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

Demonstration Years 29 and 30
Annual Report
July 1, 2023 through June 30, 2024

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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Introduction

As required by the terms and conditions approving §1115(a) waiver No. 11-W-00039/5, titled 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, 2023, through June 30, 2024. This report provides an update on the status of the PMAP + operation.

Background

The PMAP+ section 1115 waiver has been in place for over 30 years. Over this period, the waiver and the populations covered has been amended.

Three of the more significant changes were:

1. Converting the authority for the MinnesotaCare program[1] to a Basic Health Plan (BHP) under section 1331 of the Affordable Care Act on January 1, 2015. As a BHP, the state may enroll certain populations eligible for Medical Assistance[2] into managed care who otherwise would have been exempt from managed care under the Social Security Act.
2. Transitioning certain eligibility groups covered by managed care to section 1915(b) authority effective January 1, 2016. This change was based on direction from CMS in December 2014 including mandatory enrollment of American Indians as defined in 25 U.S.C. 1603(c) who would not otherwise be mandatorily enrolled in managed care; children under age 21 who were in state-subsidized foster care or other out-of-home placement; and children under age 21 who were receiving foster care under Title IV-E.
3. Discontinuing coverage of Medical Education Research Costs (MERC). In December 2021, CMS directed the state to transition the GME expenditures to the Medicaid state plan to align with CMS' policy. Subsequently in December 2022, when CMS approved an additional temporary extension of the PMAP+ waiver, the authority for GME expenditures under MERC was sunset.

This report covers the 12-month period of July 1, 2023 to June 30, 2024. It includes the six-month time period for demonstration year 29 (July 1, 2023 through December 31, 2023) and the six-month time period for demonstration year 30 (January 1, 2024 through June 30, 2024). The waiver extension was approved effective January 1, 2024. Consequently, this report includes six months of reporting under the Special Terms and Conditions (STCs) effective prior to January 1, 2024 and six months of reporting under the STCs effective January 1, 2024. For this report, the Minnesota Department of Human Services (DHS) used the general reporting format used prior to the extension approval. In accordance with the STCs the state accepted on December 21, 2023, DHS will work collaboratively with CMS to finalize the

[1] MinnesotaCare provides comprehensive health care coverage through Medicaid funding for people with incomes in excess of the standards in the Medical Assistance program

[2] Minnesota's Medicaid program

metrics to be included in subsequent annual reports. See item 7.4(c) of the STCs dated April 1, 2024. The STCs no longer require quarterly program updates.

Based on the STCs issued April 1, 2024, the annual monitoring report for demonstration year 30 was due September 30, 2024. However, the federal Performance Management Database and Analytics (PMDA) system has not been able to accept the state's required reports. The fiscal reports for the waiver included on the CMS-64 have been provided without interruption in the Medicaid and CHIP Financial (MACFin) system. In an email exchange in April of 2024, CMS offered the state the option to hold on submitting the budget neutrality workbook and reports until they could be uploaded in PMDA. The state accepted this plan, but it has taken longer than anticipated for the PMDA issue to be resolved. Consequently, DHS is submitting this annual report outside of PMDA.

PMAP+ Waiver Extension

The PMAP+ waiver continues to be necessary for certain elements of Minnesota's Medical Assistance program. On November 15, 2023, CMS approved DHS' request to renew the PMAP+ waiver for the period of January 1, 2024 through December 31, 2028. The waiver provides 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; and
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility.

The waiver extension request was submitted to CMS on June 29, 2020. On December 21, 2020, CMS approved a temporary extension of the PMAP+ waiver through December 31, 2021. On December 9, 2021, CMS approved a second temporary extension request through December 31, 2022. On December 27, 2022, CMS approved a third temporary extension of the PMAP+ waiver through June 30, 2023.

CMS' letter with the third extension (dated December 27, 2022) included a revision to the STCs that sunset Minnesota's authority to disburse certain graduate medical education (GME) funds under waiver authority. Minnesota accepted the STCs in a letter to CMS dated January 23, 2023, to continue the waiver. Additional information about the GME change was in the Operational and Policy Developments section of the previous annual report (covering demonstration year 28).

On June 15, 2023, CMS approved a fourth temporary extension of the PMAP+ waiver with an expiration date of September 30, 2023, and on September 27, 2023 CMS approved a fifth temporary extension of the waiver through December 31, 2023. On November 15, 2023, CMS approved Minnesota's request to extend the waiver for the period of January 1, 2024 through December 31, 2028 with the following demonstration years.

Table 1: Demonstration Years

Demonstration Year 30	January 1, 2024 to June 30, 2024	6 months
Demonstration Year 31	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 32	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 33	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 34	July 1, 2027 to June 30, 2028	12 months
Demonstration Year 35	July 1, 2028 to December 31, 2028	6 months

PMAP+ Waiver Amendments

Citizenship documentation timeline. On March 23, 2023, the state requested a waiver under section 1115 to extend the reasonable opportunity period for citizenship documentation during the COVID-19 public health emergency unwinding period. In a letter dated May 4, 2023, CMS approved the request as an amendment to PMAP+ for the period of April 1, 2023 through June 30, 2024.

Personal care services provided by relatives. On May 10, 2023, the state requested that CMS waive restrictions at 42 CFR §440.167 prohibiting legally responsible relatives from rendering personal care services, a policy waived during the COVID-19 public health emergency under an 1135 waiver. On July 31, 2023, CMS approved the request under the PMAP+ waiver for the period of May 10, 2023, to November 11, 2023.

Expanded and extended continuous eligibility for children. On January 25, 2024, the state submitted an amendment to CMS to expand continuous eligibility for children up to age six, and extend the 12-months of continuous eligibility to include young adults ages 19 and 20.

Former foster care for youth. On January 25, 2024, the state submitted an amendment to CMS to provide Medical Assistance eligibility for former foster care youth up to the age of 26. The PMAP+ amendment permits the state to continue the eligibility for this group (paralleling the SUPPORT Act eligibility requirements) through December 31, 2030, at which time all individuals in the group will have reached age 26. The CMS review of this amendment is pending.

Enrollment Information

The following tables provide the quarterly and annual enrollment data for the period July 1, 2023 through June 30, 2024.

Tables 2.1 and 2.2: Enrollment Data for Demonstration Year 29 Quarter 1 (July 1, 2023 – September 30, 2023)

Table 2.1: Populations 1 and 2

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (9/30/2023)	Current Enrollees (as of data pull 11/6/2023)	Disenrolled in Current Quarter (7/1/2023 to 9/30/2023)
Population 1: MA One Year Olds with incomes above 275% FPL and at or below 283% FPL	27	30	20
Population 2: Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	4,333	4,176	1,737

Table 2.2: Population 3

Demonstration Population (as hard coded in the CMS 64)	Eligibility Month: July 2023	Eligibility Month: August 2023	Eligibility Month: September 2023
Population 3: Pregnant Women in a Hospital Presumptive Eligibility Period	16	19	26

Tables 3.1 and 3.2: Enrollment Data for Demonstration Year 29 Quarter 2 (October 1, 2023 – December 31, 2023)

Table 3.1: Populations 1 and 2

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (12/31/2023)	Current Enrollees (as of data pull 2/2/2024)	Disenrolled in Current Quarter (10/1/2023 to 12/31/2023)
Population 1: MA One Year Olds with incomes above 275% FPL and at or below 283% FPL	49	55	23
Population 2: Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	4,273	4,132	1,470

Table 3.2: Population 3

Demonstration Population (as hard coded in the CMS 64)	Eligibility Month: October 2023	Eligibility Month: November 2023	Eligibility Month: December 2023
Population 3: Pregnant Women in a Hospital Presumptive Eligibility Period	23	26	35

Tables 4.1 and 4.2: Enrollment Data for Demonstration Year 30 Quarter 1 (January 1, 2024 – March 31, 2024)

Table 4.1: Populations 1 and 2

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (3/31/2024)	Current Enrollees (as of data pull 5/3/2024)	Disenrolled in Current Quarter (1/1/2024 to 3/31/2024)
Population 1: MA One Year Olds with incomes above 275% FPL and at or below 283% FPL	58	63	18
Population 2: Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	3,388	3,354	1,869

Table 4.2: Population 3

Demonstration Population (as hard coded in the CMS 64)	Eligibility Month: January 2024	Eligibility Month: February 2024	Eligibility Month: March 2024
Population 3: Pregnant Women in a Hospital Presumptive Eligibility Period	42	57	66

Tables 5.1 and 5.2: Enrollment Data for Demonstration Year 30 Quarter 2 (April 1, 2024 – June 30, 2024)

Table 5.1: Populations 1 and 2

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (6/30/2024)	Current Enrollees (as of data pull 8/2/2024)	Disenrolled in Current Quarter (4/1/2024 to 6/30/2024)
Population 1: MA One Year Olds with incomes above 275% FPL and at or below 283% FPL	72	47	73
Population 2: Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	3,248	2,682	1,209

Table 5.2: Population 3

Demonstration Population (as hard coded in the CMS 64)	Eligibility Month: April 2024	Eligibility Month: May 2024	Eligibility Month: June 2024
Population 3: Pregnant Women in a Hospital Presumptive Eligibility Period	51	51	60

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.

Assisters and navigators are also available to help people (via phone, virtual, or in-person meetings) with the eligibility and enrollment process. Contact information is available on the MNsure website.

MNsure has a navigator grantee outreach program that provides statewide activities to help individuals with enrollment.

Applicants and enrollees who receive Medical Assistance through fee-for-service may call DHS Health Care Consumer Support (HCCS) 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

DHS contracts with managed care organizations (MCOs) in each of Minnesota's 87 counties. 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.

Additional Information about Managed Care Plans

The following information is about the managed care plans the state contracts with to provide PMAP+ services. This information is provided in accordance with item 28 of the STCs dated February 11, 2016 (for the PMAP+ 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 and MCOs had an 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 A provides a summary of the MCO audited financial statements for 2023 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. The ATR presents MCO-specific performance, including strengths, opportunities for improvement and recommendations identified during the external quality review process. The ATR also 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 website 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" based on the Public Law[3]) 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 unduplicated number of people identified as American Indians who were enrolled in Medical Assistance during calendar years 2023 and 2024. The data was run on February 10, 2025. Due to retroactive Medical Assistance eligibility, the number of enrollees in calendar year 2024 may be slightly undercounted. The 2024 data is considered complete in early April 2025.

[3] P.L. 93-638 is the Indian Self Determination and Education Assistance Act (ISDEAA).

Table 6: Medical Assistance Enrollees Who Identify as American Indian in Calendar Year 2023

Population	Enrollees
Families and Children	39,086
Disabled	4,738
Elderly	1,900
Adults with no Children	17,314
Total	63,038

Table 7: Medical Assistance Enrollees Who Identify as American Indian in Calendar Year 2024

Population	Enrollees
Families and Children	37,259
Disabled	4,587
Elderly	1,991
Adults with no Children	16,737
Total	60,574

Tribal Health Workgroup

The quarterly Tribal and Urban Indian Health Directors workgroup was formed to address the need for a regular forum for formal review of topics between tribal leadership and state employees. The workgroup meets quarterly 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. During each meeting, DHS provides an update on significant waiver issues.

During this PMAP+ reporting period, the workgroup met on August 23, 2023, November 16, 2023, February 15, 2024, and June 6, 2024. The June 6, 2024 agenda for the Tribal and Urban Indian Health Directors workgroup is provided as an example showing that a waiver update is provided. See Attachment B.

Operational and Policy Developments

During demonstration years 29 and 30, the following operational and policy developments occurred.

Citizenship Documentation Timeline

As stated above on March 23, 2023, the state requested a waiver under section 1115 to extend the reasonable opportunity period for citizenship documentation during the COVID-19 public health emergency unwinding period. The state used a streamlined template provided by CMS. In a letter dated May 4, 2023, CMS approved the request as an amendment to PMAP+ for a period of 15 months starting retroactively to the beginning of the state's unwinding period. There were no changes to the PMAP+ STCs related to this amendment.

Personal Care Services Provided by Relatives

As stated above, on May 10, 2023, the state requested that CMS waive restrictions at 42 CFR §440.167 prohibiting legally responsible relatives from rendering personal care services, a policy waived during the COVID-19 public health emergency under an 1135 waiver. The request applied to recipients covered under Minnesota's section 1115 waivers. During the review process, CMS required the authority for recipients covered under Minnesota's Reform 2020 section 1115 waiver (Project Number 11-W-00286/5) to be separated and the state submitted an Appendix K request for that waiver. See Minnesota's Reform 2020 waiver report covering this period for more details. During this reporting period, the amendment request is pending.

Expanded and Extended Continuous Eligibility for Children

As stated above, on January 25, 2024, the state submitted an amendment to CMS to expand continuous eligibility for children up to age six, and extend the 12-months of continuous eligibility to include young adults ages 19 and 20. On November 14, 2024, CMS approved the request as an amendment to PMAP+.

Former Foster Care for Youth

As stated above, on January 25, 2024, the state submitted an amendment to CMS to provide Medical Assistance eligibility for former foster care youth up to the age of 26. The PMAP+ amendment permits the state to continue the eligibility for this group (paralleling the SUPPORT Act eligibility requirements) through December 31, 2030, at which time all individuals in the group will have reached age 26. The CMS review of this amendment is pending.

Budget Neutrality Developments

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10. As described earlier via an email exchange in April of 2024, CMS offered the state the option to hold on submitting the budget neutrality workbook and reports until they could be uploaded in PMDA. The state accepted this plan. DHS requires an updated budget neutrality workbook from CMS in order to submit quarterly and annual cost data. The budget neutrality data will be provided when a workbook is available.

Member Month Reporting

The following table provides both the quarterly and annual member month reporting data.

Table 8: Member Month Reporting Data for Demonstration Years 29 and 30 Quarterly and Annual (July 1, 2023 through June 30, 2024)

	DY29* Q1**	DY29 Q1	DY29 Q1	DY29 Q2	DY29 Q2	DY29 Q2	DY30 Q1	DY30 Q1	DY30 Q1	DY30 Q2	DY30 Q2	DY30 Q2
Eligibility Group	**Jul 2023**	**Aug 2023**	**Sept 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 2024**	**Apr 2024**	**May 2024**	**Jun 2024**
Population 1: MA One Year Olds with incomes above 275% FPL and at or below 283% FPL	26	33	27	44	47	49	59	60	58	71	74	72
Population 2: Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	4,672	4,442	4,333	4,194	4,206	4,273	4,181	3,690	3,388	3,346	3,330	3,248
Population 3: Pregnant Women in a hospital presumptive eligibility period	16	19	26	23	26	35	42	57	66	51	51	60

* DY = Demonstration Year
** Q = Quarter

Consumer Issues

County Advocates

County advocates are required (under state law) to assist managed care enrollees in each county with resolving MCO issues should they have a concern. In cases where an issue is not resolved 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 an appeal or state fair hearing process. State ombudspeople 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 ombudsperson

may assist managed care enrollees with grievances, appeals, and state fair hearings (as explained in the above paragraph). 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 C for a summary of state fair hearings closed during the period of July 1, 2023 through June 30, 2024.

Post Award Public Forum

In accordance with item 16 of the STCs dated February 11, 2016, DHS holds public forums to provide the public with an opportunity to comment on the progress of the PMAP+ demonstration.

The public forum for the 12-month period (of July 1, 2023 through June 30, 2024) was held on July 3, 2024. Notice was published in the State Register on June 3, 2024 and sent via GovDelivery (an official state government notification system) on May 31, 2024. Concurrently, DHS' webpage was updated to inform the public of the date and time of the forum and instructions on how to participate. Both in-person and remote participation was supported. Three people attended remotely, but did not offer any feedback or comment. The next public forum is expected to be held in June 2025.

Quality Assurance and Monitoring

Comprehensive Quality Strategy

Minnesota's quality strategy is comprehensive and includes continuous quality improvement strategies in 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 (DHS) 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 (ATR) by a contracted external quality review organization.

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) licensing 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 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

DHS submitted the draft evaluation plan on May 9, 2024 as required in STC 10, dated April 1, 2024. CMS provided feedback on July 23, 2024 and gave DHS 60-days to respond. Separate evaluation plans

were required for the amendments that extended the citizenship reasonable opportunity period (ROP) and permitted responsible relatives to provide personal care services (PCS). The ROP evaluation plan was submitted to CMS on December 5, 2023 and the combined PCS evaluation plan and final report will be submitted to CMS in the next reporting period.

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2023 Health Plan Financial Summary*
by Product (in thousands $)
Minnesota Public Programs Only

	BluePlus	HP	Itasca	Medica	Henn Health	PrimeWest	SCHA	Ucare	UHC	All Plans
PMAP										
Premium Revenues (line 8)	$2,205,431	$1,168,444	$63,569	$58,785	$357,256	$308,109	$153,016	$2,343,844	$203,908	$6,862,362
Medical/Hospital Expenses (line 18)	$1,897,139	$962,640	$54,663	$46,473	$303,722	$280,779	$127,817	$2,142,500	$163,772	$5,979,506
Administrative Expenses (lines 20-21)	$295,579	$79,790	$4,823	$7,173	$31,792	$21,944	$12,923	$204,918	$18,765	$677,707
PDR change (line 22)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Gain (loss) from operations (Line 24)	$12,713	$126,014	$4,083	$5,140	$21,741	$5,387	$12,276	-$3,575	$21,371	$205,150
Net Investment gain (or loss) and other (line 27 & 29)	$10,966	$2,439	$21	$1,044	$4,830	$3,007	$1,371	$27,032	$3,119	$53,829
Net Income (loss) before taxes (line 30)	$23,680	$128,453	$4,104	$6,183	$26,571	$8,393	$13,647	$23,457	$24,490	$258,979
Ratios:										
Medical Loss Ratio	86.0%	82.4%	86.0%	79.1%	85.0%	91.1%	83.5%	91.4%	80.3%	87.1%
Administrative/Revenue	13.4%	6.8%	7.6%	12.2%	8.9%	7.1%	8.4%	8.7%	9.2%	9.9%
Contribution to Reserves	0.6%	10.8%	6.4%	8.7%	6.1%	1.7%	8.0%	-0.2%	10.5%	3.0%
UW Gain/Prem Revenue	0.6%	10.8%	6.4%	8.7%	6.1%	1.7%	8.0%	-0.2%	10.5%	3.0%
MinnesotaCare										
Premium Revenues (line 8)	$213,620	$136,638	$4,081	$11,664	$14,062	$27,771	$15,399	$256,423	$20,254	$699,913
Medical/Hospital Expenses (line 18)	$176,954	$114,769	$3,530	$9,975	$12,104	$25,876	$13,031	$207,109	$14,536	$577,883
Administrative Expenses (lines 20-21)	$30,911	$10,129	$310	$1,634	$1,570	$2,077	$1,261	$22,696	$1,864	$72,451
PDR change (line 22)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Gain (loss) from operations (Line 24)	$5,755	$11,741	$241	$55	$388	-$183	$1,108	$26,618	$3,854	$49,578
Net Investment gain (or loss) and other (line 27 & 29)	$1,946	-$542	$1	$237	$191	$271	$0	$3,270	$310	$5,684
Net Income (loss) before taxes (line 30)	$7,701	$11,198	$242	$292	$580	$88	$1,108	$29,888	$4,164	$55,261
Ratios:										
Medical Loss Ratio	82.8%	84.0%	86.5%	85.5%	86.1%	93.2%	84.6%	80.8%	71.8%	82.6%
Administrative/Revenue	14.5%	7.4%	7.6%	14.0%	11.2%	7.5%	8.2%	8.9%	9.2%	10.4%
Contribution to Reserves	2.7%	8.6%	5.9%	0.5%	2.8%	-0.7%	7.2%	10.4%	19.0%	7.1%
UW Gain/Prem Revenue	2.7%	8.6%	5.9%	0.5%	2.8%	-0.7%	7.2%	10.4%	19.0%	7.1%
MSHO										
Premium Revenues (line 8)	$418,558	$279,487	$14,862	$517,394	$0	$77,878	$53,363	$797,691	$531	$2,159,765
Medical/Hospital Expenses (line 18)	$358,724	$244,667	$13,296	$457,577	$0	$64,109	$44,102	$716,509	$101	$1,899,084
Administrative Expenses (lines 20-21)	$22,345	$14,671	$1,122	$44,354	$0	$4,223	$3,306	$68,645	$49	$158,714
PDR change (line 22)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Gain (loss) from operations (Line 24)	$37,490	$20,149	$445	$15,464	$0	$9,546	$5,954	$12,537	$382	$101,966
Net Investment gain (or loss) and other (line 27 & 29)	$16,226	$2,506	$5	$7,333	$0	$760	$1,010	$12,289	$8	$40,137
Net Income (loss) before taxes (line 30)	$53,716	$22,655	$449	$22,797	$0	$10,306	$6,964	$24,826	$390	$142,104
Ratios:										
Medical Loss Ratio	85.7%	87.5%	89.5%	88.4%	0.0%	82.3%	82.6%	89.8%	19.0%	87.9%
Administrative/Revenue	5.3%	5.2%	7.5%	8.6%	0.0%	5.4%	6.2%	8.6%	9.2%	7.3%
Contribution to Reserves	9.0%	7.2%	3.0%	3.0%	0.0%	12.3%	11.2%	1.6%	71.8%	4.7%
UW Gain/Prem Revenue	9.0%	7.2%	3.0%	3.0%	0.0%	12.3%	11.2%	1.6%	71.8%	4.7%
MSC+										
Premium Revenues (line 8)	$114,721	$85,339	$5,525	$123,823	$0	$21,147	$13,108	$273,954	$32	$637,648
Medical/Hospital Expenses (line 18)	$84,526	$47,923	$5,409	$103,008	$0	$15,184	$8,911	$247,583	$60	$512,605
Administrative Expenses (lines 20-21)	$9,684	$4,924	$417	$8,912	$0	$1,884	$869	$23,825	$3	$50,518
PDR change (line 22)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Gain (loss) from operations (Line 24)	$20,512	$32,491	-$301	$11,902	$0	$4,079	$3,328	$2,545	-$31	$74,525
Net Investment gain (or loss) and other (line 27 & 29)	$1,612	$1,250	$2	$1,330	$0	$206	$687	-$21	$0	$5,068
Net Income (loss) before taxes (line 30)	$22,124	$33,741	-$299	$13,233	$0	$4,285	$4,015	$2,525	-$31	$79,593
Ratios:										
Medical Loss Ratio	73.7%	56.2%	97.9%	83.2%	0.0%	71.8%	68.0%	90.4%	187.6%	80.4%
Administrative/Revenue	8.4%	5.8%	7.5%	7.2%	0.0%	8.9%	6.6%	8.7%	9.2%	7.9%
Contribution to Reserves	17.9%	38.1%	-5.5%	9.6%	0.0%	19.3%	25.4%	0.9%	-96.8%	11.7%
UW Gain/Prem Revenue	17.9%	38.1%	-5.5%	9.6%	0.0%	19.3%	25.4%	0.9%	-96.8%	11.7%
SNBC (MA Only)										
Premium Revenues (line 8)	$0	$132,439	$0	$200,154	$53,889	$35,838	$24,623	$633,311	$3,446	$1,083,700
Medical/Hospital Expenses (line 18)	$0	$126,254	$0	$189,588	$49,718	$34,459	$20,788	$593,674	$2,103	$1,016,583
Administrative Expenses (lines 20-21)	$0	$9,722	$0	$19,863	$4,033	$1,996	$1,615	$54,007	$317	$91,554
PDR change (line 22)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Net Gain (loss) from operations (Line 24)	$0	-$3,537	$0	-$9,298	$137	-$617	$2,221	-$14,370	$1,026	-$24,437
Net Investment gain (or loss) and other (line 27 & 29)	$0	-$257	$0	$2,575	$729	$350	$846	$6,886	$53	$11,181
Net Income (loss) before taxes (line 30)	$0	-$3,794	$0	-$6,723	$866	-$267	$3,067	-$7,484	$1,079	-$13,255
Ratios:										
Medical Loss Ratio	0.0%	95.3%	0.0%	94.7%	92.3%	96.2%	84.4%	93.7%	61.0%	93.8%
Administrative/Revenue	0.0%	7.3%	0.0%	9.9%	7.5%	5.6%	6.6%	8.5%	9.2%	8.4%
Contribution to Reserves	0.0%	-2.7%	0.0%	-4.6%	0.3%	-1.7%	9.0%	-2.3%	29.8%	-2.3%
UW Gain/Prem Revenue	0.0%	-2.7%	0.0%	-4.6%	0.3%	-1.7%	9.0%	-2.3%	29.8%	-2.3%
SNBC (Integrated)										
Premium Revenues (line 8)	$0	$0	$0	$52,840	$0	$6,251	$11,124	$215,226	$1,177	$286,620
Medical/Hospital Expenses (line 18)	$0	$0	$0	$51,155	$0	$6,397	$11,787	$210,853	$272	$280,464
Administrative Expenses (lines 20-21)	$0	$0	$0	$1,942	$0	$676	$843	$19,167	$108	$22,736
PDR change (line 22)	$0	$0	$0	$0	$0	$0	$0	$500	$0	$500
Net Gain (loss) from operations (Line 24)	$0	$0	$0	-$256	$0	-$822	-$1,505	-$15,294	$797	-$17,081
Net Investment gain (or loss) and other (line 27 & 29)	$0	$0	$0	$565	$0	$61	$0	$968	$18	$1,612
Net Income (loss) before taxes (line 30)	$0	$0	$0	$308	$0	-$761	-$1,505	-$14,325	$815	-$15,469
Ratios:										
Medical Loss Ratio	0.0%	0.0%	0.0%	96.8%	0.0%	102.3%	106.0%	98.0%	23.1%	97.9%
Administrative/Revenue	0.0%	0.0%	0.0%	3.7%	0.0%	10.8%	7.6%	8.9%	9.2%	7.9%
Contribution to Reserves	0.0%	0.0%	0.0%	-0.5%	0.0%	-13.2%	-13.5%	-7.1%	67.7%	-6.0%
UW Gain/Prem Revenue	0.0%	0.0%	0.0%	-0.5%	0.0%	-13.2%	-13.5%	-6.9%	67.7%	-5.8%

*Source: MDH/Health Economics Program analysis of health plan financial data (supplement #1), 2021

All Public Products										
Premium Revenues (lines 8, 19, 30, 41, 52)	$2,952,330	$1,802,347	$88,037	$964,661	$425,207	$476,995	$270,633	$4,520,449	$229,349	$11,730,007
Medical/Hospital Expenses (lines 9,20,31,42,53)	$2,517,342	$1,496,253	$76,898	$857,776	$365,545	$426,804	$226,435	$4,118,228	$180,844	$10,266,125
Administrative Expenses (lines 10, 21,32,43,54)	$358,519	$119,236	$6,671	$83,878	$37,395	$32,801	$20,816	$393,260	$21,106	$1,073,681
PDR change (line 22)	$0	$0	$0	$0	$0	$0	$0	$500	$0	$500
Net Gain (loss) from operations (Line 11,22,33,44,55)	$76,470	$186,858	$4,468	$23,007	$22,267	$17,390	$23,382	$8,461	$27,399	$389,702
Net Investment gain (or loss) and other (line 27 & 29)	$30,750	$5,396	$29	$13,084	$5,750	$4,655	$3,913	$50,425	$3,508	$117,511
Net Income (loss) before taxes (line 30)	$107,220	$192,254	$4,496	$36,091	$28,017	$22,045	$27,295	$58,887	$30,907	$507,213
Ratios:										
Medical Loss Ratio	85.3%	83.0%	87.3%	88.9%	86.0%	89.5%	83.7%	91.1%	78.9%	87.5%
Administrative/Revenue	12.1%	6.6%	7.6%	8.7%	8.8%	6.9%	7.7%	8.7%	9.2%	9.2%
Contribution to Reserves	2.6%	10.4%	5.1%	2.4%	5.2%	3.6%	8.6%	0.2%	11.9%	3.3%
UW Gain/Prem Revenue	2.6%	10.4%	5.1%	2.4%	5.2%	3.6%	8.6%	0.2%	11.9%	3.3%
Investment Income	$30,750	$5,396	$29	$13,084	$5,750	$4,655	$3,913	$50,425	$3,508	$117,511
Total contribution to Reserves	$107,220	$192,254	$4,496	$36,091	$28,017	$22,045	$27,295	$58,887	$30,907	$507,213
Percent	3.6%	10.7%	5.1%	3.7%	6.6%	4.6%	10.1%	1.3%	13.5%	4.3%
Source: MDH/Health Economics Program analysis of health plan financial data (supplement #1), 2021										

DEPARTMENT OF HEALTH

Tribal and Urban Indian Health Directors Quarterly Meeting

Microsoft Teams meeting
Log-in is in calendar meeting invite

Thursday, June 6, 2024
9:00 am to 4:00 pm
AGENDA

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

9:15 am – 12:15 pm **MDH Agenda Items**

- Executive Office – ***Update from EO*** – Assistant Commissioner Tura (15 minutes)
- Health Equity Bureau - ***Office of American Indian Health Update*** – Christine Godwin (15 minutes)
- Health Improvement Bureau – ***Office of Statewide Health Improvement Initiatives Tribal Grants and Data Sovereignty*** – Sarah Brokenleg (5 minutes)
- Health Improvement Bureau – ***Health Promotion and Chronic Disease Division Update*** – Payton Counts (30 minutes)
- Health Improvement Bureau - ***Statewide Health Assessment and Improvement Framework*** – Audrey Hanson and Deanna White (30 minutes)
- Health Protection Bureau - ***MN Syphilis/Congenital Syphilis Awareness*** **and** ***2023 HIV and STI Surveillance*** – Hannah Giles, Candy Hadsall, and Khalid Bo-Subait (45 minutes)

12:15 – 1:00 pm **Lunch Break** (provided by MDH - OAIH)

1:00 – 4:00 pm **DHS Agenda Items**

- **Opening Remarks –** Angie DeLille, DHS Office of Indian Policy Director / Melorine Mokri, DHS HCA Deputy Federal Relations Director (10 min)
- **Medicaid State Plan and Waiver Activities**– Patrick Hultman, DHS Deputy Medicaid Director (30 min)
- **Housing Stabilization Services** – John Connolly, DHS Assistant Commissioner of Health Care Administration and Eric Grumdahl, DHS Assistant Commissioner of Behavioral Health, Housing, and Deaf & Hard of Hearing Services Administration (30 min)
- **Traditional Healing 1115 Waiver Discussion Planning** – Perry Moore, DHS Traditional Healing Program Coordinator (30-45 min)

- **Update on Direct Care and Treatment (DCT) Creation and Legislation** – Dan Storkamp, DCT Operations Services Executive Director and Erik Adolphson, DCT Transitions Director (30 min)
- **Updates on the New State Agency, Department of Children, Youth, and Families** – Anita Fineday, Director of Equity and Engagement for the Implementation Team (15 min)
- **Office of the Medicaid Medical Director Update** – Nathan Chomilo, MD, DHS Medicaid Medical Director, Takayla Lightfield (DHS) and Leigh Grauman (DHS) (30 min)
- **Closing Remarks –** Angie DeLille, DHS Office of Indian Policy Director / Melorine Mokri, DHS HCA Deputy Federal Relations Director (10 min)

ATTACHMENT C

State Fair Hearing Summary
Managed Care Ombudsman Report
Minnesota Prepaid Medical Assistance Program Plus (PMAP+)
Annual Report – Period of July 1, 2023 – June 30, 2024

I. 2023 Calendar Quarter 3 (July 1, 2023 – Sept. 30, 2023) Managed Care Ombudsman

Q3 2023 – Hearings closed by metro and non-metro areas

Area	n
Eleven County Metro Area	87
Non-Metro Area	35
Total	**122**

Q3 2023 - Hearing summary: All types by service category and outcome

Outcome	Dismissed	Enrollee Prevailed	Health Plan Prevailed	HP Partially Upheld/ Member Partially Denied	Resolved Before Hearing	State Affirmed	Withdrawn	Total
Service Category	***n***	***n***	***n***	***n***	***n***	***n***	***n***	***n***
Dental	5		15		6		1	27
Equipment and Supplies	1		1	2	1			5
Health Plan Change	1				2	1	4	8
Hearing Services							1	1
Home Care	4	2	6	1	2		4	19
Hospital	1							1
Mental Health					1			1
Optical Services	2						1	3
Pharmacy	9		5		7		4	25
Professional Medical Services	3	3	3		4		5	18
Restricted Recipient	4	1	4		1		1	11
Substance Use Disorder	1							1
Transportation	1						1	2
Total	**32**	**6**	**34**	**3**	**24**	**1**	**22**	**122**

Q3 2023 - Summary of closed hearings by outcome

Outcome	*n*
Dismissed	32
Enrollee prevailed	6
Health Plan prevailed	34
HP Partially Upheld/Member Partially Denied	3
Resolved before hearing	24
State affirmed	1
Withdrawn	22
Total	**122**

II. 2023 Calendar Quarter 4 (Oct. 1, 2023 – Dec. 31, 2023) Managed Care Ombudsman

Q4 2023 - Hearings closed by metro and non-metro areas

Area	n
Eleven County Metro Area	78
Non-Metro Area	47
Total	**125**

Q4 2023 - Hearing summary: All types by service category and outcome

Outcome	Dismissed	Enrollee Prevailed	Health Plan Prevailed	HP Partially Upheld/ Member Partially Denied	Resolved Before Hearing	State Affirmed	Withdrawn	Total
Service Category	***n***	***n***	***n***	***n***	***n***	***n***	***n***	***n***
Dental	5			9	4		1	19
Elderly Waivers			1					1
Emergency Room					1			1
Equipment and Supplies			1		3		1	5
Health Plan Change	4				5		2	11
Home Care	2	5	4	3	2		2	18
Pharmacy	5		3		12		5	25
Professional Medical Services	4	5	6		10		5	30
Restricted Recipient	3	5	4				1	13
Transportation		1	1					2
Total	**23**	**16**	**29**	**3**	**37**	**0**	**17**	**125**

Q4 2023 - Summary of closed hearings by outcome

Outcome	*n*
Dismissed	23
Enrollee prevailed	16
Health Plan prevailed	29
HP Partially Upheld/Member Partially Denied	3
Resolved before hearing	37
Withdrawn	17
Total	**125**

III. 2024 Calendar Quarter 1 (Jan. 1, 2024 – Mar. 31, 2024) Managed Care Ombudsman

Q1 2024 - Hearings closed by metro and non-metro areas

Area	n
Eleven County Metro Area	111
Non-Metro Area	44
Total	**155**

Q1 2024 - Hearing summary: All types by service category and outcome

Outcome	Dismissed	Enrollee Prevailed	Health Plan Prevailed	HP Partially Upheld/ Member Partially Denied	Resolved Before Hearing	State Affirmed	Withdrawn	Total
Service Category	***n***	***n***	***n***	***n***	***n***	***n***	***n***	***n***
Chiropractic			1		1			**2**
Dental	2	1	10		6		5	**24**
Elderly Waivers	1		1		1			**3**
Emergency Room			1					**1**
Equipment and Supplies	1				1		1	**3**
Health Plan Change	10	1			20	4	2	**36**
Home Care	5	3	10	1	4		3	**26**
Mental Health		1						**1**
Optical Services					1			**1**
Pharmacy	3		4		14		4	**25**
Professional Medical Services	2	3	6		3		3	**17**
Restricted Recipient	4	3	5					**12**
Transportation	1	1	1		1			**4**
Total	**29**	**13**	**39**	**1**	**52**	**3**	**18**	**155**

Q1 2024 - Summary of closed hearings by outcome

Outcome	*n*
Dismissed	29
Enrollee prevailed	13
Health Plan prevailed	39
HP Partially Upheld/Member Partially Denied	1
Resolved before hearing	52
State affirmed	3
Withdrawn	18
Total	**155**

IV. 2024 Calendar Quarter 2 (Apr. 1, 2024 – June 31, 2024) Managed Care Ombudsman

Q2 2024 - Hearings closed by metro and non-metro areas

Area	n
Eleven County Metro Area	103
Non-Metro Area	28
Total	**131**

Q2 2024 - Hearing summary: All types by service category and outcome

Outcome	Dismissed	Enrollee Prevailed	Health Plan Prevailed	HP Partially Upheld/ Member Partially Denied	Resolved After Hearing	Resolved Before Hearing	State Affirmed	Withdrawn	Total
Service Category	***n***	***n***	***n***	***n***	***n***	***n***	***n***	***n***	***n***
Chiropractic						2		1	3
Dental	1		8			1		3	13
Early Intensive Behavioral Developmental Intervention						1			1
Elderly Waivers	1		1						2
Equipment and Supplies	2		1						3
Health Plan Change	6					7	2	2	17
Home Care	4	2	7	8		3			24
Mental Health	1								1
Optical Services	1		1						2
Pharmacy	4	2	3			18		3	30
Professional Medical Services	6	5	7			5		3	26
Restricted Recipient	2	3	1						6
Transportation			1			1		1	3
Total	**28**	**12**	**30**	**8**	**0**	**38**	**2**	**13**	**131**

Q2 2024 - Summary of closed hearings by outcome

Outcome	*n*
Dismissed	28
Enrollee prevailed	12
Health Plan prevailed	30
HP Partially Upheld/Member Partially Denied	8
Resolved before hearing	38
State affirmed	2
Withdrawn	13
Total	**131**