievance or an appeal with the MCO either orally or in writing. A grievance is an expression of dissatisfaction about any matter other than an action, including but not limited to, the quality of

care or services provided, or failure to respect the enrollee's rights. An appeal is a request for a review of an action, which means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part of payment for a service, the failure to provide services in a timely manner, the failure of the MCO to act within designated timeframes for grievances or appeals, or for a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right to obtain services outside the network.

The MCO must make a determination as expeditiously as an enrollee's health requires, but no later than ten days for an oral grievance, thirty days for a written grievance, and for appeals, no later than thirty days. An MCO may extend the timeframe for determination by 14 days if requested by the enrollee, or the MCO justifies both the need for more information and that the extension will be in the enrollee's best interest.

Enrollees also have the right to request a state fair hearing with DHS anytime during the grievance and appeal process. After a state fair hearing is filed, the hearing is scheduled within a few weeks. DHS' appeals referees conduct the hearing and an order is written within ninety days of either the date the enrollee filed an appeal with the MCO excluding the days it subsequently took the enrollee to file for the state fair hearing) or the date the request for the state fair hearing was filed, whichever is earlier. Enrollees may file a grievance or appeal with the MCO, file a state fair hearing with DHS, or file both procedures simultaneously. The MCO must comply with the decision in the state fair hearing promptly and as expeditiously as the enrollee's health condition requires.

If an enrollee files an appeal or a state fair hearing before either the date of the proposed action in the MCO's DTR notice or the MCO's determination of the grievance or appeal, the MCO may not reduce or terminate the service until ten days after a written determination is issued in response to the appeal, or a written decision is issued by the State in the state fair hearing supporting the MCO's action, or the enrollee withdraws the request for the appeal or the state fair hearing.

Enrollees also have the right to an independent external medical review of medical necessity determinations. The reviews are paid for by DHS, and reviewed as additional evidence in state fair hearings. DHS contracts with MAXIMUS – Center for Health Dispute Resolution (CHDR) for the independent external medical reviews.

There are two expedited processes, one for appeals and one for state fair hearings. If urgently needed care is denied by the MCO, the enrollee or their designated representative may request an expedited appeal through the MCO. The MCO is required to resolve and provide written notice for appeals as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request. The second expedited process is for state hearings. If the enrollee requests an expedited state fair hearing, the DHS referee will conduct the state fair hearing and render a decision within three working days, or a time period commensurate with the level of urgency involved, based on the individual circumstances of the case.

4.82 Grievance, Appeal and State Fair Hearing Notifications and Continuation of Services

PMAP enrollees receive a certificate of coverage (COC) from their MCO that provides a description of all grievance, appeal and state fair hearing rights and procedures available to enrollees, including the MCO's internal system for the grievance and appeal process, the availability of an independent external medical review through DHS, the right to a second medical opinion within the MCO, and the ability of grievances, appeals and state fair hearings to run concurrently. Phone numbers for the grievance and appeal procedures and instructions for accessing the state fair hearing process are also included in the MCO's COC and other enrollee materials. A notice describing grievance and appeal rights, and the right to tile a state fair hearing, is sent to each enrollee with their initial enrollment materials, each year at open enrollment and is included with the recipient notice that is sent whenever there are legislative changes to eligibility and/or covered services. County advocates and the DHS ombudsman also send the notice of rights each time an enrollee requests assistance with the grievance, appeal or state fair hearing process.

MCOs must notify the DHS ombudsman within three working days of the enrollee filing a written grievance or appeal and must include a copy of the grievance or appeal request. The MCO must also send a monthly electronic report of all written grievances and all appeals according to State specifications and a monthly summary report of oral grievances.

When services have been denied, terminated, or reduced (DTR), the MCO must notify the enrollee in writing of the action taken by the MCO in the DTR notice. The language used in the DTR notice must be prior approved by DHS and must include the following:

A. a clear detailed description in plain language of the basis for the negative action and the enrollee's rights;

B. the action the MCO has taken or intends to take and the reasons for it;

C. the type of service or claim that is being denied, terminated or reduced;

D. the specific federal or state regulations, or MCO policies, that require or support the action;

E. an explanation of the enrollee's right, or provider on behalf of the enrollee with enrollee's written consent, to file a grievance or appeal with the MCO, or state fair hearing with DHS, or both;

F. the process the enrollee must follow in order to exercise these rights;

G. the circumstances under which expedited determination is available for appeals and state fair hearings;

H. the enrollee's right to continuation of benefits;

I. the notice of rights;

J. the requirements and timelines for filing a grievance or appeal;

K. the right to seek an independent external medical review for consideration at state fair hearings;

L. a notice that translation into other languages is available upon request, translated in the languages specified in the MCO contract; and

M. a phone number at the MCO enrollees can call to obtain information about the DTR, including how to receive a translation of the notice.

A DTR notice must be provided ten days in advance of the MCO's decision to reduce or terminate the enrollee's ongoing medical services that an MCO provider (physician, osteopath, dentist, mental health professional, or chiropractor) has ordered. For standard and expedited authorizations that deny or limit services, notice must be provided as expeditiously as the enrollee's health condition requires, and must not exceed ten business days following receipt of the request for standard authorizations, and within 72 hours of the receipt of the request for expedited authorizations. The MCO may extend the timeframe by an additional fourteen days for resolution of standard or expedited authorizations if the enrollee or the provider requests the extension, or if the MCO justifies a need for additional information and how the extension is in the enrollee's interest.

4.83 County Advocates

Under Minnesota law, county advocates are required to assist enrollees in each PMAP county. The advocates assist enrollees to resolve PMAP MCO issues. When unable to resolve issues informally, the county advocates help PMAP enrollees to state their complaints and to make informed decisions in resolving a complaint. County advocates provide assistance in filing grievances through both formal and informal processes, and are available to assist in the appeal process, including attending appeal hearings. State ombudsmen and county advocates meet regularly to identify complaint and appeal issues and to cooperate in resolving problematic cases.

4.84 Ombudsman Activities

The ombudsman's office ensures enrollees receive medically necessary health care services

through the complaint and appeals process. The ombudsman's office also assists in resolving enrollee complaints regarding health care delivery and billing issues.

Section Five Evaluation

Please refer to Attachment C for an interim progress report on Minnesota's PMAP+ waiver evaluation for the current waiver period July 1, 2008 through June 30, 2011.

Please refer to Attachment D for Minnesota's proposed PMAP+ waiver evaluation design.

Section Six Case Load and Cost Estimates

The spreadsheet in Attachment E presents Minnesota's budget neutrality proposal for the PMAP+ waiver extension period of July 1, 2011 through June 30, 2014. The budget neutrality data includes proposed per member per month (PMPM) caps and expenditures for each of the four PMAP waiver expansion groups and total expenditures overall.

To arrive at the proposed limits for the waiver extension period, the PMPM limits for waiver year 2008-2009 have been set as the adjusted actual PMPM expenditures for that year. The PMPM limits for subsequent years have been set by applying the budget neutrality trend rates to the adjusted 2008-2009 limits. The budget neutrality trend rates are 6.95 percent and remain unchanged at the levels specified in the previous extension period.

Section Seven Waivers Requested to Implement PMAP+ Continuation

The following section summarizes the authorities sought for the period of this extension and the previously approved waiver and expenditure authorities currently in place to permit the demonstration project to function, as well as the Medicaid requirements that are currently not applicable to demonstration populations who are not otherwise eligible under the State plan.

7.1 Title XIX Waivers

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of provisions of the Act are in effect to enable Minnesota to carry out the PMAP+ demonstration:

1. Statewideness/Uniformity	**Section 1902(a)(l) as implemented by 42 CFR 431.50**

To the extent necessary to enable the State to provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas of the State.

2. Freedom of Choice	**Section 1902(a)(23) as implemented by 42 CFR 431.51**

To the extent necessary to enable the State to restrict the freedom of choice of providers for demonstration participants who are made eligible through the State plan.

3. Amount, Duration, and Scope	**Section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b)**

To the extent necessary to enable the State to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or on the absence of managed care arrangements, and to enable the State to provide a different benefit package to persons who elect to participate in MinnesotaCare than is being offered to the traditional Medicaid population.

4. Coverage /Benefits for Pregnant Women	**Section 1902(a)(10)(A)(i)(IV) in the matter after 1902(a)(10)(G)(Vll)**

To exempt the State from the requirement that it limit medical assistance to certain pregnant

women for services related to pregnancy and conditions that may complicate pregnancy.

5. Comparability of Eligibility Standards **Section 1902(a)(17)**

This waiver enables the State to perform annual income reviews for certain medically needy recipients who have only unvarying unearned income or whose sole income is from a source excluded by law, whereas other medically needy recipients are subject to 6-month income reviews.

6. Disproportionate Share Hospital (DSH) Payments **Section 1902(a)(13)(A), insofar as it incorporates 1923(c)**

To enable the State to reimburse uncompensated care, this waiver allows matching funds for expenditures for capitation payments for health coverage of adults ages 21 through 64 years, who are not pregnant and have no children, with family incomes at or below 250 percent of the FPL, up to the amount of the State's DSH allotment remaining after the DSH obligation under the State Plan has been satisfied. The DSH State Plan obligation is for payment add-ons for inpatient hospital services under the Medical Assistance fee for service program.[26]

7.2 Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) will be regarded as expenditures under the State's title XIX plan for the period of this extension.

1. Expenditures to permit Medicaid coverage to children age 1 with family incomes at or below 275 percent of the Federal poverty level (FPL) who would not be otherwise eligible for Medicaid.

2. Expenditures for MinnesotaCare coverage for children through age 20 at or below 200[27] percent of the FPL who (a) either would not be otherwise eligible for Medicaid under the State Plan or would be eligible under the State plan but who have elected not to apply under the State plan and (b) are not entitled to Medicare.

3. Expenditures for MinnesotaCare coverage for children through age 20 above 200[28] and at

[26] PMAP+ waiver amendment pending Federal approval.
[27] Ibid.
[28] Ibid.

or below 275 percent of the FPL who (a) either would not be otherwise eligible for Medicaid under the State Plan or would be eligible under the State plan but who have elected not to apply under the State plan, (b) are not entitled to Medicare, and (c) meet other eligibility criteria described in STC 19 and 20.

4. Expenditures for two months of additional Medical Assistance for children through 18 years of age who are enrolled in Medical Assistance under the State Plan and who become ineligible due to excess income.[29]

5. Expenditures for up to twelve months of MinnesotaCare coverage during a period of automatic MinnesotaCare eligibility for children who receive two months of Additional Medical Assistance, as described above, and who continue to pay their MinnesotaCare premium. During the automatic MinnesotaCare eligibility period, these children will be exempt from the MinnesotaCare insurance barrier requirements and the MinnesotaCare income limits. The length of the automatic MinnesotaCare eligibility period will be determined as follows: Children with other family members enrolled in MinnesotaCare will remain automatically eligible until the family's next scheduled renewal. Children with no other family members enrolled in MinnesotaCare will remain automatically eligible for 12 months, until the first MinnesotaCare renewal. These children must continue to pay the MinnesotaCare premium to remain enrolled during the period of automatic eligibility. To continue MinnesotaCare eligibility beyond renewal, these children must meet all MinnesotaCare eligibility criteria.[30]

6. Expenditures for MinnesotaCare coverage for caretaker adults of children who are eligible for Medicaid, SCHIP or MinnesotaCare with family incomes at or below 275 percent of the FPL or $57,500 per year[31] (whichever is lower), and who (a) either would themselves not be otherwise eligible for Medicaid under the State Plan or who would be eligible under the State plan but who have elected not to apply under the State plan, (b) are not eligible for Medicare, and (c) meet other eligibility criteria described in STC 19.

7. Expenditures for Medicaid for medically needy individuals who have unvarying unearned income or whose sole income is from a source excluded from consideration by law, to the extent that they would be ineligible under the State plan using a 6-month budget period instead of a 12-month budget period.

8. Expenditures for payments made directly to medical education institutions or medical providers and restricted for use to fund graduate medical education (GME) of the recipient institution or entity. In each Demonstration Year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC

[29] Ibid.
[30] Ibid.
[31] Ibid.

expenditures for SFY 2009. Except as specifically authorized in STC # 37, the State may not include GME as a component of capitation rates or as the basis for other direct payment under the State plan. This expenditure authority will be subject to changes in Federal law or regulation that may restrict the availability of Federal financial participation for GME expenditures.

9. Expenditures for Medicaid coverage to pregnant women described in section 1902(a)(10)(A)(i)(IV) of the Act, to the extent that services are provided that are in addition to services related to pregnancy and conditions which may complicate pregnancy.

10. Expenditures for MinnesotaCare coverage to pregnant women with incomes at or below 275 percent of the FPL, who would not otherwise be eligible for Medicaid or who would be eligible under the State plan but who have elected not to apply under the State plan.

11. Expenditures for Medicaid coverage to pregnant women with incomes at or below 275 percent of the FPL who would not otherwise be eligible for Medicaid.

12. Waiver of 1903(a)(1) of the Act, insofar as it incorporates 1923(c), to enable the State to reimburse uncompensated care by allowing federal DSH allotment matching funds for capitation payments for health coverage of adults ages 21 through 64 years, who are not pregnant and have no children, up to the amount of the State's DSH allotment remaining after the State Plan DSH obligation has been satisfied. The State Plan DSH obligation is for payment add-ons for inpatient hospital services under the Medical Assistance fee for service program.[32]

13. Waiver of section 1902(r)(2) as implemented by 42 CFR §435.601 requiring the use of resource methodologies for AFDC-related populations that are not more restrictive than in the former AFDC program, to permit the State to require applicants and enrollees who are self-employed to segregate liquid assets excluded under the $200,000 exclusion for capital or operating assets of a trade or business.[33]

7.3 Requirements Not Applicable to the Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the list below, shall apply to the expenditure authorities beginning August 11, 2008, through June 30, 2011. The list below is applicable to demonstrations participants receiving MinnesotaCare coverage who would not otherwise be eligible for Medicaid or who would be eligible under the State plan but who have elected not to

[32] Ibid.
[33] Ibid.

apply under the State plan. This list does not pertain to MA One Year Olds.

1. Cost Sharing **Sections 1902(a)(14) and 1916**

To enable the State to impose premiums and cost sharing that are above the limits in current Medicaid statutes.

2. Financial Responsibility/Deeming **Section 1902(a)(17)(D)**

To exempt the State from the limits on whose income and resources may be used in determining the eligibility of family members.

3. Methods of Administration: Transportation **Section 1902(a)(4), insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the State to not assure transportation to and from providers.

4. Eligibility Section **Section 1902(a)(10)(A)**

To the extent necessary to allow the State not to provide coverage until the first day of the month following an individual's first premium payment.

5. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow the State to not provide coverage for any time prior to the first of the month following an individual's first premium payment.

Section Eight Attachments

Attachment A	MinnesotaCare Premium Table
Attachment B	Public Notice Documents
Attachment C	Interim Progress Report on Minnesota's PMAP+ §1115 Waiver Evaluation
Attachment D	Minnesota's Proposed PMAP+ §1115 Waiver Evaluation Design
Attachment E	Budget Neutrality Spreadsheet