

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

**Demonstration Year 28**

**Third Quarter Report  
January 1, 2023, through March 31, 2023**

**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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**State of Minnesota**  
**Department of Human Services**  
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## **LIST OF ATTACHMENTS**

- A Tribal Health Directors Meeting Agenda, March 9, 2023
- B State Fair Hearing Summary for the First Quarter of Calendar Year 2023

## **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, 2023, through March 31, 2023. 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. On December 9, 2021, CMS approved a second temporary extension of the PMAP+ waiver through December 31, 2022.

On December 27, 2022, CMS approved a third temporary extension of the PMAP+ waiver through June 30, 2023. CMS’ award letter (of December 27) included a revision to the special terms and conditions that sunset Minnesota’s authority to disburse graduate medical education (GME) funds included under waiver authority. Minnesota accepted the special terms and conditions in a letter dated January 23, 2023, to continue the waiver. More information about the GME change is in the Operational and Policy Development section of this report.

## Enrollment Information

Please refer to the table below for PMAP+ enrollment activity for the period of January 1, 2023, through March 31, 2023.

<b>Demonstration Populations (as hard coded in the CMS 64)</b>	<b>Enrollees at close of quarter Dec. 31, 2022</b>	<b>Current Enrollees (as of data pull on Feb. 2, 2023)</b>	<b>Disenrolled in Current Quarter (Oct. 1, 2022 through Dec. 31, 2022)</b>
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	52	51	11
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	4,613	4,646	1,178

## Pregnant Women in a Hospital Presumptive Eligibility Period

Eligibility Month	Eligibility Year	Unique Enrollees
January	2023	13
February	2023	17
March	2023	17

## 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. DHS contracts with MCOs in each of Minnesota's 87 counties. 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.

### 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 2022.

**Medical Assistance Enrollees who are American Indian  
Calendar Year 2021**

<b>Population</b>	<b>Enrollees</b>
Families and Children	38,333
Disabled	4,617
Elderly	1,729
Adults with no Children	15,906
Total	60,585

**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 on March 9, 2023. Please see Attachment A for a copy of the meeting agenda. The next work group meeting is planned for May 25, 2023.

## **Operational and Policy Developments**

The special terms and conditions in CMS’ award letter (received December 27, 2022) to temporarily extend the waiver through June 30, 2023, ended Minnesota’s authority to disburse graduate medical education (GME) funds included under the waiver authority. This is the first reporting period following that change. The GME payments attributable to state fiscal year 2022 will be made in April 2023 and claimed on the CMS-64 report (for the quarter ending June 30, 2023).

## **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 fourth quarter of calendar year 2022.

## **Post Award Public Forum on PMAP+ Waiver**

DHS held a virtual public forum on April 29, 2022, 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 March 30, 2022 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 was anticipated to be held in the fall of 2022. Two meetings in calendar year 2022 were planned. One was carried over from 2021. However, it was not held due to reasons related to the public health emergency. Due to state staffing changes, the forum planned for the fall of 2022 was not held. CMS informed DHS that it is not necessary to hold a forum to cover a past period as the intent is for the public to provide feedback for the related time period. The next public forum is planned for August 22, 2023. It will be in-person and the related information posted no less than 30 days prior to the meeting.

## **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 Michelle Long. She can be reached by telephone at (651) 431-2224 or email at [michelle.long@state.mn.us](mailto:michelle.long@state.mn.us)

***Tribal and Urban Indian Health Directors Quarterly Meeting***

***Join us Remote only***

Microsoft Teams meeting

Log-in is in calendar meeting invite

**Thursday, March 9, 2023**

**9:00 am to 3:00 pm**

**AGENDA**

**9:00 – 9:15 am**      **Welcome opening/prayer and roll call**

**DHS Agenda Items**

**9:15 am – 11:00 am**    **Morning Session Opening Remarks** – Vern LaPlante, Indian Policy Director and Patrick Hultman, Deputy Medicaid Director  
**Medicaid State Plan Amendment and Waiver Activities** – Patrick Hultman, Deputy Medicaid Director  
**Four Walls Update** – Julie Marquardt, Deputy Assistant Commissioner and Deputy Medicaid Director  
**Medicaid Continuous Coverage Unwinding Communications, Outreach, and Data** – Karen Giusto, Meghan Lee, and Kevan Edwards, Health Care Administration  
**Community Engagement** – Dr. Nathan Chomilo, Medicaid Medical Director  
**Operation Swiss Watch 14: Medicaid Policy Changes Impacting Tribes** – Angie DeLille, Deputy Director, Office of Indian Policy  
**Re-invigorating Tribal Long Term Support Services Workgroup** – Vern LaPlante, Director, Office of Indian Policy  
**Morning Session Closing Remarks**

**MDH Agenda Items**

**11:00 to Noon**      **MDH Commissioner Dr. Brooke Cunningham**

**Noon – 12:30 pm**    **Lunch Break**

**12:30 – 1:00 pm**    **Health Protection Bureau – Assistant Commissioner Dan Huff**

**1:00 – 1:30 pm**      **GLITEC Drinking Water Testing Program – Will Funmaker & Jacob Riemer**  
**NIHB Updates – Sam Moose**

## **Indian Health Services Updates**

<b>1:30 – 2:00 pm</b>	<b>Syphilis update – Dr. Nick Lehnertz</b>
<b>2:00 – 2:30 pm</b>	<b>Office of American Indian Health Updates</b> <b>Hiring process for OAIH Director</b> <b>Policy Updates – IDEPC JPA;</b> <b>MDH Updated Tribal Consultation Policy</b> <b>OAIH Grant Updates</b> <b>Tribal Public Health Block Grant update</b> <b>Tribal COVID 19 Vaccine Implementation update</b> <b>Tribal Public Health Infrastructure update</b>

**Tribal Health Directors 2023 remaining meeting dates (last Thursday of each quarters month, except Nov 2023):**

**May 25-26, 2023**

**August 17-18, 2023**

**November 16-17, 2023**

**Time and Location – Hybrid**

## Managed Care Ombudsman CMS Report

### State Fair Hearings Closed in Quarter 1 of CY 2023 by Metro and Non-Metro Areas

Area	n
Eleven County Metro Area	014
Non-Metro Area	57
<b>Total</b>	<b>161</b>

### State Fair Hearings Closed in Quarter 1 of CY 2023 by Type, Service Category and Outcome

	Dismissed	Enrollee Prevailed	HP and Enrollee prevailed in part	HP Prevailed	Resolved after hearing	Resolved before hearing	State Affirmed	With-drawn	Total
Chemical Dependency						1			1
Therapies / Rehabilitation				1					1
DME-Medical Supplies	1	2		1	2	2		2	10
Dental	4			14		1		1	21
Elderly Waiver Service						1		1	2
Health Plan Change	10	2				135	3		28
Home Care	5		1	3		4		2	15
Hospital	1			1					2
Mental Health	2								2
Pharmacy	5			2		23		5	35
Professional Medical Services	6	3		7		12		6	34
Restricted Recipient	4	1		2					7
Transportation						1			1
Vision Services	1			1					2
<b>Total</b>	<b>39</b>	<b>8</b>	<b>1</b>	<b>32</b>	<b>2</b>	<b>58</b>	<b>3</b>	<b>18</b>	<b>161</b>

### Summary of State Fair Hearings Closed in Quarter 4 of CY 2022 by Outcome

Outcome	n
Dismissed	39
Enrollee Prevailed	8
Health Plan Prevailed	32
HP Partially Upheld/Member Partially Denied	1
Resolved after hearing	2
Resolved before hearing	58
State Affirmed	3
Withdrawn	18
<b>Total</b>	