Minnesota Prepaid Medical Assistance Project Plus (PMAP+)
§1115 Waiver No. 11-W-0039/5

Demonstration Year 25
Annual Report
July 1, 2019 through June 30, 2020

Submitted to:

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services

Submitted by:

Minnesota Department of Human Services
540 Cedar Street
St. Paul, Minnesota 55164-0983

State of Minnesota
Department of Human Services

Table of Contents

ATTACHMENTS

FORWARD

As required by the terms and conditions approving §1115(a) waiver No. 11 -W-00039/5, entitled "Minnesota Prepaid Medical Assistance Project Plus (PMAP+)," this document is submitted to the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services as the annual report for the period of July 1, 2019 through June 30, 2020. This document provides an update on the status of the implementation of the PMAP + Program.

Introduction

Background

The PMAP+ Section 1115 Waiver has been in place for over 30 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care coverage through Medicaid funding for people with incomes in excess of the standards in the Medical Assistance program. On January 1, 2015, MinnesotaCare was converted to a basic health plan, under section 1331 of the Affordable Care Act. As a basic health plan, MinnesotaCare is no longer funded through Medicaid. Instead, the state receives federal payments based on the premium tax credits and cost-sharing subsidies that would have been available through the health insurance exchange.

The PMAP+ waiver also provided the State with longstanding federal authority to enroll certain populations eligible for Medical Assistance into managed care who otherwise would have been exempt from managed care under the Social Security Act. In December of 2014, CMS notified the Department of Human Services (DHS) that it would need to transition this portion of its PMAP+ waiver authority to a section 1915(b) waiver. Therefore, on October 30, 2015, DHS submitted a request to transfer this authority to its Minnesota Senior Care Plus section 1915(b) waiver.

During this process, DHS determined that continued waiver authority was unnecessary for all of the groups historically included under the PMAP+ waiver. Because of the state's updated eligibility and enrollment processes for Medical Assistance, some of these populations are no longer mandatorily enrolled into managed care. Instead, they can enroll in managed care on a voluntary or an optional basis.

Therefore, the amendment to the MSC+ 1915(b) waiver only sought to continue federal waiver authority to require the following groups to enroll in managed care:

- American Indians, as defined in 25 U.S.C. 1603(c), who otherwise would not be mandatorily enrolled in managed care;

- Children under age 21 who are in state-subsidized foster care or other out-of-home placement; and

- Children under age 21 who are receiving foster care under Title IV-E.

CMS approved the amendment to the MSC+ waiver on December 22, 2015 with an effective date of January 1, 2016.

PMAP+ Waiver Renewal

The PMAP+ waiver continues to be necessary to continue certain elements of Minnesota's Medical Assistance program. On February 11, 2016, CMS approved DHS's request to renew the PMAP+ waiver for the period of January 1, 2016 through December 31, 2020.

The current waiver provides continued federal authority to:

- Cover children as "infants" under Medical Assistance who are 12 to 23 months old with income eligibility above 275 percent and at or below 283 percent of the federal poverty level (FPL) (referred to herein as "MA One Year Olds");
- Waive the federal requirement to redetermine the basis of Medical Assistance eligibility for caretaker adults with incomes at or below 133 percent of the FPL who live with children age 18 who are not full-time secondary school students;
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility; and
- Fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

On June 29, 2020 a request to renew the PMAP+ waiver for an additional five year period was submitted to CMS.

Enrollment Information

Please refer to Attachment A for PMAP+ enrollment activity for the period July 1, 2019 through June 30, 2020.

Outreach and Marketing

Education and Enrollment

DHS uses a common streamlined application for Medical Assistance, MinnesotaCare and MNsure coverage. Medical Assistance and MinnesotaCare applicants have the option of applying online through the MNsure website or by mail with a paper application.

The MNsure website provides information on Minnesota's health care programs. The site is designed to assist individuals with determining their eligibility status for insurance affordability programs in Minnesota. The site provides a description of coverage options through qualified health plans, Medical Assistance and MinnesotaCare. It also provides information about the application, enrollment and appeal processes for these coverage options.

In-person assisters and navigators are also available to assist individuals with the eligibility and enrollment process through the MNsure website. MNsure has a navigator grantee outreach program that does statewide activities to help individuals with enrollment.

Applicants and enrollees who receive Medical Assistance through fee for service can call the DHS Member Help Desk for assistance with questions about eligibility, information on coverage options, status of claims, spenddowns, prior authorizations, reporting changes that may affect program eligibility, and other health care program information.

PMAP Purchasing

Coverage for a large portion of enrollees in Medical Assistance is purchased on a prepaid capitated basis. The remaining recipients receive services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities. DHS contracts with MCOs in each of Minnesota's 87 counties.

Additional Information Regarding Managed Care Plans the State Contracts With

The following information regarding the managed care plans the State contracts with to provide PMAP+ services is provided in accordance with item 28 of the special terms and conditions for the PMAP+ §1115 waiver.

28(a)(i) A description of the process for managed care capitation rate setting.

Minnesota uses both state-set rates and competitive bidding to arrive at appropriate rate ranges for the Families and Children contract. Rates continue to reflect the influence of both previous years bidding results and subsequent adjustments. For all areas, the actuaries consider factors including but not limited to health care inflationary trends, morbidity (changing age/illness of the population), and changes in benefits. The State then sets the rates using emerging MCO encounter, financial and other information at a level that meets budget projections and is expected to produce appropriate access and quality of care. The PMAP capitation rates are risk adjusted. The methodology for developing rate ranges was provided to all MCOs. MCOs had opportunity to review and respond to the methodology.

28(a)(ii) The number of contract submissions, the names of the plans, and a summary of the financial information, including detailed information on administrative expenses, premium revenues, provider payments and reimbursement rates, contributions to reserves, service costs and utilization, and capitation rate-setting and risk adjustments methods submitted by each bidder.

A graphic representation of the MCO service areas and information about the number of plans under contract in each county for PMAP and Minnesota Care can be found at Health Plan Service Areas.

28(a)(iii) Annual managed care plan financial audit report summary.

Attachment B contains a summary of the MCO audited financial statements for 2019, by public program product (PMAP, MinnesotaCare), including a comparison of medical and administrative expenses to premium revenue.

28(a)(iv) A description of any corrective action plans required of the managed care plans.

The Annual Technical Report (ATR) is an evaluation of MCO compliance with federal and state quality, timeliness and access to care requirements. The report is published on the DHS site at Managed Care Reporting. The report summarizes the results of the independent external quality review of Minnesota's publicly funded managed care programs. Chapter 3 of the ATR presents MCO-specific performance, including strengths, opportunities for improvement and

recommendations identified during the external quality review process. Chapter 4 of the ATR presents improvement recommendations from the previous year's external quality review and includes a discussion on how effectively each MCO addressed the recommendations. The Minnesota Department of Health's managed care licensing examination and the on-site triennial compliance assessment is used by the external quality review organization along with information from other sources to generate the ATR. The most recent results from the managed care licensing examinations and the triennial compliance assessment can be found on the Minnesota Department of Health web site at Quality Assurance and Performance Measurement.

PMAP Purchasing for American Indian Recipients

The Minnesota Legislature enacted a number of provisions, subsequently authorized by CMS, to address issues related to tribal sovereignty that prevent Indian Health Service (IHS) facilities from entering into contracts with MCOs, and other provisions that have posed obstacles to enrolling American Indian recipients who live on reservations into PMAP. The legislation allows American Indian beneficiaries who are enrolled in managed care to receive covered services under Medical Assistance through an IHS or other tribal provider (commonly referred to as "638s") whether or not these providers are in the MCO's network.

Contracts with MCOs include provisions designed to facilitate access to providers for American Indian recipients, including direct access to IHS and 638 providers. IHS and 638 providers may refer recipients to MCO-network specialists without requiring the recipient to first see a primary care provider. DHS has implemented the PMAP+ out-of-network purchasing model for American Indian recipients of Medical Assistance who are not residents of reservations.

Summary Data. The following is a summary of the number of people identified as American Indians who were enrolled in Medical Assistance during calendar year 2018.

Medical Assistance Enrollees who are American Indian Calendar Year 2019	
Families and Children	38,815
Disabled	4,583
Elderly	1,543
Adults with no Children	13,510
Total	58,451

Tribal Health Workgroup. The quarterly Tribal Health Workgroup was formed to address the need for a regular forum for formal consultation between tribes and state employees. The workgroup meets on a quarterly basis and is regularly attended by Tribal Health Directors, Tribal Human Services Directors, and representatives from the Indian Health Service, the Minnesota Department of Health and the Minnesota Department of Human Services. During the period of July 1, 2019 through June 30, 2020 (PMAP demonstration year 25) the work group met on August 22, 2019, November 21, 2019, and February 20, 2020. The agendas for each of these meetings are provided at Attachment C.

Operational and Policy Developments

There were no significant program developments or operational issues for populations covered under this waiver during the demonstration year ending June 30, 2020.

Budget Neutrality Developments

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10. DHS also provides quarterly budget neutrality status updates, including baseline and member months data, using the budget neutrality monitoring tool provided through the performance metrics database and analytics (PMDA) system.

Consumer Issues

County Advocates

Under Minnesota law, county advocates are required to assist managed care enrollees in each county. The advocates assist enrollees with resolving issues related to their MCO. When unable to resolve issues informally, the county advocates educate enrollees about their rights under the grievance system. County advocates provide assistance in filing grievances through both formal and informal processes, and are available to assist in the appeal or state fair hearing process. State ombudsmen and county advocates meet regularly to identify issues that arise and to cooperate in resolving problematic cases.

Grievance System

The grievance system is available to managed care enrollees who have problems accessing necessary care, billing issues or quality of care issues. Enrollees may file a grievance or an appeal with the MCO and may file a state fair hearing through DHS. A county advocate or a state managed care ombudsman may assist managed care enrollees with grievances, appeals, and state fair hearings. The provider or health plan must respond directly to county advocates and the state ombudsman regarding service delivery and must be accountable to the state regarding contracts with Medical Assistance funds.

Please refer to Attachment D for a summary of state fair hearings closed in quarters one through four of PMAP+ demonstration year 25.

Post Award Public Forum on PMAP+ Waiver

In accordance with the PMAP+ Special Terms and Conditions (STCs), paragraph 16, DHS holds public forums to provide the public with an opportunity to comment on the progress of the PMAP+ Demonstration.

DHS held a post award public forum on September 30, 2020 to provide the public with an opportunity to comment on the progress of the PMAP+ demonstration. The forum was held virtually via teleconference due to the social distancing requirements presented by COVID-19. A notice was published on the DHS Public Participation web site on August 28, 2020 informing the

public of the date, time and location of the forum. There were no members of the public in attendance at this forum. The next public forum is planned for the summer of 2021.

Quality Assurance and Monitoring

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

Quality Strategy

In accordance with 42 C.F.R. §438.202(a), the state's quality strategy was developed to monitor and oversee the quality of PMAP and other publicly funded managed care programs in Minnesota.

This quality strategy assesses the quality and appropriateness of care and services provided by MCOs for all enrollees in managed care. It incorporates elements of current MCO contract requirements, state health maintenance organization (HMO) licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 C.F.R. §438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) are at the core of DHS's quality strategy. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcomes of these quality improvement activities are included in the Annual Technical Report (ATR).

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 HMO licensure requirements. The Minnesota Department of Health conducts triennial audits of the HMO licensing requirements.

External Review Process

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

1) Determination of compliance with federal and state requirements,

2) Validation of performance measures, and performance improvement projects, and

3) 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, 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 charge of the review organization is to identify areas of strength and weakness and to make recommendations for change. Where the technical report 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 review organization follows up on the MCO's response to the areas identified in the past year's ATR. The technical report is published on the DHS website at Managed Care Reporting.

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 survey results are published annually and are available on the DHS website at Managed Care Reporting.

Consumer Satisfaction

DHS sponsors an annual satisfaction survey of public program managed care enrollees using the Consumer Assessment of Health Plans 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 website at Managed Care Reporting.

Comprehensive Quality Strategy

Minnesota's Comprehensive Quality Strategy is an overarching and dynamic continuous quality improvement strategy integrating processes across Minnesota's Medicaid program. The Comprehensive Quality Strategy includes measures and processes related to the programs affected by the PMAP+ waiver. Minnesota's Comprehensive Quality Strategy can be found on the DHS website at Quality Outcome and Performance Measures.

Demonstration Evaluation

The evaluation plan for the PMAP+ waiver period from January 1, 2015 through December 31, 2018 was initially submitted with Minnesota's PMAP+ waiver extension request in December of 2014. In May of 2016 the evaluation plan was revised to reflect the approved terms of our waiver with an end date of 2020 instead of the previous draft timeline which ended in 2018. The evaluation plan was updated in November 2016, and again in June 2017, to address CMS comments. In August 2017, CMS approved the PMAP+ evaluation plan. The PMAP+ STCs were updated to incorporate the approved evaluation plan as Attachment B of the STCs.

State Contact

The state contact person for this waiver is Jan Kooistra. She can be reached by telephone at (651) 431-2118, or email at jan.kooistra@state.mn.us.

PMAP+ enrollment activity for the period July 1, 2019 through September 30, 2019.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter September 30, 2019	Current Enrollees (as of data pull on November 4, 2019)	Disenrolled in Current Quarter (July 1, 2019 through September 30, 2019)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	60	54	40
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	2,625	2,641	961

Pregnant Women in a Hospital Presumptive Eligibility Period		
Eligibility Month	**Eligibility Year**	**Unique Enrollees**
July	2019	31
August	2019	46
September	2019	52

PMAP+ enrollment activity for the period October 1, 2019 through December 31, 2019.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter December 31, 2019	Current Enrollees (as of data pull on February 5, 2020)	Disenrolled in Current Quarter (October 1, 2019 through December 31, 2019)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	68	55	33
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	2,627	2,569	1,101

Pregnant Women in a Hospital Presumptive Eligibility Period		
Eligibility Month	**Eligibility Year**	**Unique Enrollees**
October	2019	48
November	2019	45
December	2019	40

PMAP+ enrollment activity for the period January 1, 2020 through March 31, 2020.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter March 31, 2020	Current Enrollees (as of data pull on May 5, 2020)	Disenrolled in Current Quarter (January 1, 2020 through March 31, 2020)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	67	63	35
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	2,686	2,787	828

Pregnant Women in a Hospital Presumptive Eligibility Period		
Eligibility Month	**Eligibility Year**	**Unique Enrollees**
January	2020	28
February	2020	36
March	2020	39

PMAP+ enrollment activity for the period April 1, 2020 through June 30, 2020.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter June 30, 2020	Current Enrollees (as of data pull on August 5, 2020)	Disenrolled in Current Quarter (April 1, 2020 through June 30, 2020)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	77	52	44
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	2,849	2,964	585

Pregnant Women in a Hospital Presumptive Eligibility Period		
Eligibility Month	**Eligibility Year**	**Unique Enrollees**
April	2020	26
May	2020	26
June	2020	41

2019 Health Plan Financial Summary
by Product (in thousands $)
Minnesota Public Programs Only

	BluePlus	HP	Itasca	Medica	Metropolit.	PrimeWest	South C.	Ucare	All Plans
PMAP									
Premium Revenues (line 8)	$1,589,396	$675,490	$38,789	($219)	$167,102	$174,347	$154,436	$1,161,490	$3,960,830
Medical/Hospital Expenses (line 18)	$1,415,387	$698,417	$37,486	$603	$156,065	$166,076	$146,830	$1,151,458	$3,772,321
Administrative Expenses (lines 20-21)	$183,259	$50,902	$3,107	($2)	$22,717	$12,658	$13,334	$85,798	$371,771
Member Months	3,589,763	1,508,146	80,362	-	253,655	398,556	361,488	2,653,071	8,845,041
PMPM - rev	$442.76	$447.89	$482.67		$658.78	$437.45	$427.22	$437.79	$447.80
PMPM - clms	$394.28	$463.10	$466.46		$615.26	$416.69	$406.18	$434.01	$426.49
PMPM - admin	$51.05	$33.75	$38.66		$89.56	$31.76	$36.89	$32.34	$42.03
MinnesotaCare									
Premium Revenues (line 8)	$166,161	$97,118	$3,886	($23)	$7,759	$16,076	$16,538	$137,297	$444,812
Medical/Hospital Expenses (line 18)	$139,891	$94,524	$3,945	($85)	$7,777	$15,909	$14,797	$123,535	$400,293
Administrative Expenses (lines 20-21)	$23,014	$7,416	$309	($0)	$1,187	$1,574	$1,377	$10,338	$45,215
Member Months	337,590	215,235	7,110	-	17,309	33,087	33,638	278,703	922,672
PMPM - rev	$492.20	$451.22	$546.55		$448.26	$485.88	$491.63	$492.63	$482.09
PMPM - clms	$414.38	$439.17	$554.83		$449.29	$480.82	$439.89	$443.25	$433.84
PMPM - admin	$68.17	$34.46	$43.50		$68.60	$47.57	$40.93	$37.09	$49.00
MSHO									
Premium Revenues (line 8)	$327,778	$153,003	$16,084	$451,727	$0	$67,624	$63,152	$516,287	$1,595,654
Medical/Hospital Expenses (line 18)	$291,876	$128,649	$14,975	$401,992	$0	$61,405	$54,242	$467,277	$1,420,416
Administrative Expenses (lines 20-21)	$22,903	$8,640	$1,272	$17,164	$0	$2,588	$3,938	$36,477	$92,982
Member Months	106,978	43,130	5,372	131,193	-	23,485	22,148	158,462	490,768
PMPM - rev	$3,063.97	$3,547.48	$2,993.98	$3,443.22		$2,879.46	$2,851.35	$3,258.11	$3,251.34
PMPM - clms	$2,728.37	$2,982.81	$2,787.58	$3,064.12		$2,614.66	$2,449.07	$2,948.83	$2,894.27
PMPM - admin	$214.09	$200.33	$236.81	$130.83		$110.20	$177.82	$230.20	$189.46
MSC+									
Premium Revenues (line 8)	$60,654	$44,622	$3,167	$85,573	$0	$12,639	$11,954	$133,916	$352,526
Medical/Hospital Expenses (line 18)	$57,623	$32,340	$2,721	$80,826	$0	$11,370	$10,387	$139,356	$334,623
Administrative Expenses (lines 20-21)	$6,439	$3,203	$233	$4,028	$0	$1,036	$772	$9,932	$25,643
Member Months	40,235	28,280	2,757	49,701	-	10,592	10,506	66,629	208,700
PMPM - rev	$1,507.50	$1,577.86	$1,148.66	$1,721.76		$1,193.27	$1,137.87	$2,009.87	$1,689.15
PMPM - clms	$1,432.16	$1,143.57	$987.03	$1,626.25		$1,073.42	$988.70	$2,091.52	$1,603.37
PMPM - admin	$160.03	$113.25	$84.69	$81.04		$97.82	$73.50	$149.06	$122.87
SNBC									
Premium Revenues (line 8)		$92,013		$200,333	$38,950	$32,191	$44,289	$502,719	$910,495
Medical/Hospital Expenses (line 18)		$90,834		$181,485	$33,264	$31,491	$40,709	$468,920	$846,702
Administrative Expenses (lines 20-21)		$6,393		$14,941	$4,474	$2,229	$3,053	$36,767	$67,857
Member Months		73,318		147,356	24,389	27,870	36,115	364,074	673,122
PMPM - rev		$1,254.98		$1,359.51	$1,597.02	$1,155.05	$1,226.34	$1,380.82	$1,352.64
PMPM - clms		$1,238.91		$1,231.61	$1,363.88	$1,129.92	$1,127.20	$1,287.98	$1,257.87
PMPM - admin		$87.20		$101.39	$183.45	$79.97	$84.55	$100.99	$100.81

Admin does not include PDRs

Attachment C

Tribal and Urban Indian Health Directors Meeting
SMSC – The Link Conference Center
2200 Trail of Dreams
Prior Lake, MN 55372

Thursday, August 22, 2019
9:00 am to 3:00 pm

9:00 – 10:30 a.m.
Opening Prayer/Invocation/Moment of Silence
Welcome and Introductions
Tribal Health Directors only

10:30 - 10:45 p.m. Break

10:45 – 12:30 p.m. DHS

10:45- 11:00 am Introduction of DHS Executive Leadership

11:00 – 11:15 a.m. Krista O'Connor Blue Ribbon Commission and Medical Services Committee

11:15- 11:45 am Governor Exec Order: Identification of priorities for DHS Legislative consideration discussion—what priorities do THD have? - Vern LaPlante, DHS Office of Indian Policy

11:45- 11:55 am Tribal Vulnerable Adult Summit
Jacob Day, DHS Office of Indian Policy

11:55 - 12:10 pm EIDBI / White Earth progrom
Nicole Berning – DHS, Medicaid Payment and Provider Services

12:10- 12:15 pm General updates (EAB/ METs, State Plan Amendments and Waivers, Etc.)
Linda Monchamp , Sam Mills, DHS Health Care Administration

12:30 – 1:00 p.m. Lunch Break – pay your own; everyone is welcome to stay and join us for lunch

1:00- 1:30 pm MDH Deputy Commissioner Margaret Kelly; AC Health Regulations, Marie Dotseth; Assistant Commissioner Health Protection Daniel Huff and Deputy Assistant Commissioner Health Promotion Deb Burns

1:30 – 2:00 pm IDEPC – Division Director
2018 STD/HIV Data Release
Hep A outreach and reported recent cases
Kris Ehresmann and staff

2:00 – 2:30 pm **Injury and Violence Prevention**
Opiate Overdose data report

2:30 – 2:45 pm **Children and Family Health**
Early Childhood/Prenatal Online Navigator
Adolescent Mental Health Clinic Screening QI Project

2:45 – 3:00 pm **Strengthening Tribal Public Health Infrastructure and Tribal State Data Workgroup and Meeting schedule and location for 2020 – Jackie Dionne**
Announcements – open to all

Other agencies

Tribal Health Directors 2019 Meeting Dates: Thursday, November 21

Agenda items for next meeting
Adjourn

Tribal and Urban Indian Health Directors Meeting
SMSC – The Link Conference Center
2200 Trail of Dreams
Prior Lake, MN 55372

QUARTERLY MEETING

Thursday, November 21, 2019
9:00 am to 3:30 pm
AGENDA

9:00 a.m.

Opening Prayer/Invocation/Moment of Silence
Welcome and Introductions

9:30 – 10:30 p.m.

MDH Commissioner Malcolm (confirmed) and DHS Commissioner Jodi Harpstead (to be invited)

10:30 to 12:30 pm

Medical Cannabis Data Report
Chris Tholkes

Suicide Prevention
Mark Kinde & staff

OSHII Tribal SHIP/Tobacco
Deb Burns, Kris Igo & Christine Smith

Syphilis Outbreak/Congenital Syphilis
IDEPC

Strengthening the Public Health Infrastructure
Deb Burns & Chelsie Huntley

12:30 – 1:00 p.m.

Lunch Break – pay your own; everyone is welcome to stay and join us for lunch

1:30 – 3:30 p.m.

State Plan Amendments and Waivers
Linda Monchamp

Update on VA Summit
Jacob Day

Update on Modernization Committee
Rhiannon Black Deer-Prago

Update on Consultation Summit Results
Vern La Plante

Blue Ribbon Commission and Medicaid Services Committee

Transportation?

Announcements – open to all

Tribal Health Directors 2020 Meeting Dates:

Agenda items for next meeting
Adjourn

Tribal and Urban Indian Health Directors Meeting
SMSC – The Link Conference Center
2200 Trail of Dreams
Prior Lake, MN 55372

QUARTERLY MEETING AGENDA
Thursday, February 20, 2020
9:00 am to 3:30 pm

9:00 a.m.

Opening Prayer/Invocation/Moment of Silence
Welcome and Introductions

9:30 – 11:30 p.m.

DHS Commissioner and/or Executive Leadership (invited – not confirmed)
MDH Commissioner and/or Executive Leadership (invited – confirmed)

11:30 to 12:30 pm

Tribal Program Highlighted

12:30 – 1:30 p.m.

Lunch Break – pay your own; everyone is welcome to stay and join us for lunch
Announcements – Open to all

1:30 – 3:30 p.m.

Housing Support DHS
HCBS Disparities Evaluation Project Blen Shoakena
Vulnerable Adult Summit
State Plan Amendments/Waivers – Linda Monchamp
Tribal Healthcare Policy Finance Workgroup
Tribal State Data Workgroup
21st Century Public Health Infrastructure Report
Tribal Overdose Fatality Review – Injury and Violence Prevention team
Children Cabinet – Infant and Maternal Mortality
CAIMH "Holding Spaces" Tribal Research – Mary Owen

Tribal Health Directors 2020 Meeting Dates:

Thursday, February 20, 2020 – THD and All
Friday, February 21, 2020 – THD only

Thursday, May 21, 2020 – THD and All
Friday, May 22, 2020 – THD only

Thursday, August 20, 2020 – THD and All
Friday, August 21, 2020 – THD only

Thursday, November 19, 2020 – THD and All
Friday, November 20, 2020 – THD only

Calendar Year 2019 3rd Quarter – Managed Care Ombudsman CMS Report

Table 1. State Fair Hearings Closed in Quarter 3 of 2019 by Metro and Non−Metro Areas

Area	n
Eleven County Metro Area	67
Non-Metro Area	32
Total	99

State Fair Hearings Closed in Quarter 3 of 2019 by Type, Service Category and Outcome

Table 2. Admin Type by Service Category and Outcome

Outcome	Dismissed	Health Plan prevailed	Resolved before hearing	State affirmed	Withdrawn	Total
Service Category	n	n	n	n	n	n
Health Plan Change	2		5	1	1	9
Restricted Recipient	3	3				6
Total	5	3	5	1	1	15

Table 3. Billing Type by Service Category and Outcome

Outcome	Dismissed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n
Chiropractic	1		1	2		4
DME-Medical Supplies		1		1		2
Dental			2		1	3
Emergency Room				1		1
Hospital				1		1
Nursing Facility				1		1
Pharmacy	1			1		2
Professional Medical Services	2		1	4		7
Transportation				1		1
Total	4	1	4	12	1	22

Table 4. Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n	n
Chiropractic					1		1
DME-Medical Supplies	1			4	2	2	9
Dental				4			4
Home Care	6	3	1	5	1	2	18
Pharmacy	5				10	1	16
Professional Medical Services		3		4	6		13
Transportation					1		1
Total	12	6	1	17	21	5	62

Table 5. Access Type by Service Category and Outcome

No values were returned for this table.

Table 6. Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	State affirmed	Withdrawn	Total
Service Category	n	n	n	n	n	n	n	n
Chiropractic	1			1	3			5
DME-Medical Supplies	1		1	4	3		2	11
Dental				6			1	7
Emergency Room					1			1
Health Plan Change	2				5	1	1	9
Home Care	6	3	1	5	1		2	18
Hospital					1			1
Nursing Facility					1			1
Pharmacy	6				11		1	18
Professional Medical Services	2	3		5	10			20
Restricted Recipient	3			3				6
Transportation					2			2
Total	21	6	2	24	38	1	7	99

2019 3rd Quarter – Managed Care Ombudsman CMS Report

Table 7. Summary of SFHs Closed in Quarter 3 of 2019 by Outcome

Outcome	n
Dismissed	21
Enrollee prevailed	6
HP Partially Upheld/Member Partially Denied	2
Health Plan prevailed	24
Resolved before hearing	38
State affirmed	1
Withdrawn	7
Total	**99**

Calendar Year 2019 4th Quarter - Managed Care Ombudsman CMS Report

Table 1. State Fair Hearings Closed in Quarter 4 of 2019 by Metro and Non−Metro Areas

Area	n
Eleven County Metro Area	76
Non-Metro Area	39
Total	115

State Fair Hearings Closed in Quarter 4 of 2019 by Type, Service Category and Outcome

Table 2. Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	Total
Service Category	n	n	n	n	n
Health Plan Change	2			2	4
Restricted Recipient	4	3	3	1	11
Total	6	3	3	3	15

Table 3. Billing Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n
Chemical Dependency	1					1
DME-Medical Supplies			1			1
Hospital				1	1	2
Mental Health		1				1
Nursing Facility					1	1
Professional Medical Services	1			2		3
Therapies/Rehabilitation				1		1
Transportation					1	1
Vision Services			1	1		2
Total	2	1	2	5	3	13

Table 4. Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n
DME-Medical Supplies	1	5	3			9
Dental			3	4	1	8
EW Services					1	1
Home Care	3	1	8	3	4	19
Hospital				1		1
Mental Health			1			1
Pharmacy	3		4	19		26
Professional Medical Services	4	3	4	5	2	18
Therapies/Rehabilitation			1			1
Transportation				1	1	2
Vision Services	1					1
Total	12	9	24	33	9	87

Table 5. Access Type by Service Category and Outcome

No values were returned for this table.

Table 6. Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
Service Category	**n**	**n**	**n**	**n**	**n**	**n**
Chemical Dependency	1					**1**
DME-Medical Supplies	1	5	4			**10**
Dental			3	4	1	**8**
EW Services					1	**1**
Health Plan Change	2			2		**4**
Home Care	3	1	8	3	4	**19**
Hospital				2	1	**3**
Mental Health		1	1			**2**
Nursing Facility					1	**1**
Pharmacy	3		4	19		**26**
Professional Medical Services	5	3	4	7	2	**21**
Restricted Recipient	4	3	3	1		**11**
Therapies/Rehabilitation			1	1		**2**
Transportation				1	2	**3**
Vision Services	1		1	1		**3**
Total	**20**	**13**	**29**	**41**	**12**	**115**

Table 7. Summary of SFHs Closed in Quarter 4 of 2019 by Outcome

Outcome	n
Dismissed	20
Enrollee prevailed	13
Health Plan prevailed	29
Resolved before hearing	41
Withdrawn	12
Total	**115**

Calendar Year 2020 1st Quarter - Managed Care Ombudsman CMS Report

Table 1. State Fair Hearings Closed in Quarter 1 of 2020 by Metro and Non−Metro Areas

Area	n
Eleven County Metro Area	94
Non-Metro Area	41
Total	135

State Fair Hearings Closed in Quarter 1 of 2020 by Type, Service Category and Outcome

Table 2. Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee Prevailed	Health Plan Prevailed	Resolved bf Hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n
Health Plan Change	3			2	3	8
Restricted Recipient	5	6	2	2	2	17
Total	8	6	2	4	5	25

Table 3. Billing Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan Prevailed	Resolved bf Hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n
Chemical Dependency	1		1			2
DME-Medical Supplies				1		1
Dental			1	1		2
Professional Medical Services	2	1	2		1	6
Total	3	1	4	2	1	11

Table 4. Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee Prevailed	HP Partially Upheld	Health Plan Prevailed	Resolved bf Hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n	n
Chiropractic							1
DME-Medical Supplies	3	2		5	4	3	17
Dental	2			7	4		13
EW Services						1	1
Emergency Room					1		1
Hearing Services				1			1
Home Care	8	3	3	6	4		24
Hospital					1		1
Pharmacy	3			6	5	4	18
Professional Medical Services	2	1		2	9	2	16
Therapies/Rehabilitation	1				1		2
Transportation	1						1
Urgent Care						1	1
Vision Services	2						2
Total	22	6	3	27	30	11	99

Table 5. Access Type by Service Category and Outcome

No values were returned for this table.

Table 6. Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld	Health Plan Prevailed	Resolved bf Hearing	Withdrawn	Total
Service Category	**n**	**n**	**n**	**n**	**n**	**n**	**n**
Chemical Dependency	1			1			**2**
Chiropractic					1		**1**
DME-Medical Supplies	3	2		5	5	3	**18**
Dental	2			8	5		**15**
EW Services						1	**1**
Emergency Room					1		**1**
Health Plan Change	3				2	3	**8**
Hearing Services				1			**1**
Home Care	8	3	3	6	4		**24**
Hospital					1		**1**
Pharmacy	3			6	5	4	**18**
Professional Medical Services	4	2		4	9	3	**22**
Restricted Recipient	5	6		2	2	2	**17**
Therapies/Rehabilitation	1				1		**2**
Transportation	1						**1**
Urgent Care						1	**1**
Vision Services	2						**2**
Total	**33**	**13**	**3**	**33**	**36**	**17**	**135**

Table 7. Summary of SFHs Closed in Quarter 1 of 2020 by Outcome

Outcome	n
Dismissed	33
Enrollee prevailed	13
HP Partially Upheld/Member Partially Denied	3
Health Plan prevailed	33
Resolved before hearing	36
Withdrawn	17
Total	**135**

Calendar Year 2020 2nd Quarter - Managed Care Ombudsman CMS Report

Table 1. State Fair Hearings Closed in Quarter 2 of 2020 by Metro and Non−Metro Areas

Area	n
Eleven County Metro Area	76
Non-Metro Area	35
Total	111

State Fair Hearings Closed in Quarter 2 of 2020 by Type, Service Category and Outcome

Table 2. Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee Prevailed	Health Plan Prevailed	Resolved bf Hearing	State Affirmed	Total
Service Category	n	n	n	n	n	n
Health Plan Change				7	3	10
Restricted Recipient	2	4	3			9
Total	2	4	3	7	3	19

Table 3. Billing Type by Service Category and Outcome

Outcome	Withdrawn	Total
Service Category	n	n
Vision Services	1	1
Total	1	1

Table 4. Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee Prevailed	HP Partially Upheld	Health Plan Prevailed	Resolved bf Hearing	Withdrawn	Total
Service Category	n	n	n	n	n	n	Number of SFHs
Chemical Dependency	1						1
Chiropractic				1			1
DME-Medical Supplies				3	2	1	6
Dental	2			7	3		12
EW Services	1			1			2
Home Care	5	5	1	6	3		20
Hospital	1				2		3
Interpreter Services						1	1
Mental Health					1		1
Pharmacy	2	3		1	16	2	24
Professional Medical Services	2	2		1	9	2	16
Therapies/Rehabilitation	1						1
Transportation				1			1
Vision Services					2		2
Total	15	10	1	21	38	6	91

Table 5. Access Type by Service Category and Outcome

No values were returned for this table.

Table 6. Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee Prevailed	HP Partially Upheld	Health Plan Prevailed	Resolved bf Hearing	State Affirmed	Withdrawn	Total
Service Category	**n**	**n**	**n**	**n**	**n**	**n**	**n**	**n**
Chemical Dependency	1							**1**
Chiropractic				1				**1**
DME-Medical Supplies				3	2		1	**6**
Dental	2			7	3			**12**
EW Services	1			1				**2**
Health Plan Change					7	3		**10**
Home Care	5	5	1	6	3			**20**
Hospital	1				2			**3**
Interpreter Services							1	**1**
Mental Health					1			**1**
Pharmacy	2	3		1	16		2	**24**
Professional Medical Services	2	2		1	9		2	**16**
Restricted Recipient	2	4		3				**9**
Therapies/Rehabilitation	1							**1**
Transportation				1				**1**
Vision Services					2		1	**3**
Total	**17**	**14**	**1**	**24**	**45**	**3**	**7**	**111**

Table 7. Summary of SFHs Closed in Quarter 2 of 2020 by Outcome

Outcome	n
Dismissed	17
Enrollee prevailed	14
HP Partially Upheld/Member Partially Denied	1
Health Plan prevailed	24
Resolved before hearing	45
State affirmed	3
Withdrawn	7
Total	**111**