

# Basic Health Program-State Background Information

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**State Name:** Minnesota

**Program Name (if different than Basic Health Program):** MinnesotaCare

## BHP Blueprint Designated State Contact:

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**Program Effective Date:** January 1, 2015

**Administrative agency responsible for BHP:** Minnesota Department of Human Services

## BHP State Administrative Officers:

<b>Program Administration: (Management, Policy, Oversight)</b>			
Position:	Title:	Location:	Responsible for:
Lucinda Jesson	Commissioner MN Dept. Health and Human Services	St. Paul, MN	Management Oversight Implementation
Nathan Moracco	Assistant Commissioner Health Care Administration MN Dept. Health and Human Services	St. Paul, MN	Management Oversight Implementation Administration
James Golden	Medicaid Director Health Care Administration MN Dept. Health and Human Services	St. Paul, MN	Management Oversight Implementation

<b>Program Operations: (Contracting, Eligibility, Appeals)</b>			
Nathan Moracco	Assistant Commissioner	St. Paul, MN	Signs MCO Contracts
Julie Marquardt	Director, Benefits and Service Delivery	St. Paul, MN	Service Delivery and Benefits Policy
Chandra Breen	Manager, Managed Care	St. Paul, MN	Contracting Negotiations
Karen Gibson	Director, Health Care Eligibility and Access	St. Paul, MN	Eligibility Policy
Pamela Daniels	Director Health Care Eligibility Operations	St. Paul, MN	Operations and Administration
Louis Thayer Inta Sellars	Co-Chief Human Services Judges	St. Paul, MN	Appeals
<b>Finance: (Budget, Payments)</b>			
Margaret Kelly	State Budget Officer MN Management and Budget	St. Paul, MN	Budget
Angela Vogt	MN Management and Budget	St. Paul, MN	Budget
Shawn Welch	Reports and Forecasts	St. Paul, MN	Budget
Marty Cammack	Director Financial Operation Division	St. Paul, MN	Budget Management Payments
Christopher Ricker	Director Financial Management	St. Paul, MN	Payments Reconciliation

**Governor/Governor's designee:**

**Signature:**

**Date of Submission:**

# Basic Health Program-Eligibility

**This section of the Blueprint records the states choices in determining eligibility procedures for BHP and records assurances that demonstrate comporment with BHP standards. The state must check all pertinent boxes and fill in dates where applicable.**

Attestation		Completed	Expected Completion date	Exchange Policy	Medicaid Policy
<b>1. Eligibility Standards</b>					
The state can enroll an individual in a Standard Health Plan who meets ALL of the following standards.		Y	Date if first column is no.		
305(a)(1)	Resident of the State.				
305(a)(2)	Citizen with household income exceeding 133 but not exceeding 200% FPL or lawfully present non-citizen ineligible for Medicaid or CHIP due to immigration status with household income below 200% FPL. <sup>1</sup>				
305(a)(3)	Not eligible to enroll in MEC or affordable ESI.				
305(a)(4)	Is less than 65 years				
305(a)(6)	Is not incarcerated other than during disposition of charges.				
	Is the state submitting a transition plan in accordance with 600.305(b)?	No. The process of transitioning MinnesotaCare from 1115 waiver to BHP authority should be seamless for the enrollees. Effective January 1, 2014 Minnesota modified the income and eligibility rules in MinnesotaCare to meet the anticipated BHP requirements and built them into our new eligibility system. Therefore effective October 1, 2013 eligibility determinations for all new applicants have been made using the BHP standards, with the exceptions of applicants who are age 65 or older and non-tax filers as discussed elsewhere in this document. In addition, we are in the process of converting the 28,000 clients remaining in MinnesotaCare on our legacy system to the new system. Each of these legacy clients will have had an eligibility re-determination using the BHP			

		standards prior to October 1, 2014.			
Attestation		Completed	Expected Completion date	Exchange Policy	Medicaid Policy
<b>2. Application Activities</b>					
310(a)	Single streamlined application includes relevant BHP information.	Y	Date if first column is no.		
310(b)	Application assistance is equal to Medicaid.	Y	Date if first column is no.		
310(c)	If the State is permitting authorized reps, indicate which standards will be used.	Y	Date if first column is no.		X
315	If the State is using certified application counselors, indicate which standards will be used.	Y	Date if first column is no.		X
<b>3. Eligibility determinations and Enrollment</b>					
Please describe what agency will be performing eligibility determinations: <b>Health Care Administration, MN Department of Human Services – Medicaid Single State Agency</b>					
320(c)	Indicate the standard used to determine the effective date for eligibility.				X <sup>2</sup>
320(d)	Indicate the enrollment policy used in BHP (the open and special enrollment periods of the Exchange OR the continuous enrollment process of Medicaid).				X
335(b)	Indicate the standard used for applicants to appeal an eligibility determination.				X

Attestation		Completed	Expected Completion date	Exchange Policy	Medicaid Policy
340(c)	Indicate the standard used to re-determine BHP eligibility.				X
345	Indicated the standard to verify the eligibility of applicants for BHP.			X	
340(f)	Continuous eligibility. The state will re-determine enrollees eligible only every 12 months as long as enrollees are under 65, are not enrolled in MEC and remain state residents.	No – DHS will implement 12 month enrollment periods but enrollees will be required to report changes in circumstance within 30 days.			

**Please list the standards established by the state to ensure timely eligibility determinations. (These standards must be in compliance with 42 CFR 435.912 exclusive of 435.912(c)(3)(i)).**

Minnesota’s on-line line eligibility system makes real-time eligibility determinations for MinnesotaCare. Online applications cannot be submitted by the applicant unless they are complete. Online applications for MinnesotaCare will not pend for verifications. All verifications for MinnesotaCare cases will be post-eligibility verifications with applicants given at least 90 days to supply the requested information. We have attached an updated version of our verification plan (Exhibit 1).

Minnesota will also accept paper applications. The paper application that will be used is the single streamlined application for all Insurance Affordability Programs. All paper applications will be processed to an eligibility determination or an application denial within 45 days from the date of our receipt of the application as required in 42 CFR 435.912. Paper applications that are incomplete will be denied if the applicant does not supply the requested information within 10 days of the date on the letter we send requesting the additional information. Individuals may appeal eligibility decisions.

DHS is currently developing a plan to pilot test taking applications over the phone. The pilot testing will be done with current MinnesotaCare and Medical Assistance enrollees that are converting from the legacy systems to the new MNsure system. We will use this pilot testing to finalize the plan for fully implementing phone applications.

MinnesotaCare applications are processed by the 200 state employees that comprise the Health Care Eligibility Operations Division within the Health Care Administration of DHS. These employees handle all operational aspects of administering the MinnesotaCare program including: processing paper applications (and phone applications when that function is added), resolving application problems with

applicants, processing changes in circumstances, resolving client issues with premiums billing and payments, and answering client questions.

**Please describe the state's process and timeline for incorporating BHP into the eligibility service in the state including the State's marketplace. Include pertinent timeframes and any contingencies that will be used until system changes (if necessary) can be made.**

Minnesota uses a single shared eligibility system to determine eligibility for both public and Marketplace programs. This shared system currently processes MinnesotaCare eligibility determinations, which are very similar to the requirements of the BHP. Minnesota will have incorporated all of the eligibility rules for MinnesotaCare into the state's on-line eligibility system by January 1, 2015. If it appears that we will miss this deadline, we will implement contingency plans so that individuals who meet the criteria for MinnesotaCare are manually determined eligible for and enrolled in the program.

#### Changes Required in the Eligibility Determination System

- Incorporate new household composition rules for BHP eligible non-tax filers.
- Eligibility age limit of 64 for federally funded BHP.<sup>3</sup>
- Change eligibility rules to allow BHP funded eligibility for lawfully present non-citizens with incomes below 200% FPL<sup>4</sup>

The last two items listed above are simple changes and we do not anticipate any delay in getting them implemented by January 1, 2015. Incorporating the rule set for MinnesotaCare individuals and families that do not intend to file taxes is a larger project. We will incorporate rules that will construct the household as if it were a tax filing unit. This work may need to be completed in phases. If that is case we have two contingency plans to identify and move these cases to the correct eligibility result.

The first contingency plan is already designed and can be continued into 2015. Currently, MinnesotaCare applicants who are not tax filers get an incorrect eligibility result from the online system (they are determined eligible to purchase a QHP without financial assistance). Each week a report would be run to identify applicants who got an Unassisted QHP eligibility result, who have household incomes under 200% FPL and who stated that they did not intend to file taxes. DHS staff would then review these cases to determine if they are otherwise eligible for MinnesotaCare. If the family is eligible for MinnesotaCare, the worker would make the changes in the system via system workaround instructions to enroll the family into MinnesotaCare if they indicate they want to be enrolled.

This contingency works but we would like to move to a more real time solution. To that end, we are exploring moving to a second incremental contingency. We will consult with our vendors about the possibility of including a message on the Eligibility Results screen that would pop-up whenever an applicant is denied MinnesotaCare solely due to answering "No" to the tax filing questions on the application. The message would inform the applicant that the system is unable to make a final determination for MinnesotaCare, and direct the applicant to contact MinnesotaCare Operations for

further information. The message will also direct the applicant to the contact information for MinnesotaCare Operations.

Staff will consult with applicants who contact MinnesotaCare Operations after seeing the message to update the tax filing data using the workaround instructions to get a correct eligibility result.

**Please describe the process the state is using to coordinate BHP eligibility and enrollment with other IAPs in such a manner as to ensure seamlessness to enrollees.**

Minnesota uses an eligibility system that determines eligibility for all Minnesota health care programs and Qualified Health Plans (i.e., MA, MinnesotaCare, QHP eligibility, Premium Tax Credits and Cost Sharing Reductions). The system is shared by DHS and MNsure with each agency retaining responsibility for their clients on the shared system. When client reported changes in circumstance are entered into the system by an eligibility worker, the system automatically re-runs all of the eligibility rules and re-determines eligibility.

When reported changes result in new or continued eligibility for Medical Assistance or MinnesotaCare, the updated client information is automatically interfaced to the DHS MMIS system in real time<sup>5</sup>. MMIS incorporates automated processes for generating client notices and information packets in those instances where a health plan disenrollment or change in health plan is required.

**Process for client movement from MinnesotaCare to Qualified Health Plan with/without Advanced Premium Tax Credit and Cost Sharing Reduction:**

1. An individual who is enrolled in MinnesotaCare reports a change of circumstances to DHS, MNsure, or a county or tribal agency.
2. An eligibility worker updates the system evidence about the individual and applies the changes, triggering the system to run verifications rules and a preliminary redetermination.
  - a. If the individual is required to provide paper verification, the worker gathers that verification from the individual prior to approving the preliminary redetermination and making it final.
  - b. Once verifications are received, or in the event there are no verifications needed from the individual, the worker triggers the system to approve the changes and provide a new eligibility result.
3. If the system determines the individual is no longer eligible for MinnesotaCare, and is newly eligible for QHP with/without APTC:
  - c. MinnesotaCare eligibility and benefits end with at least 10-day advance notice. If there are fewer than 10 days from the end of the current month, MinnesotaCare eligibility and benefits end at the end of the current month plus one.
    - i. A cancellation notice is mailed to the individual.
    - ii. The system automatically sends MinnesotaCare eligibility closing data to MMIS. This triggers an MMIS system-generated managed care plan disenrollment notice to be mailed to the individual.
    - iii. The system will automatically determine eligibility for QHP and subsidies.

- iv. QHP with/without APTC: The MinnesotaCare worker will create a work task in MNsure for the QHP case worker to review the outcome of the eligibility redetermination based on the change in evidence.
  - d. The QHP case worker will review the work task and determine if the individual meets a qualifying special enrollment period (SEP) event which allows enrollment to occur outside of open enrollment. In this scenario the consumer will meet the SEP criteria of loss of minimum essential coverage (e.g. MinnesotaCare).
- 4. If the individual is determined eligible for a qualifying SEP event the QHP case worker will connect with the consumer to complete a manual QHP enrollment and application of any APTC benefits.
- 5. QHP plan coverage will be effective the first of the month following the month in which plan selection occurred if the individual pays their QHP premium by the carrier billing due date. Plan selection must occur by the last day of the SEP period.

**Process for client movement from Qualified Health Plan with/without Advanced Premium Tax Credit/CSR to MinnesotaCare:**

1. An individual who is enrolled in QHP with/without APTC/CSR reports a change of circumstances to MNsure or DHS.
2. An eligibility worker updates the system evidence about the individual and applies the changes, triggering the system to run verifications rules and a preliminary redetermination.
  - a. If the individual is required to provide paper verification, the worker gathers that verification from the individual prior to approving the preliminary redetermination and making it final.
  - b. Once verifications are received, or in the event there are no verifications needed from the individual, the worker triggers the system to approve and finalize the preliminary eligibility result.
3. If the system determines the individual is no longer eligible for QHP with/without APTC, and newly eligible for MinnesotaCare:
  - a. The QHP eligibility worker will complete a manual QHP termination transaction and send it to the carrier to terminate QHP coverage. This will also terminate APTC benefits. The QHP eligibility worker will issue a notice to the individual indicating that their APTC benefits and health plan have been terminated.
  - b. MinnesotaCare eligibility is effective in the month the change was entered and eligibility determined. MinnesotaCare benefits begin the first day of the month after the initial premium payment is paid. For individuals who are not required to pay a MinnesotaCare premium, benefits begin the first day of the month after the eligibility determination is made.
4. An eligibility notice indicating approval of MinnesotaCare is sent.
5. If a premium is required, a premium invoice is to the individual.
6. The eligibility system sends MinnesotaCare eligibility data to MMIS.



7. A Minnesota Health Care Programs identification card and MinnesotaCare managed care enrollment materials (a managed care enrollment form and health plan provider network directories) are mailed to the individual.
8. Coverage in MinnesotaCare begins on the first day of the month following payment of a premium, or if no premium is owed, the first day of the month following the month in which MinnesotaCare eligibility is determined.

**If the state has indicated it will submit a transition plan in Question 1 above, please attach the transition plan.**

# Basic Health Program-Premiums and Cost-sharing

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**This section of the Blueprint collects information from the state documenting compliance with requirements for establishing premiums and cost-sharing. Additionally, it provides CMS general information about the states planned premium and cost sharing structures and administration.**

## Premiums

<b>Premium Assurances</b>	
<b>The State assures that:</b>	
X	The monthly premium imposed on any enrollee does not exceed the monthly premium the individual would have been required to pay had he/she been enrolled in the applicable benchmark plan as defined in the tax code.
X	When determining premiums, the State has taken into account reductions in the premium resulting from the premium tax credit that the enrollee would have been paid if he/she were in the Exchange.
X	It will make the amount of premiums for all standard health plans available to any member of the public either through posting on a website or upon request. Additionally, enrollees will be notified of premiums at the time of enrollment, reenrollment or when premiums change.

**Please provide the weblink or other instructions for accessing premiums which will be provided to enrollees.**

Applicants and enrollees can access the MinnesotaCare Premium Estimator at the following website:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG>

**Please describe:**

**1.) The group(s) of enrollees subject to premiums.**

All MinnesotaCare enrollees are required to pay premiums with the exception of:

- individuals under age 21
- American Indians (as defined at 42 C.F.R. 447.50) and their family members
- Members of the military who have completed a tour of active duty within 24 months and their family members for a period of 12 months
- Enrollees with income below 55% FPL<sup>6</sup>

**2.) The collection method and procedure for the payment of premiums.**

Premium invoices are mailed to enrollees approximately 30 days prior to the month of coverage. Premiums can be paid via mail or in person at the MinnesotaCare office located in Saint Paul. Minnesota is working towards accepting on-line premium payments and hopes to be able to implement this functionality before or during 2015.

**3.) The consequences for an enrollee or applicant who does not pay a premium.**

Enrollees who do not pay their premium by the due date are dis-enrolled from their health plan beginning in the coverage month for which the premium was due. If the individual pays the past due premium and the next month's premium within 20 days of disenrollment, the individual is re-enrolled in MinnesotaCare on a fee-for-service basis administered by DHS until they can be re-enrolled in their health plan in the next available month.

Minnesota is requesting an exemption from the 30-day grace period requirement at 42 CFR 457.570(c) for 2015. Our exemption request is attached.

## Cost-sharing

Cost-sharing Assurances	
The State assures that:	
X	Cost sharing imposed on enrollees meets the standards imposed by 45 CFR 156.420(c), 45 CFR 156.420(e), 45 CFR 156.420(a)(1) and 45 CFR 156.420(a)(2).
X	Cost sharing for Indians meets the standards of 45 CFR 156.420(b)(1) and (d) <sup>7</sup> .
X	The State has not imposed cost sharing for preventive health services or items as defined in accordance with 45 CFR 147.130.
X	The State has provided the amount and type of cost-sharing for each standard health plan that is applicable to every income level either on a public website or upon request to any member of the public, and specifically to applicants at the time of enrollment, reenrollment or when cost-sharing and coverage limitations change.

**Please provide the weblink or other method of public access to cost-sharing.**

Applicants and enrollees can access information about cost sharing in the Minnesota Health Care Programs Benefits Summary, which is available at the following website:

<http://edocs.dhs.state.mn.us/lfserver/public/DHS-3860-ENG>

**Please describe:**

**1.) The group(s) subject to cost sharing.**

All MinnesotaCare enrollees are subject to cost-sharing with the exception of:

- Enrollees under age 21;
- American Indians enrolled in a federally recognized tribe<sup>8</sup>;

Mental health services are not subject to co-pays.

**2.) The system in place to monitor compliance with cost-sharing protections described above.**

MinnesotaCare health plan contracts include descriptions of the enrolled populations that receive cost-sharing protections and a description of the cost-sharing protections. Execution of the contracts provides assurance that the cost-sharing protections will be put into effect. MinnesotaCare enrollees are excluded from cost-sharing based on certain characteristics that are identified in the enrollment files sent to the health plans. In addition

to the contract language and the files sent to the providers, health plans also send each enrollee an Evidence of Coverage document that details their benefits and cost-sharing protections. This document is reviewed and approved by DHS. Annually enrollees are sent a Rights Notice that includes information on cost-sharing protections. Each of these actions serves to ensure that MinnesotaCare enrollees are afforded all of the required cost-sharing protections.

DHS monitors and responds to enrollees complaints related to benefits and cost-sharing. Finally, the encounter claim data submitted to DHS by the health plans includes information about payment amounts that were allocated as the Patient Responsibility. DHS also monitors the encounter claim data for signs that cost-sharing is being applied or excluded appropriately.

## Disenrollment Procedures

**Has the state elected to offer the enrollment periods equal to the Exchange defined at 45 CFR 155.410 and 410? If yes, the state assures that it will comply with the premium grace periods standards at 45 CFR 156.270 prior to disenrollment and that it will not restrict reenrollment beyond the next open enrollment period.** No

**If No above, the state assures that it is providing a minimum grace period of 30 days for the payment of any required premium prior to disenrollment and that it will comply with reenrollment standards set forth in 457.570(c).**

Minnesota is requesting an exemption from the reenrollment standards at 457.570(c) for the 2015 coverage year. Our exemption request is attached (Attachment A).

**If the state is offering continuous enrollment and is imposing a premium lock-out period, the lock-out period in number of days is \_\_\_\_ N/A \_\_\_\_.**

Our alternative to the 30-day grace period does not include a lock-out period.

# Basic Health Program-Standard Health Plan Contracting

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This portion of the Blueprint is dedicated to the collection of information about the service delivery system that will be used in the state as well as how the state plans to contract within that system.

## Delivery Systems

1) **The State is offering Standard Health Plans through:**

Type	Number of Plans	Service Delivery Mechanism
Y	5	Licensed Health Maintenance Organizations
N	-	Licensed Health Insurance Issuers
N	-	Networks of Health Care Providers
Y	3	Non-licensed Health Maintenance Organizations participating in Medicaid/CHIP [County-based Purchasing Plans]

The information in the table is applicable to the 2015 coverage year. As noted below, DHS will do a full procurement for the 2016 coverage year. As a result of that procurement, DHS expects an increase in the number of participating plans as well as a possible increase in the types of service delivery entities (i.e. Health Insurance Issuers and Networks of Health Care Providers) that will be available to MinnesotaCare enrollees in 2016.

2) **Please assure that standard health plans from at least two offerors are available to enrollees:**

Minnesota is requesting an exemption from this requirement for the 2015 coverage year. For 2015 we cannot ensure that two offerors will be available in each county. In 2015, 15 counties in Greater Minnesota (accounting for approximately 5% of MinnesotaCare enrollment) will have only one plan available. In the remaining 72 counties, at least two plans will be available.

3) **If applicable, please describe any additional activities the state will use to further ensure choice of standard health plans to BHP enrollees.**

In 2015, DHS will do a full procurement for all allowable service delivery entities for the 2016 coverage year. DHS will also ensure that every MinnesotaCare enrollee has a choice of at least two offerors for the 2016 coverage year.

- 4) **If the state is not able to assure choice of at least two standard health plan offerors as described in question 2, please attach the state’s exception request. This exception request must include a justification as to why it cannot assure choice of standard health plan offeror and demonstrate that it has reviewed its competitive contracting process in accordance with 42 CFR 600.420(a)(i) – (iii).**

Our exception request is attached as Attachment A

- 5) **Is the state participating in a regional compact? If yes, please answer questions 6 – 10. If no, please skip question 6 – 10. No.**
- 6) **Please indicate the other states participating in the regional compact.**
- 7) **Are there specific areas within the participating states that the standard health plans will operate?**
- 8) **If a state contracts for the provision of a geographically specific standard health plan, please describe how it will assure that enrollees, regardless of location within the state, continue to have choice of at least two standard health plan offerors.**
- 9) **Please assure that the regional compact’s competitive contracting process complies with the requirements set forth in 42 CFR 600.410.**
- 10) **If applicable, please indicate any variations in benefits, premiums and cost sharing, and contracting requirements that may occur as a result of regional differences between the participating regional compact states.**

Minnesota is not participating in a regional compact.

## Contracting Process

States must respond to all of the following assurances. If the state has requested an exception to the competitive process for 2015, the State is providing the following assurances in response to how it will conduct contracting beginning in program year 2016.

The State assures that it has or will:		
Assurance	Conducted the contracting process in a manner providing full and open competition including:	
X	45 CFR 92.36(b)	Following its own procurement standards in conformance with applicable federal law.
X	45 CFR 92.36 (c)	Conducting the procurement in a manner providing full and open competition.
X	45 CFR	Using permitted methods of procurement.

	92.36(d)	
X	45 CFR 92.36(e)	Contracting with small, minority and women owned firms to the greatest extent possible.
X	45 CFR 92.36(f)	Providing a cost or price analysis in connection with every procurement action.
X	45 CFR 92.36(g)	Making available the Technical specifications for review.
X	45 CFR 92.36(h)	Following policies for minimum binding requirements.
X	45 CFR 92.36 (i)	Including all the required contract terms in all executed contracts.
	Included a negotiation of the following elements on a fair and adequate basis <sup>9</sup> :	
X		Premiums and cost sharing <sup>10</sup>
X		Benefits <sup>11</sup>
X		Innovative features such as care coordination and care management
X		Incentives for the use of preventive services
X		Maximization of patient involvement in health care decision making
	Included criteria in the competitive process to ensure:	
X		Health care needs of enrollees
X		Local availability of and access to providers to ensure the appropriate number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area so that access to services is at least sufficient to meet the standards applicable under 42 CFR Part 438, Subpart D, or 45 CFR 156.230 and 156.235.
X		Use of managed care or a similar process to improve the quality accessibility, appropriate utilization and efficiency of services provided to enrollees
X		Performance measures and standards
X		Coordination between other Insurance Affordability Programs
X		Measures to address fraud, waste and abuse and ensure consumer protections
	Established protections against discrimination including:	
X		Safeguards against any enrollment discrimination based on pre-existing condition or other health status related factors.
	Established a Medical Loss Ratio of at least 85% for any participating health insurance issuer.	
X		The minimum standard is reflected in contracts.

## Standard Health Plan Contracting Requirements

States are required to include the standard set of contract requirements that will be incorporated into its Standard Health Plan contracts. Please reproduce in the text box below. Standard Health Plan contracts are required to include contract provisions addressing network adequacy, service provision



**and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, and provisions protecting the privacy and security of personally identifiable information. However, we have given states a “safe harbor” option of re-using either approved Medicaid or Exchange contracting standards. If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.**

For the 2015 coverage year, Minnesota will continue to contract with our current health plans Health Plans. The relevant sections demonstrating our compliance with each of the provisions listed above are included as Attachment 4. Our 2014 competitive bidding process complied with all applicable Medicaid requirements. We have attached a copy of our 2014 Model Contract (Exhibit 6) and our 2014 RFP (Exhibit 7).

## **Coordination of Health Care Services**

**Please describe how the state will ensure coordination for the provision of health care services to promote enrollee continuity of care between Medicaid, CHIP, the Exchange and any other state administered health insurance programs. Describe below:**

DHS contracts for Medical Assistance and MinnesotaCare currently include language requiring health plans to allow for continuity of care whenever an enrollee is required to change health plans due to a change in health care program or a change in circumstance. Our transition provisions are detailed at section 6.21.2 of the 2014 Model Contract (Exhibit 6).

For clients moving from Medical Assistance or MinnesotaCare to QHPs, MNsure provides information about the covered benefits and provider networks for each available QHP plan. Clients can use this information to choose the most appropriate plan from the QHP plans offered through MNsure.

## **Risk Adjustment**

**Is the state expecting or considering whether risk adjustment will effect plan contracting? If so, how?**

Minnesota currently uses risk adjustment to adjust capitation payments to health plans serving the MinnesotaCare population. We intend to continue risk adjustment and believe that health plans would consider it a requirement for contracting.

**Please describe how the state will get data on the Marketplace and BHP for purposes of risk adjustment?**

The DHS contract with health plans requires the submission of encounter data as a condition of contracting. DHS uses the encounter data to generate risk scores for MinnesotaCare enrollees using the Chronic Illness and Disability Payment System plus Medicaid Rx (CPDS+Rx) version 5.4 risk adjuster.

**What model is the state considering?**

The Chronic Illness and Disability Payment System plus Medicaid Rx (CPDS+Rx) version 5.4 risk adjuster.

**How do the data account for differences in demographics/benefits/cost-sharing?**

Encounter data used for risk adjustment contains demographic information age, gender and location. Benefit information is accounted for based on eligibility codes associated with each member. Members risk scores are aggregated by rate cell and normalized over a determined region.

**For purposes of measurement: What is the state measuring against (BHP v. Marketplace, or BHP v. Marketplace and BHP)?** DHS is measuring the relative health status of each health plans MinnesotaCare population in relation to the overall MinnesotaCare population.

# Operational Assessment

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The State assures that it can or will be able to:		
Full Assurance	Contingent	Eligibility and Renewals
	X	Accept an application online, via paper and via phone.
	X	Return an accurate eligibility result for all BHP eligible applicants.
	X	Process a reported change and re-determine eligibility.
	X	Comply with the <i>ex-parte</i> renewal process.
	X	Issue an eligibility notice
	X	Issue a renewal notice
Benefits and Cost-Sharing		
X		Provide the enrollee with the correct benefit set
X		Exempt American Indians from Cost-sharing
X		Apply appropriate cost-sharing amounts to enrollees subject to cost-sharing
Premium Payment and Plan Enrollment		
	X	Issue and accurate and timely premium invoice
	X	Receipt a premium and apply the premium payment correctly
X		Notify enrollee of health plan choices and complete plan enrollment
X		Issue a health plan dis-enrollment notice
X		Coordinate enrollment with other Insurance Affordability Programs

## Contingency Descriptions

Accepting Applications – DHS can currently accept applications filed via the online system or paper applications. DHS is developing a process that will allow us to accept applications via phone.

Eligibility Results – the MNsure eligibility system will return the correct eligibility result for all BHP applicants with the following exceptions:

- Lawfully Present Non-Citizens with attested immigration status of “Temporary Protected Status” or “Other”. These applicants currently receive Medical Assistance eligibility results.

This is due to a defect in the system rules. We plan to correct the defect prior to implementing the BHP.

- Non-Tax Filers – applicants who respond that they do not intend to file taxes but who otherwise meet all of the other BHP eligibility criteria currently receive an Unassisted QHP eligibility result.

It is unlikely that we will be able to implement the correct rule set in the system prior to the implementation date for the BHP. Instead, we will run regular reports to identify these applicants and manually correct the evidence. For these cases, MinnesotaCare eligibility will be available back to the month of application, with benefits beginning the first day of the month following the original determination.

Processing Reported Changes – We anticipate that the system functionality to process reported changes will be available prior to the BHP implementation date. We do not currently have a functioning contingency plan in place for this functionality; we are simply recording the reported changes until such time as we are able to act on them.

Renewal Process – DHS does not currently have the ability to comply with either the Medicaid or Tax Credit renewal process. As stated, our preference would be to use the *ex-parte* renewal process at 42 C.F.R. § 435.916(a)(2) for all MinnesotaCare enrollees for the 2016 Open Enrollment period. We anticipate that functionality to comply with the Medicaid renewal provisions will be available for the Medicaid enrollees in the system by the 2015 Open Enrollment starting November of 2014. However, we may not be able to apply the Medicaid process to the MinnesotaCare enrollees for the 2015 Open Enrollment period. If that is the case, current MinnesotaCare enrollees would be handled in the same manner as Tax Credit enrollees for the 2015 Open Enrollment and DHS would switch to the Medicaid process for MinnesotaCare by the 2016 Open Enrollment period. We are also developing a manual contingency plan to put in place if all renewal system functionality is delayed.

Eligibility Notices – Although DHS is not currently issuing eligibility notices for approvals, denials, changes or closings, we anticipate that system functionality will be put in place to generate all appropriate notices automatically prior to the BHP implementation date. We anticipate automated eligibility approval and denial notices will be re-implemented by August, 2014.

Renewal Notices – DHS does not currently have the ability to issue a renewal notice. We anticipate that this functionality will be in place prior to the 2015 Open Enrollment period in November of 2014. The contingency plan for the renewal notices will be developed in concert with the contingency plan for the *ex-parte* renewal process.

American Indian Cost-Sharing – DHS does not currently have the ability to automate the cost-sharing exemption for American Indians. However we will have a fully compliant contingency in place prior to the BHP implementation date. Our contingency is to print a list of the MinnesotaCare enrollees that qualify for the cost-sharing exemption each month, send the list to the health plans and direct them to update the files they send to providers.

Premium Billing and Receipting – Currently, DHS can correctly compute a premium for each MinnesotaCare enrollee, issue a premium invoice and receipt the premium payments. We have verified that enrollees that are exempt from premiums are not being billed for premiums. In a small percentage of cases (10% to 15%), MinnesotaCare households are being double billed for premiums, under billed for premiums (only one household member is being billed instead of two), or are not receiving their premium bills. We are working with our vendors to research and correct the billing errors. We will provide refunds to any enrollee who overpaid premiums. We are not able to manually override the incorrect bills within the financial system.

Coordinate Plan Enrollment with Other Health Care Programs – DHS does not currently have the ability to automate health plan selection or enrollment when MinnesotaCare clients move from MinnesotaCare to a Marketplace program. We can automatically coordinate health plan selection when a MinnesotaCare enrollee moves to Medicaid. Currently, we use the manual enrollment process described in other sections of this document when an enrollee needs to move from a public program to a Marketplace program and vice versa.

# Basic Health Program-Trust Fund

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## Please provide the BHP Trust Fund location and relevant account information:

Similar to our accounting of other federal funds, and consistent with state law, the BHD Trust Fund will be contained within Fund 3000 (the accounting fund in which federal funds are held) on Minnesota's state-wide accounting system (SWIFT). Additional expenditure and revenue accounts will be established in order to meet OMB A-87 and A-133 requirements. Once established, Minnesota will communicate those account and subaccount specifics to CMS.

## If there is separation between the entity holding the trust fund and the entity operating the trust fund, please describe the relationship below:

### Trustees:

Name	Title	May authorize withdrawals?
Lucinda Jesson	DHS – Commissioner (or designee)	Y
Jim Schowalter	Commissioner – MMB (or designee)	Y
Alexandra Kotze	DHS – Chief Financial Officer	Y
Jim Golden	State Medicaid Director	Y
Marty Cammack	DHS – Financial Operations CFO	Y

**Is anyone other than Trustees indicated above able to authorize withdrawals?** No

**If Yes, who by name and title has this authority?**

**Please name the CMS primary contact for the BHP trust fund and provide contact information.**

Marty Cammack  
Minnesota Department of Human Services  
PO Box 64940  
St. Paul, MN 55164-0940

(651).431.3742  
[Marty.Cammack@state.mn.us](mailto:Marty.Cammack@state.mn.us)

**Please describe the process of appointing trustees.**

The named appointees are assigned as trustees on the basis of their current positions within DHS and MMB. Based on existing procedures and the way the state oversees all financials, including federal funds, the appropriate lead fiscal representatives were named as Trustees for the BHD Trust Fund. This allows the state to follow the same procedures, review and oversight as is conducted for other state related business.

**Provide a list of all qualifications and responsibilities of Trustees.**

The Trustees are assigned based on their current positions within DHS and MMB. The Trustees all go through extensive review, interviews and minimum qualification assessments prior to being hired into their positions. Therefore, all Trustees listed have significant financial responsibility within the state and have the qualifications to make decisions related to this matter.

Trustees will provide oversight to ensure that all trust fund expenditures are made in an allowable manner. In addition, trustees will specify individuals with authority to make withdrawals from the fund to make allowable expenditures.

**Has the state made any arrangements to insure or indemnify trustees against claims for breaches of fiduciary responsibility? If yes, what are they?**

Because the Trustees are appointed based on their current employment positions within DHS and MMB, they are indemnified against claims of breaches in fiduciary responsibility under Minnesota Statutes, Section 3.3736.

<b>Trust Fund Attestation</b>		Attest that the Agency is immediately ready and able.	Date the Agency commits to being ready to perform task if not immediately able.
<b>The BHP Administering Agency will:</b>			
600.710(a)	Maintain an accounting system and fiscal records in compliance with Federal requirements including OMB circulars A-87 and A-133.	X	
600.710(b)	Obtain an annual certification from the BHP Trustees, the State's CFO, or designee, certifying the state's BHP Trust Fund FY financial statements, and that BHP trust funds are not being used for any non-federal share for any Federally-funded program, and the use of BHP trust funds is in accordance with Federal requirements.	X	
600.710(c)	Conduct an independent audit of Trust Fund expenditures over a 3-year period in accordance with chapter 3 of GAO's Government Auditing Standards.	X	



600.710(d)	Publish annual reports on the use of funds within 10 days of approval by the trustees.	X	
600.710(e)	Establish and maintain BHP Trust Fund restitution procedures.		10/1/14
600.710(f) and (g)	Retain records for 3 years from the date of submission of a final expenditure report or until the resolution and final actions are completed on any claims, audit or litigation involving the records.	X	

## **Attachment A: Transition Plan for the 2015 Coverage Year**

Minnesota is requesting a transition plan for the 2015 implementation year of our Basic Health Program. During this transitional year, Minnesota requests an exemption from:

1. The requirement at 42 CFR 600.420 to provide a choice of health plans to all BHP enrollees in program year 2015.
2. The ability to apply the Minimum Value Test as defined in 36B(c)(2)(C) in conjunction with the Affordability test in 42 CFR 600.305(a)(3)(ii).
3. The 30-day grace period required at 42 CFR 605.525. Minnesota is proposing to maintain its current 20-day reinstatement policy for individuals who do not pay the monthly premium by the due date.

### **Request for Exemption from Health Plan Choice Requirements (42 CFR 600.420)**

The final BHP regulations require states to offer a choice of standard health plans to all BHP enrollees. Minnesota requests an exemption from this requirement for program year 2015.

Minnesota does not currently provide a choice of health plans to all MinnesotaCare enrollees. Enrollees in 15 of Minnesota's 87 counties (approximately 5% of all MinnesotaCare enrollees) have only one health plan available to serve them. These counties are located in rural areas in northern and southeastern Minnesota (see Attachment 6: MinnesotaCare Health Plan Choices by County). Enrollees in the remaining 72 counties will have at least two health plan choices for the 2015 coverage year.

The timing of the final rule did not allow sufficient time for Minnesota to complete a full procurement process for the 2015 coverage year. Instead we will continue to contract in 2015 with the health plans that signed 2014 contracts to serve the current MinnesotaCare populations.

In 2014, Minnesota used a competitive bidding process that complied with all applicable Medicaid requirements. As attested to in the Blueprint template, our 2014 competitive bidding process complied with the full and open competition provisions consistent with 45 CFR 92.36(b) through (i). We will renegotiate all of our current contracts for the 2015 coverage year and the contract negotiations will include the criteria listed at 42 CFR 600.410(d). Finally, because our 2014 procurement process followed Medicaid rules, that procurement process meet the criteria at 42 CFR 600.410(e) and (f)

Minnesota provides assurances that all BHP enrollees will have a choice of health plans for program year 2016.

## **Request to Continue Applying Minimum Value Test in Conjunction with the Affordability Test (600.305(a)(3)(ii))**

Minnesota requests an exemption that would allow us to apply both the minimum value and the affordability components of the Employer Sponsored Insurance (ESI) affordability test for BHP applicants who have access to employer-sponsored insurance. Alternatively, Minnesota requests permission to apply the minimum value test on a transitional basis during program year 2015 while it makes the necessary changes to state law and the eligibility system to ensure compliance with the final rule beginning in 2016.

In the final rule governing eligibility for the basic health plan (BHP), DHHS interpreted the BHP statute at section 1331(e)(1)(C) of the Affordable Care Act (ACA) to allow BHP eligibility when an applicant has access to ESI, but the ESI is unaffordable according to the portion of the premium tax credit (PTC) affordability test that relates to 9.5% of income. In its commentary supporting the final rule, DHHS specifically noted that the minimum value prong of the PTC affordability test does not apply. We believe that section 1331(e) can and should be interpreted as including both the income test and the minimum value test associated with ESI and eligibility for PTCs as the most reasonable and fair policy position. We also believe that our proposed interpretation may be the only workable interpretation of section 1331(e).

Section 1331(e)(1)(C) of the ACA prohibits eligibility for BHP for an applicant:

...who is not eligible for minimum essential coverage (as defined in section 5000(A)(f) of the Internal Revenue Code of 1986) or is eligible for an employer sponsored plan that is not affordable coverage (as determined under section 5000(A)(e)(2) of such Code)...

Subparagraphs (e) and (f) of section 5000A of the IRC referenced in the BHP statute are related to the imposition of the individual responsibility to maintain minimum essential coverage. As such, section 5000(A) defines minimum essential coverage (MEC) as government-sponsored programs, ESI, individual market plans, etc. Whether or not the coverage is affordable, and whether a person is “eligible for” but not enrolled in such MEC is not relevant to the individual mandate and its penalties, and therefore neither concept is mentioned in section 5000A.

Because section 1331(e) clearly intended to provide BHP eligibility to someone with access to unaffordable ESI, in the final BHP rule, DHHS acknowledged the drafting error referring to section 5000(A)(e)(2) of the code, and instead, allowed for BHP eligibility for someone with access to unaffordable ESI as defined in section 36B(c)(2)(C) of the Internal Revenue Code (IRC), which is the affordability test used for purposes of eligibility for PTCs. *42 C.F.R. § 600.306(3)(iii) and 79 Fed. Reg. 14119 (March 12, 2014).*

The affordability test for purposes of PTCs at section 36B(c)(2)(C) of the IRC includes both an income test and a minimum value test. In other words, if an individual has access to coverage for which at least 60%

of cost is paid by the plan (the minimum value test) and the out of pocket premium cost is less than 9.5% of household income (the income test), the individual may not purchase coverage through the Exchange and receive tax subsidies. Unfortunately, in its explanation of the final rule, DHHS interpreted the statute to prevent BHP eligibility for an individual with access to minimum essential coverage (MEC) that meets the income test but does not meet the minimum value test.

Comment: Another commenter wanted clarity that an individual may be eligible to enroll in a standard health plan through BHP if the individual has access to employer sponsored coverage that fails to meet the minimum value standards.

Response: As noted above, the standard for eligibility for BHP is based on statutory language in section 1331(e)(1) of the Affordable Care Act, which specifies that only individuals ineligible for MEC or individuals eligible for an employer-sponsored plan that is not affordable coverage are eligible for BHP. Minimum value is not a standard authorized by the statute.

*79 Fed. Reg. 14119 (March 12, 2014).*

In other words, access to inferior coverage that costs less than 9.5% of income is a bar to BHP eligibility, even though access to inferior coverage is not a bar to receiving tax credits in the Exchange. The DHHS response quoted above is inconsistent with DHHS' interpretation of section 1331(e)(1)(C) as barring BHP eligibility using the PTC affordability test, which includes both the minimum value and the income test.

Section 36B(c)(2)(C) of the IRC is an exception to a rule that prohibits tax subsidies in a month in which an individual was eligible for MEC coverage (other than individual coverage), where the access is to coverage of less than minimum value or the cost is more than 9.5% of income. This section is now used in the BHP rule to define affordability. The rule itself therefore includes the minimum value test. Further, the law defines coverage that doesn't meet minimum value as something other than minimum essential coverage. The test at paragraph (C)(i), which deals with the income test, specifically refers to minimum essential coverage, which is defined in paragraph (ii) of that same section to exclude coverage that does not meet minimum value. It is not possible to separate the income and the minimum value tests – they are interrelated. From a policy perspective, the affordability test should be against some minimum value, since most policies that provide very little coverage will likely cost less than 9.5% of income.

There are interpretations other than the DHHS interpretation in the final BHP regulation provided at section 600.305(3)(i) that a person is ineligible for BHP if they are eligible for MEC as defined in section 26 CFR 1.5000A-2, which is the rule implementing the individual mandate portion of the statute.

Section 600.305 provides:

- (a) Eligibility standards. The state must determine individuals eligible to enroll in a standard health plan if they:

... (3) Are not eligible to enroll in minimum essential coverage... If an individual meets all other eligibility standards, and---

- (i) is eligible for, or enrolled in, coverage that does not meet the definition of minimum essential coverage, the individual is eligible to enroll in a standard health plan without regard to eligibility or enrollment in Medicaid; or
- (ii) is eligible for Employer Sponsored Insurance (ESI) that is unaffordable (as determined under section 36B(c)(2)(C)...), the individual is eligible to enroll in a standard health plan.

The definition of MEC in the BHP rule refers to 26 CFR 1.5000A-2. That section of rule implements the individual mandate and, as noted above, includes coverage in the individual market because an individual should be able to meet the mandate by purchasing individual coverage as well as group coverage or coverage through a government program. However, the BHP statute and regulation require “ineligibility” for MEC as a condition of BHP eligibility. Since everyone is going to be eligible to purchase coverage in the individual market, the use of the MEC definition in the individual mandate section results in making *everyone* ineligible for the BHP.

The most straightforward solution would be to allow Minnesota to substitute the PTC definition of MEC, in the same manner as the substitution of the PTC definition of affordability, in an effort to give meaning to the BHP statute. The PTC definition of MEC at § 36B(c)(2) of the IRC defines MEC as government-sponsored programs, affordable ESI, and other coverage designated by the Secretary, but specifically excludes coverage in the individual market. This in combination with the reference to the appropriate PTC affordability test, gives full meaning to section 1331(e)(1)(C) because section 36B(c)(2) both excludes individual market coverage and incorporates the affordability and minimum value tests for ESI into its definition of MEC.

From a fairness perspective, if Minnesota were to operationalize the BHP rule as interpreted without the minimum value test, applicants with income below 200% FPL who have access to ESI plans that do not provide coverage meeting the minimum value test will very likely be barred from the program that was specifically designed to aid them. Lower wage workers are more likely to be part time workers who may only have access to low cost, low benefit plans via their employer. These plans may very well cost less than 9.5% of income but not offer meaningful coverage.

Moreover, IRS staff have confirmed that workers with incomes under 200% FPL who have access to these low cost, low benefit ESI plans would remain eligible for PTC in the Exchange (because they would be ineligible for MEC via the BHP plan). This would subject these lower wage workers to the higher QHP premium and cost-sharing requirements that Minnesota is attempting to mitigate by implementing the BHP program.

Given that these applicants would be eligible for PTC, allowing Minnesota to maintain the current two-pronged test would also result in savings for the federal government. The federal government would be

responsible for the full amount of tax credits and cost-sharing reductions for those individuals that enroll in PTC as a result of being determined ineligible for the BHP. The federal government would be responsible for only 95% of the cost of tax credits and cost-sharing reductions for the same individuals if they are allowed to remain enrolled in the BHP.

### **Request for Exemption from 30-Day Grace Period (600.525(a)(3))**

Minnesota has had a 30-day grace period in place for MinnesotaCare in the past. The grace period provision was repealed because it presented significant administrative burdens and resulted in enrollees failing to come back onto coverage after missing premium payments. Our experience with the 30-day grace period was that individuals would often stop paying premiums in lieu of formally dis-enrolling from MinnesotaCare. However, when they attempted to re-enroll in MinnesotaCare, sometimes several months after leaving the program, they were unable to pay the premium for the first month of the new coverage span plus the past due premium from the “grace month”. Because individuals often resisted paying the past due premiums, our experience was that the 30-day grace period resulted in a high number of appeals and that the policy generally acted as a barrier to re-enrollment.

Minnesota replaced the grace month with the 20-day re-instatement period as a way to address these shortcomings of the 30-day grace period. Current MinnesotaCare policy provides notice of past due premiums and the ability to reinstate coverage without a gap. While we do not currently provide an explicit opportunity to demonstrate a change in income prior to disenrollment from the health plan this step can easily be implemented by the January 2015 implementation date. Enrollees also have the opportunity to appeal their disenrollment from their health plan. Finally, because Minnesota is implementing 12 month coverage periods for MinnesotaCare, enrollees that lose health care coverage will not lose eligibility and will not have to re-apply to reinstate coverage.

We are also concerned that the 30-day grace period as set forth in the final rules would result in some enrollees paying a premium only every other month unless a lock-out period was included. We understand that such a lock-out period is allowed under the CHIP regulations. However, Minnesota would need explicit statutory authority to reinstitute the 30-day grace period with a lock-out period for MinnesotaCare and we will not have an opportunity to get a legislative change until our next legislative session begins in January of 2015.

Therefore, Minnesota is requesting an exemption from the requirement at 42 CFR 600.525(a)(3) to implement a 30-day grace period process related to non-payment of premiums. Minnesota requests that we be able to maintain our 20-day reinstatement policy in its current form. Below is an example of the current 20-day reinstatement process:

- MinnesotaCare enrollee has paid for the month of February.
- In mid-January, an invoice is sent for March coverage with a due date in mid-February (11 working days before the end of the month).
- The enrollee does not pay the premium by the due date and is removed from list of capitation payments to be paid to the health plan.
- The enrollee does not pay the premium by February 28th.
- On March 1st. MMIS is notified that the enrollee did not pay the March premium.

- MMIS cancels the health care plan and puts it in the 20-day grace period for possible reinstatement.
- In mid-February, an invoice is sent for April coverage that shows the “Past Due” amount for March and includes a Notice that says the enrollee must pay the full amount due for March and April by March 20th or the enrollee will lose coverage for March.
- On March 19th, the enrollee pays the full amount due for March and April and the payment is recorded.
- On March 19th, MMIS is notified of the payment.
- On March 19th, MMIS extends coverage retroactively back to the first of March as “fee-for-service”, and reinstates the health plan policy for the month of April.

Understanding that there may be concerns about the small FFS component of the 20-day reinstatement process. We would like to reiterate that MinnesotaCare is currently and will remain a mandatory managed care program in 2015. Unlike Medicaid, MinnesotaCare clients do not have an option to enroll in MinnesotaCare on a FFS basis. With two exceptions, all coverage in MinnesotaCare is managed care coverage.

The first exception is the retroactive coverage related to the 20-reinstatement procedure described above. The second exception occurs less often and is related to new applicants that receive an eligibility determination that is on a day that is one of the last days of the month and is not a working day.

The capitation payment runs for the MinnesotaCare health plans always occur on the last working day of the month. All new applicants that have gotten an eligibility determination prior to the capitation payment run are enrolled in a health plan effective the first day of the month following the month of application.

However, since we have implemented our online application system, new applicants can apply online every day from 6am to midnight and get a real time eligibility result. For the 2014 calendar year, there are three months (May, August, and November) in which applicants that apply on a Saturday, Sunday or holiday and get a MinnesotaCare eligibility determination would be covered FFS in their initial month of coverage. In these situations, the capitation payment run for the next month’s coverage would have been completed on the last working day prior to the new applicant receiving the MinnesotaCare eligibility result. These applicants would be covered on a FFS basis for the first month of coverage and enrolled in a health plan the next month.

MinnesotaCare clients covered in a FFS month have access to the identical benefit set, identical cost-sharing, and a near identical provider network as they would have when covered via a managed care plan. MinnesotaCare enrollees owe the same premium without regard to whether coverage is via FFS or a managed care.



## Endnotes

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<sup>1</sup> Minnesota currently covers infants (up to age 2) up to 283% FPL, pregnant women up to 278% FPL and children age 2 to 18 up to 275% FPL in our Medical Assistance program. This means that MinnesotaCare enrollment will generally be limited to citizen children aged 19 and 20, parents and childless adults with incomes between 133% and 200% FPL and non-citizen parents and adults with incomes below 200% FPL.

<sup>2</sup> Eligibility will be determined in the month of application. The effective date of coverage will be the first day of the month after the date of premium payment or, if a premium is not required, the first day of the month following the month of application.

<sup>3</sup> No age limit is currently coded into the system. Minnesota is considering allowing individuals age 65 and over who do not have access to premium free Medicare Part A to continue to get a MinnesotaCare benefit set. All costs for these individuals will be covered with state-only funding. If the state-funded option is adopted, the only systems change needed will be the funding code change for individuals age 65 and over.

<sup>4</sup> Current rules allow state-funded MinnesotaCare eligibility for these individuals. The only systems change required will be the funding code change.

<sup>5</sup> The procedure described in the text is the procedure Minnesota uses in those instances in which a change in circumstance can be processed in the system. As noted in the Operational Assessment section, Minnesota is still developing the procedures for processing the majority of the changes in circumstance that clients are currently reporting.

<sup>6</sup> Minnesota currently covers lawfully present non-citizens in MinnesotaCare with state-only funding and charges a \$4 premium to enrollees with income up to 55% FPL. This premium requirement will be eliminated for enrollees with incomes below 55% FPL effective January 1, 2015.

<sup>7</sup> Minnesota currently exempts all American Indians (as defined at 42 C.F.R. 447.50) from premiums in MinnesotaCare. Effective January 1, 2015, Minnesota will exempt American Indians enrolled in a federally recognized tribe from all cost-sharing in a BHP. In addition, Minnesota is considering extending the cost-sharing exemption in a BHP to all American Indians (as defined at 42 C.F.R. 447.50). This expansion of the cost-sharing protections would be funded with state-only dollars.

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<sup>8</sup> Minnesota is considering extending the BHP cost-sharing exemption to all American Indians (as defined at 42 C.F.R. 447.50). This expansion of the cost-sharing protections would be funded with state-only dollars.

<sup>9</sup> The timing of the publication of the CMS regulation did not allow enough time for DHS to initiate and complete a full procurement for the 2015 coverage year. DHS has state statutory authority (MN. State 256B.69 subd. 35) to not do a procurement for the 2015 coverage year. Instead we will continue to contract with our current 2014 health plans for the 2015 contract year. We have attached our 2014 RFP and our 2014 Model Contract.

<sup>10</sup> The floor for MinnesotaCare client premiums and cost-sharing is set in state statute. DHS negotiates health plan premiums for every contracting period. All plans understand that they must at least meet the statutory requirements for cost-sharing in MinnesotaCare. Plans will also be given the opportunity to offer cost-sharing that is lower than the statutory required amounts.

<sup>11</sup> The minimum allowable MinnesotaCare benefit set is set in state statute. All health plans will have an opportunity to offer additional benefits or substitute benefits for the 2015 coverage year.