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

Demonstration Year 26

Third Quarter Report
January 1, 2021 through March 31, 2021

Submitted to:

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

Submitted by:

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LIST OF 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 third quarter report for the period of January 1, 2021 through March 31, 2021. 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. On December 21, 2020, CMS approved a temporary extension of the PMAP+ waiver through December 31, 2021 in order to allow the state and CMS to continue working together on approval of the extension of this demonstration.

Enrollment Information

Please refer to the table below for PMAP+ enrollment activity for the period October 1, 2020 through December 31, 2020.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter March 31, 2021	Current Enrollees (as of data pull on May 3, 2021)	Disenrolled in Current Quarter (January 1, 2021 through March 31, 2021)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	44	45	17
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	3,450	3,494	858

Pregnant Women in a Hospital Presumptive Eligibility Period

Eligibility Month	Eligibility Year	Unique Enrollees
January	2021	25
February	2021	20
March	2021	22

Outreach and Marketing

Education and Enrollment

DHS utilizes 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.

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 2020.

Medical Assistance Enrollees who are American Indian
Calendar Year 2020

Population	Enrollees
Families and Children	36,087
Disabled	4,438
Elderly	1,553
Adults with no Children	12,634
Total	54,712

Tribal Health Workgroup. The quarterly Tribal and Urban Indian Health Directors 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 and Urban Indian Health Directors, Tribal Human Services Directors, and representatives from the Indian Health Service, the Minnesota Department of Health and DHS. The work group met virtually on February 18, 2021. Please see Attachment A for a copy of the meeting agenda. The next work group meeting is planned for May 20, 2021.

Operational and Policy Developments

There were no significant program developments or operational issues for populations covered under this waiver during the quarter ending March 31, 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 B for a summary of state fair hearings closed in the first quarter of calendar year 2021.

Post Award Public Forum on PMAP+ Waiver

DHS held a virtual public forum on September 30, 2020 to provide the public with an opportunity to comment on the progress of the PMAP+ demonstration. A notice was published on the DHS Public Participation web site on August 28, 2020 informing the public of the date and time of the forum and instructions on how to join the forum. There were no members of the public in attendance at the forum. The next public forum is planned for fall of 2021.

Quality Assurance and Monitoring

Comprehensive Quality Strategy

Minnesota's quality strategy is an overarching comprehensive and dynamic continuous quality improvement strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota's Medicaid managed care program. Minnesota has incorporated into its quality strategy measures and processes related to the programs affected by this waiver. The current version of the quality strategy can be accessed on the DHS website at Managed Care Reporting.

The quality strategy is developed in accordance with 42 C.F.R. § 438.340, which 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 assesses the quality and appropriateness of care and services provided by MCOs for all managed care program enrollees. It incorporates elements of current DHS/MCO contract requirements, State licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 C.F.R. 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 managed health care programs. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with state and federal Medicaid and Medicare 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 by a contracted external quality review organization.

The quality strategy will evolve over time as the external quality review activities continue. DHS intends to review the effectiveness of the quality strategy.

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 the state Medicaid agency 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:

- Determination of compliance with federal and state requirements,
- Validation of performance measures, and performance improvement projects, and
- 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 managed care organization (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 for Minnesota Health Care Programs enrollees. Part of 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 follows up on the MCO's response to the areas identified in the past year's ATR. The ATR is shared with all MCOs under contract and other interested parties and is available upon request. The ATR is published 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.

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 [redacted] or email at [redacted]

Attachment A

Tribal and Urban Indian Health Directors Meeting
WebEx Link

Join from the meeting link

https://minnesota.webex.com/minnesota/j.php?MTID=mf822fcf5b20d48c95df0d5db5a25a8b7

QUARTERLY MEETING
Thursday, February 18, 2021
9:00 am to 1:00 pm
AGENDA

9:00 a.m.	**Opening Prayer/Invocation/Moment of Silence** **Welcome and Introductions**
DHS Agenda Items	
9:15 – 9:30 a.m.	**SPA and Waivers - Patrick Hultman, Jan Kooistra**
9:30 – 9:45 a.m.	**MCO RFP – Pamela Weiner**
9:45 – 10:15 a.m.	**SOAR – Catie LeMay, Jill Hillebreg**
10:15 – 10:30 a.m.	**Housing w Services Provider Enrollment Opportunity** **Mark Caldwell, Heidi Hamilton**
10:30 to 10:45 a.m.	**Continued: Four Walls Discussion**
10:45 – 11:00 am	**National Indian Health Board Update – Sam Moose FDL Human Services Director**
11:00 – 11:15 am	**Stretch Break**
MDH Agenda Items	
11:15 to 11:30 a.m.	**MDH Tribal Per Capita formula – update number for each Tribe for 2021 – Jackie Dionne**
11:30 a.m. – Noon	**Commissioner Jan Malcolm** **COVID 19 Update/Report** **MDH '22-'23 Budget**
Noon – 12:15 pm	**MDH Tribal Infectious Disease Data Joint Powers Agreement – Mariah Norwood**
12:15 to 12:30 pm	**MDH Tribal Data Reports Project – Meredith Cooney and Dan Fernandez-Baca**

12:30 to 12:45 pm Syphilis Outbreak Update

12:45 – 1:00 pm

Announcement and updates - open

Tribal Health Directors 2021 Meeting Dates:

Thursday, February 18 – virtual meeting
Thursday, May 20 – virtual meeting
Thursday, August 19 – in-person @ The Link Meeting Center at Shakopee (if conditions allow)
Thursday, November 18 – in-person @ The Link Meeting Center at Shakopee (if conditions allow)

Time and Location - TBD

Agenda items for next meeting
Adjourn

Attachment B - 2021 1st Quarter - Managed Care Ombudsman CMS Report

DEPARTMENT OF HUMAN SERVICES

Table 1. State Fair Hearings Closed in Quarter 1 of 2021 by Metro and Non−Metro Areas

Area	n
Eleven County Metro Area	83
Non-Metro Area	55
Total	138

State Fair Hearings Closed in Quarter 1 of 2021 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	3	1		4	2	10
Restricted Recipient		2	6	3		11
Total	3	3	6	7	2	21

Table 3. Billing Type by Service Category and Outcome

Outcome	Dismissed	Resolved bf Hearing	Total
Service Category	n	n	n
Hospital	1		1
Professional Medical Services		1	1
Total	1	1	2

Table 4. Service 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
DME-Medical Supplies	2	2	4	7	1	16
Dental	4		6	3		13
Home Care	1	2	4	2		9
Hospital				1		1
Mental Health	1			2		3
Pharmacy	7		1	21	3	32
Professional Medical Services	3	3	2	21		29
Restricted Recipient	1	2	1		1	5
Transportation				1		1
Vision Services	1			4		5
Total	20	9	18	63	5	115

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 bf Hearing	State Affirmed	Withdrawn	Total
Service Category	n	n	n	n	n	n	n
Chemical Dependency				1			1
DME-Medical Supplies	2	2	4	7		1	16
Dental	4		6	3			13
Health Plan Change	3	1		4	2		10
Home Care	1	2	4	2			9
Hospital	1			1			2
Mental Health	1			2			3
Pharmacy	7		1	21		3	32
Professional Medical Services	3	3	2	22			30
Restricted Recipient	1	4	7	3		1	16
Transportation				1			1
Vision Services	1			4			5
Total	24	12	24	71	2	5	138

Table 7. Summary of SFHs Closed in Quarter 1 of 2021 by Outcome

Outcome	n
Dismissed	24
Enrollee prevailed	12
Health Plan prevailed	24
Resolved before hearing	71
State affirmed	2
Withdrawn	5
Total	138