

Basic Health Program Blueprint

Introduction

Section 1331(a) of the Affordable Care Act directs the Secretary to establish a Basic Health Program (BHP) that provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage.

States choosing to operate a BHP must submit this BHP Blueprint as an official request for certification of the program.

States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace. A state that operates a BHP will receive federal funding equal to 95 percent of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals, using a methodology set forth in a separate funding protocol based on a methodology set forth in companion rulemaking.

Given the population served under BHP, the program will sit between Medicaid and the Marketplace, and while states will have significant flexibility in how to establish a BHP, the program must fit within this broader construct and be coordinated with other insurance affordability programs. Regulations for the BHP were finalized on March 12, 2014 and are available at www.Medicaid.gov/BHP.

The BHP Blueprint is intended to collect the design choices of the state and ensure that we have a full understanding of the operations and management of the program and its compliance with the federal rules; it is not intended to duplicate information that we have collected through state applications for other insurance affordability programs. In the event that a State seeks to make a significant change(s) that alter program operations described in the certified Blueprint, the state must submit a revised Blueprint to the Secretary for review and certification.

The BHP Blueprint sections reflect the final rule that codified program establishment standards, eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and Secretarial oversight relating to BHP.

Acronyms List

BHP	Basic Health Program
CHIP	Children's Health Insurance Program
CSR	Cost Sharing Reduction
ESI	Employer Sponsored Insurance
EHB	Essential Health Benefits
FPL	Federal Poverty Level
IAP	Insurance Affordability Program
MEC	Minimum Essential Coverage
OMB	Office of Management and Budget
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SHP	Standard Health Plan

Section 1: Basic Health Program-State Background Information

State Name: Minnesota

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

BHP Blueprint Designated State Contact:

Name:	Ann Berg	
Title:	Deputy Medicaid Director	
Telephone number:	651-431-2193	
E-mail:	ann.berg@state.mn.us	

Requested Interim Certification Date (if applicable) (mm/dd/yyyy): N/A

Requested Full Certification Date (mm/dd/yyyy): April 1, 2016

Requested Program Effective Date (mm/dd/yyyy): April 1, 2016

Administrative agency responsible for BHP (“BHP Administering Agency”):
Minnesota Department of Human Services, Single State Medicaid Agency

BHP State Administrative Officers:

Program Administration: (Management, Policy, Oversight)			
Position:	Title:	Location (Agency):	Responsible for:
Emily Johnson Piper	Commissioner MN Dept. of Human Services	DHS, St. Paul, MN	Management Oversight Implementation
Nathan Moracco	Assistant Commissioner Health Care Administration MN Dept. of Human Services	DHS, St. Paul, MN	Management Oversight Implementation Administration
Marie Zimmerman	Medicaid Director	DHS, St. Paul, MN	Management Oversight Implementation Administration

Position:	Title:	Location (Agency):	Responsible for:
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
Position:	Title:	Location (Agency):	Responsible for:
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	Manager Financial Management	St. Paul, MN	Payments Reconciliation

Governor/Governor's designee:

Signature: _____

Date of Official Submission (mm/dd/yyyy): 3/15/2016

Section 2: Public Input

This section of the Blueprint records the state’s method for meeting the public comment process required for Blueprint submission.

Date public comment period opened (mm/dd/yyyy): February 8, 2016

Date public comment period closed (mm/dd/yyyy): March 9, 2016

Please describe the public comment process used in your state, such as public meetings, legislative sessions/hearing, the use of electronic listservs, etc.

DHS posted this proposed amendment to the approved blueprint on the “Public Participation” page of its public website on February 8, 2016. The public comment period ended on March 9, 2016.

Provide a list below of the groups/individuals that provided public comment.

- No comments have been received.

If the state has federally recognized tribes, list them below. Provide an assurance that they were included in public comment and note if comments were received.

Federally recognized tribe:	State Agency Solicited Input:	Input Received:
Bois Forte Band of Chippewa	Y	DHS e-mailed this proposed amendment to the tribes on February 8, 2016, and accept comments until March 9, 2016. No comments were received.
Fond du Lac Band of Lake Superior Chippewa	Y	
Grand Portage Band of Chippewa	Y	
Leech Lake Band of Ojibwe	Y	
Lower Sioux Community	Y	
Mille Lacs Band of Ojibwe	Y	
Prairie Island Indian Community	Y	
Red Lake Band of Ojibwe	Y	
Shakopee-Mdewakanton Sioux (Dakota) Community	Y	

Upper Sioux Community Pejuhutazzi Oyate	Y	
White Earth Band of Ojibwe	Y	

Provide a brief summary of public comments received and the changes made, if any, in response to public comments:

Due to the prospective nature of the public comment period for this amendment, DHS will consider comments received after the effective date of this amendment. If necessary, DHS will submit a revised amendment to address the comments.

Section 3: Trust Fund

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 BHP Trust Fund is 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 were established in order to meet the requirements of OMB A-87, A-133, and 45 C.F.R. Part 75. The BHP funding is segregated within the established account and is not comingled with other funding.

BHP Trust Fund Location (Institution, address, phone number)

Institution: Minnesota Department of Human Services

Address: 540 Cedar Street, St. Paul, MN 55101

Phone Number: 651-431-3545

Account Name: See paragraph above

Account Number: See paragraph above

Trustees:

Name	Organization	Title	May authorize withdrawals?
Emily Johnson Piper	Department of Human Services	Commissioner	Y
Myron Frans	Minnesota Management and Budget	Commissioner	Y
Alexandra Kotze	Department of Human Services	Chief Financial Officer	Y
Marty Cammack	Department of Human Services	Financial Operations CFO	Y

Is anyone other than Trustees indicated above able to authorize withdrawals?

No other individuals are allowed to authorize withdrawals. The Trustees delegate to front line employees within their respective agencies the actual disbursement of BHP Trust funds as directed by the Trustees.

If yes, please include the name and title of everyone with this authority.

Name	Organization	Title

Name	Organization	Title

If there is separation between the entity holding the trust fund (“Trustees”) and the entity operating the trust fund, please describe the relationship below. Include the name, and contacts for the entity operating the trust fund. Also include a copy of a written agreement outlining the responsibilities of the entity operating the trust fund.

The Minnesota Department of Human Services is the holder and operator of the trust fund. The state’s responsibilities regarding the oversight and administration of funds is set forth in [Minnesota Statutes, section 16A.055](#).

Name	Organization	Title	Contact

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

CMS Primary Contact Name: Marty Cammack
CMS Primary Contact Phone Number: 651-431-3742
CMS Primary Contact E-mail Address: 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 BHP 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 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 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.

Trust Fund Attestation		Attest that the Agency is immediately ready and able. (yes/no)	Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)
The BHP Administering Agency will:			
600.710(a)	Maintain an accounting system and fiscal records in compliance with Federal requirements for state grantees, including OMB circulars A-87 and A-133 and applicable federal regulations.	Y	

Trust Fund Attestation		Attest that the Agency is immediately ready and able. (yes/no)	Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)
The BHP Administering Agency will:			
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 certifying that BHP trust funds are not being used for the non-federal share for any Federally-funded program, and that the use of BHP trust funds is otherwise in accordance with Federal requirements (including that use of BHP funds is limited to permissible purposes).	Y	
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.	Y	
600.710(d)	Publish annual reports on the use of funds within 10 days of approval by the trustees.	Y	
600.710(e)	Establish and maintain BHP Trust Fund restitution procedures.	Y	

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.	Y	
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Section 4: Eligibility & Enrollment

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

Note: Blacked out areas indicate that there are no choices available.

Please name the agency with primary responsibility for the function of performing eligibility determinations: **Minnesota Department of Human Services**

Attestation		Completed	If No, Expected Completion date (mm/dd/yyyy)	Marketplace Policy	Medicaid Policy
Eligibility Standards					
The state can enroll an individual in a Standard Health Plan who meets ALL of the following standards.		Y			
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. ¹				
305(a)(3)	Not eligible to enroll in MEC or affordable ESI. ²				
305(a)(4)	Less than 65 years old.				

Attestation		Completed	If No, Expected Completion date (mm/dd/yyyy)	Marketplace Policy	Medicaid Policy
305(a)(6)	Not incarcerated other than during disposition of charges.				
Application Activities					
310(a)	Single streamlined application includes relevant BHP information.	Y			
310(b)	Application assistance, including being accessible to persons who are limited English proficient and persons who have disabilities consistent with 42 CFR435.905(b), is equal to Medicaid.	Y			
310(c)	State is permitting authorized representatives; indicate which standards will be used.	Y			X
315	State is using certified application counselors; indicate which standards will be used.	Y			X
Eligibility Determinations and Enrollment					
320(c)	Indicate the standard used to determine the effective date for eligibility.				X ³
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

Attestation		Completed	If No, Expected Completion date (mm/dd/yyyy)	Marketplace Policy	Medicaid Policy
335(b)	Indicate the standard used for applicants to appeal an eligibility determination.				X ⁴
340(c)	Indicate the standard used to redetermine BHP eligibility.				X
345	Indicate the standard to verify the eligibility of applicants for BHP.			X	

1) Please indicate whether the state will implement the option to redetermine enrollees every 12 months as long as enrollees are under 65, not enrolled in alternative MEC and remain state residents. If no, please explain redetermination standards. (These standards must be in compliance with 42 CFR 600.340(f).)

DHS has implemented 12- month enrollment periods, but enrollees are required to report changes in circumstance within 30 days.

For renewals effective January 1, 2016, Minnesota elects the Medicaid redetermination and Medicaid verification processes at 42 C.F.R. § 435.916(a) and 42 C.F.R. §§ 435.945 through 435.956.

The new eligibility system uses a batch process to determine those cases that automatically renew based on electronic information available, and those cases those that require further information from clients. The batch process uses the federal hub to check income on file against three electronic sources FTI, TALX, and Social Security.

For 2016 redeterminations, out of 90,000 cases, 78,723 cases could not be automatically renewed, because no electronic source is found for income, or electronic sources are not reasonably compatible with income in the case.

For those 78,723 cases, mailing of pre-populated renewal notices began on November 10, 2015 and will be completed by November 18, 2015. The pre-populated forms provide clients with 30 days to respond, and encourages clients to include paper documentation with their response. The 30-day response time ends between December 10th and December 19th, depending on when the notice was issued to the family.

When the worker receives the response, the information from the signed form is entered into the system whether the consumer attests that the case information is unchanged, or reports a change. The system then does two things: 1) it compares the new or attested information with the information already returned from the federal hub, to determine reasonable compatibility, and 2) it runs the eligibility determination process. The system will either confirm eligibility without a need for further verification, or will alert the worker to the need for further verification from the consumer.

In response to a system alert for further verifications, the worker will evaluate whether paper documentation submitted by the consumer is adequate, in which case the worker finalizes eligibility for 2016.

If paper documentation was not included with the pre-populated response, or if inadequate documentation was submitted, the worker must determine what more is needed and send the request to the client, which will include another deadline. At this point in time, we will be at December 19, 2015. It is at this stage of the process that we need to provide the consumer with a reasonable period of time to respond—ten days, but may need to make the consumer eligible for the month of January to receive responses. In addition, a reasonable period of time is necessary to process cases that responded in December, including cases that could not be processed because of unidentified system defects.

Because of defects found in the programming necessary to close cases and issue notices, we were unable to issue notices ten days in advance of January 1. We therefore left open all cases for the month of January, 2016 that would have otherwise closed because they did not respond by the December deadline. We are paying claims via fee-for-service for this group. A notice was issued on January 8, 2016, providing an additional opportunity to respond by January 20, 2016.

For all of the above reasons, all cases scheduled for renewal effective January 1, 2016 will be completed by March 1, 2016, for purposes of federal funding.

Enrollees being renewed for 2017 who are not auto-renewed will receive notices in time to complete the redetermination process prior to January 1, 2017.

2) 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 online 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 are post-

eligibility verifications with applicants given at least 90 days to supply the requested information. Supplement 2 contains the verification plan.

Minnesota also accepts paper applications. The paper application is the single, streamlined application for all Insurance Affordability Programs. All paper applications are 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 C.F.R. § 435.912. Paper applications that are incomplete are 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.

MinnesotaCare applications are processed by county staff, and by state employees in the Health Care Eligibility Operations Division within the Health Care Administration of DHS. DHS and county 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 premium billing and payments, and answering client questions.

3) Please describe the state’s process and timeline for incorporating BHP into the eligibility service in the state including the State’s Marketplace (if applicable). 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. Minnesota has incorporated all of the eligibility rules for MinnesotaCare into the state’s online eligibility system...

4) 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 applicants and enrollees.

Minnesota uses an eligibility system that determines eligibility for all Minnesota health care programs and Qualified Health Plans (i.e., MA, MinnesotaCare, QHP, 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 changes in circumstance are reported, they are entered into the system by an eligibility worker, and the system re-determines eligibility.

When reported changes result in new or continued eligibility for Medical Assistance or MinnesotaCare, the updated information is automatically interfaced to the MMIS system in real time. 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 redetermine eligibility. If the individual is required to provide verification, the worker gathers that verification from the individual prior to approving the redetermination and making it final. 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:
 - a. 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 next month.
 - i. A cancellation notice is mailed to the individual.
 - ii. The system automatically sends MinnesotaCare eligibility closing data to MMIS. This triggers a notice of disenrollment from managed care 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.
 - b. 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 redetermine eligibility. If the individual is required to provide verification, the worker gathers that verification from the individual prior to approving the redetermination and making it final. 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 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.
4. A notice indicating eligibility for MinnesotaCare is sent.
5. If a premium is required, a premium invoice is mailed to the individual.
6. The eligibility system sends MinnesotaCare eligibility data to MMIS.
7. A Minnesota Health Care Programs identification card and managed care enrollment materials (a managed care enrollment form and a provider listing) 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.

Process for client movement from MinnesotaCare to Medical Assistance:

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 redetermine eligibility. If the individual is required to provide verification, the worker gathers that verification from the individual prior to approving the redetermination and making it final. 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.
4. If the system determines the individual is no longer eligible for MinnesotaCare:
 - a. 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 next month.
 - i. A cancellation notice is mailed to the individual.
 - ii. The system automatically sends MinnesotaCare eligibility closing data to MMIS. This triggers a notice of disenrollment from managed care, which is mailed to the individual.
 - iii. The system automatically determines Medical Assistance eligibility for individuals with a MAGI basis for eligibility.
 - iv. Individuals with a possible non-MAGI basis of eligibility may be required to submit additional information.
5. Once eligibility for Medical Assistance is determined, an eligibility notice indicating approval of Medical Assistance eligibility is mailed to the individual.
6. If the individual's current health plan is not available under Medical Assistance, enrollment materials are mailed to the individual. If the individual's current health plan is available under Medical Assistance, the individual will remain in the current health plan and given an opportunity to change health plans.
7. The eligibility system sends Medical Assistance eligibility data to MMIS.
8. Medical Assistance eligibility begins on the first day of the month the individual meets Medical Assistance eligibility factors based on the reported change.

Process for client movement from Medical Assistance to MinnesotaCare:

1. An individual who is enrolled in Medical Assistance 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 redetermine eligibility. If the individual is required to provide verification, the worker gathers that verification from the individual prior to approving the redetermination and making it final. 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 Medical Assistance:
 - a. Medical Assistance 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, Medical Assistance eligibility and benefits end at the end of the next month.
 - i. A cancellation notice is mailed to the individual.
 - ii. The system automatically sends Medical Assistance eligibility closing data to MMIS. This triggers a notice of disenrollment from managed care, to be mailed to the individual.
 - iii. The system will automatically determine MinnesotaCare eligibility.
4. Once eligibility for MinnesotaCare is determined, an eligibility notice indicating approval of MinnesotaCare eligibility is mailed to the individual.
5. If the individual's current health plan is not available under MinnesotaCare, enrollment materials are mailed to the individual. If the individual's current health plan is available under MinnesotaCare, the individual will remain in the current health plan and given an opportunity to change health plans.
6. If a premium is required, a premium invoice is mailed to the individual.
7. The eligibility system sends MinnesotaCare eligibility data to MMIS.
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 Medical Assistance eligibility ends.

5) If the state is submitting a transition plan in accordance with 600.305(b), please describe the transition plan in the box below. The plan must include dates by which the state intends to complete transition processes and convert to full implementation.

Section 5: Standard Health Plan Contracting

This portion of the Blueprint collects 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) Please fill out a separate row for each plan participating in the BHP:

Standard HIOS Plan ID (14 digits + 2 digit variants)	Name of Issuer(s)	Delivery Mechanism (e.g., Licensed HMO, Health Insurance, Network of Health Care providers, Non-licensed HMOs participating in Medicaid/CHIP)	Standard Plan Actuarial Value (please include for individuals < 150% FPL and for individuals > 150% FPL)
Not Applicable	HealthPartners	Licensed HMO	94% for all
Not Applicable	Medica	Licensed HMO	94% for all
Not Applicable	Metropolitan Health Plan	Licensed HMO	94% for all
Not Applicable	UCare	Licensed HMO	94% for all
Not Applicable	Blue Plus	Licensed HMO	94% for all
Not Applicable	Itasca Medical Care	Non-licensed HMO participating in Medicaid/CHIP	94% for all
Not Applicable	PrimeWest Health	Non-licensed HMO participating in Medicaid/CHIP	94% for all
Not Applicable	South Country Health Alliance	Non-licensed HMO participating in Medicaid/CHIP	94% for all

The information in the table is applicable to the 2016 coverage year. The actuarial value was determined by Milliman, an actuarial firm under contract with the Department.

Although Minnesota contracts for both Medical Assistance and MinnesotaCare at the same time, the rates for each program are developed separately for each population. Medical Assistance rates are developed using Medical Assistance enrollee's utilization and experience. MinnesotaCare rates are developed using MinnesotaCare enrollees' utilization and experience.

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

Minnesota offers health plans from at least two offerors to all MinnesotaCare enrollees.

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

As noted above, health plans from at least two offerors are available to all MinnesotaCare enrollees beginning in the 2016 program year. No additional activities are planned.

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).

N/A

5) Is the state participating in a regional compact? No
If yes, please answer questions 6 – 10. If no, please skip questions 6 – 10.

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? If yes, please describe.

8) If a state contracts for the provision of geographically specific standard health plans, please describe how it will assure that enrollees, regardless of location within the state, have choice of at least two standard health plan offerors. Please indicate plans by area.

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.

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 with regard to how it will conduct contracting beginning in program year 2016.

The State assures that it has or will:		
Assurance (These are mandatory elements. Each box below must be checked to approve Blueprint)	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 92.36(d)	Using permitted methods of procurement.
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 bonding requirements.
X	45 CFR 92.36 (i)	Including all the required contract terms in all executed contracts.
	Included a negotiation of the following elements:	
X		Premiums and cost sharing ⁵ .
X		Benefits ⁶ .

X		Innovative features, such as:
X		<ul style="list-style-type: none"> Care coordination and care management
X		<ul style="list-style-type: none"> Incentives for the use of preventive services
X		<ul style="list-style-type: none"> Maximization of patient involvement in health care decision making
		<ul style="list-style-type: none"> Other (Specify)
X		Meeting health care needs of enrollees.
		Included criteria in the competitive process to ensure:
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		Development and use of 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, other health status related factors, and comply with the nondiscrimination standards set forth at 42 CFR 600.165.
		Established a Medical Loss Ratio of at least 85% for any participating health insurance issuer.
X ⁷		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.

Minnesota’s contracts with standard health plans for the 2016 coverage year are modeled on standard Medicaid contracting requirements as required under the “safe harbor” provision set forth in the proposed rules for the Basic Health Program (see 78 FR 59130 and 59131). The “safe harbor” provision provides that contracts that meet Medicaid or Exchange requirements will meet the contract requirements for purposes of BHP until the next contract cycle after the Department of Health and Human Services issues additional guidance on contracting standards. As HHS has yet to issue such guidance, Minnesota seeks continued application of the safe harbor provision for the 2016 coverage year. The 2016 contracts will be available on the Department’s website when they have been fully executed.

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 BHP and Medicaid, CHIP, the Exchange and any other state administered health insurance programs. Describe below:

DHS contracts for Medical Assistance and MinnesotaCare include language requiring health plans to allow for continuity of care whenever an enrollee is required to change health plans due to change in health care program or a change in circumstance. See Minnesota Statutes 2015, section 62Q.56.

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.

Please provide copies of all notices that will be issued for BHP applicants and beneficiaries.

Copies of the notices are included as Exhibit 11.

Risk Adjustment

Is the state proposing a health risk adjustment protocol as part of the payment methodology?

We have opted to not use a health risk adjustment for 2016.

If so,

Has the state submitted the health risk adjustment protocol to CMS?

Not applicable.

Will the payments to plans be adjusted retrospectively based on the outcome of the health risk adjustment?

Not applicable.

If yes, how will they be adjusted? Is this reflected in the contracts to plans?

Not applicable.

Section 6: Premiums and Cost-sharing

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

Premium Assurances	
The State assures that (check all that apply):	
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, along with ways to report changes in income that might affect premiums.

Please provide the web address or other source for public access to premiums.

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

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

Other Source: N/A

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. § 447.51) 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 35% FPL⁸

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.

3) The consequences for an enrollee or applicant who does not pay a premium, including grace periods and re-enrollment procedures

Improvement in functionality for collecting premiums and closing cases for failure to pay premiums was delayed in large part as a byproduct of the delay in eligibility renewals for 2015. In addition, we have not been able to prioritize improvements in the premium collection function of the financial management module that would allow for the accurate and timely processing of premium payments. Consequently, we are moving the premium collection process back to the legacy system (MMIS) in January, to be effective for coverage in the spring of 2016. When these changes occur, the process as described below will be in effect.

Enrollees who do not pay their premium by the due date are dis-enrolled from their health plan at the end of the coverage month for which the premium was due. This coverage month for which the premium was not paid is a grace month. If the individual pays the past due (grace month) premium prior to the last working day of the grace month, the individual is re-enrolled in their health plan without a break in coverage. If the enrollee fails to pay the past due premium amount by the last working day of the grace month, the enrollee’s coverage ends at the end of the grace month. In order to re-enroll in coverage effective less than 90 days from the date of disenrollment, the enrollee must pay the premium for the grace month and the re-enrollment month. In order to re-enroll in coverage effective 90 days or later from the date of disenrollment, the individual must pay only the premium for the prospective month of coverage.

Example:

John Doe is enrolled in MinnesotaCare from January to May of 2016 and timely pays premiums of \$25 each month. John’s June premium is due on May 15th. John has not paid his June premium by the last working day of May.

- John is disenrolled from his health plan effective June 30, 2016.
- In order to reinstate coverage effective prior to October 1, John must pay both the premium for the grace month (June) and the premium for the prospective month of coverage.
- In order to reinstate coverage effective October 1 or later, John must only pay the premium for the prospective month of coverage.

MinnesotaCare Premium Estimator Table

Effective January 1, 2016

Federal Poverty Guidelines (FPG) % Below	Family Size								Monthly Premium Per Person
	1	2	3	4	5	6	7	8	
35%	\$4,119	\$5,575	\$7,031	8,487	9,943	11,399	12,855	14,311	\$0
55%	6,473	8,761	11,049	13,337	15,625	17,913	20,201	22,489	\$4
80%	9,416	12,744	16,072	19,400	22,728	26,056	29,384	32,712	\$6
90%	10,593	14,337	18,081	21,825	25,569	29,313	33,057	36,801	\$8
100%	11,770	15,930	20,090	24,250	28,410	32,570	36,730	40,890	\$10
110%	12,947	17,523	22,099	26,675	31,251	35,827	40,403	44,979	\$12
120%	14,124	19,116	24,108	29,100	34,092	39,084	44,076	49,068	\$14
130%	15,301	20,709	26,117	31,525	36,933	42,341	47,749	53,157	\$15
140%	16,478	22,302	28,126	33,950	39,774	45,598	51,422	57,246	\$16
150%	17,655	23,895	30,135	36,375	42,615	48,855	55,095	61,335	\$25

160%	18,832	25,488	32,144	38,800	45,456	52,112	58,768	65,424	\$37
170%	20,009	27,081	34,153	41,225	48,297	55,369	62,441	69,513	\$44
180%	21,186	28,674	36,162	43,650	51,138	58,626	66,114	73,602	\$52
190%	22,363	30,267	38,171	46,075	53,979	61,883	69,787	77,691	\$61
200%	23,540	31,860	40,180	48,500	56,820	65,140	73,460	81,780	\$71
Exactly 200%	23,540	31,860	40,180	48,500	56,820	65,140	73,460	81,780	\$80

Cost-Sharing

Cost-Sharing Assurances	
The State assures that (check all that apply):	
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).
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, along with ways to report changes in income that might affect cost-sharing amounts.

Please provide the web address or other source for public access to cost-sharing rules.

Effective January 1, 2016, co-pays for services are as follows:

- Inpatient Hospital--\$150 per admission
- Outpatient Hospital--\$25 per visit

- Ambulatory Surgery: \$50 per visit
- Emergency Room: \$50 per visit⁹
- Non-Preventative Physician: \$15 per visit¹⁰
- Radiology: \$25 per visit
- Eyeglasses: \$25 per pair
- Prescription Drugs, Generic: \$6 per prescription
- Prescription Drugs, Brand: \$20 per prescription
- Prescription Drug Maximum Out-of-Pocket: \$60 maximum per month

Web Address: 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>

Other Source: N/A

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; and
- American Indians enrolled in a federally recognized tribe.

Mental health services are not subject to copayments.

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

The contracts with the health plans describe the cost-sharing protections. 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. Enrollees are sent a rights notice each year, which includes information on 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 for Non-Payment of Premiums

Has the state elected to offer the enrollment periods equal to the Exchange defined at 45 CFR 155.410 and 410? No

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.

If no, 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). The state assures that a grace period of at least 30 days will be available prior to disenrollment and the state will comply with the reenrollment standards.

If the state is offering continuous enrollment and is imposing a premium lock-out period, the lock-out period in number of days is: Upon implementation of the appropriate technical changes to the eligibility system, individuals who are disenrolled for failure to pay a premium and apply for coverage effective less than 90 days from disenrollment must pay the premiums for both the grace month and the prospective month of coverage before they can re-enroll. Individuals applying for coverage effective 90 days or later from disenrollment must pay only the premium for the prospective month of coverage.

Section 7: Operational Assessment

The State assures that it can or will be able to:		
Full Assurance	Contingent Assurance	Eligibility and Renewals
	X	Accept an application online, via paper and via phone and provide in alternative formats in accordance with 42 CFR §600.310(b).
X		Return an accurate and timely eligibility result for all BHP eligible applicants.
	X	Process a reported change and redetermine eligibility.
	X	Comply with the ex-parte renewal process.
	X	Issue an eligibility notice and share such notice with CMS.
	X	Issue a renewal notice and share such notice with CMS.
	X	Ability to terminate/disenroll from BHP for a variety of reasons, such as reaching age 65, obtaining MEC
	X	Issue termination/disenrollment notice to enrollees
Benefits and Cost-Sharing.		
X		Exempt American Indians from Cost-sharing.
X		Apply appropriate cost-sharing amounts to enrollees subject to cost-sharing limits.
Premium Payment and Plan Enrollment.		
	X	Issue an accurate and timely premium invoice.
	X	Receipt and apply the premium payment correctly.
X		Notify enrollee of health plan choices and complete plan enrollment.
X		Issue a health plan disenrollment notice.
Coordinate enrollment with other Insurance Affordability Programs.		
X ¹¹		Transfer accounts and provide notification in accordance with 42 CFR 600.330(c) through (e).

Contingency Descriptions

Please describe the contingency or dependency that limits full assurance.

Accepting Applications – DHS can currently accept applications filed via the online system or paper applications. The online application is currently only available in English. The paper application is available in Spanish, Hmong, Somali, Russian and Vietnamese. Applicants with limited English proficiency can receive application assistance from navigators who speak their language, or from other navigators via our language line telephone translation service.

Processing Reported Changes – We do not currently have fully supported functionality to process reported changes in circumstance. We have developed sets of instructions to allow workers to manually

input the required information into the system to update cases appropriately and get the correct updated eligibility result for the following changes: change in income, change in address, add a newborn, add a household member, and remove a household member.

Eligibility Notices –DHS is currently issuing eligibility notices manually for denials, changes, or closings.

Ability to Terminate BHP Coverage – DHS is currently processing manually all reported changes in circumstance. DHS’ ability to terminate coverage due to the enrollee obtaining other MEC coverage varies based on the type of MEC coverage the enrollee obtains. If the enrollee obtains a type of MEC that DHS can verify via an electronic data source (i.e. Medicare), the enrollee will be manually closed based on the electronic reports. Termination based on other types of MEC (i.e. employer sponsored insurance) can only be done once the enrollee reports that other MEC has been obtained. Termination based on age is also currently a manual process based on regular system reports.

Termination Notices – Termination notices are currently being issued manually.

Exemption from Cost-Sharing – DHS does not currently have the ability to automate the cost-sharing exemption for American Indians. We generate a list of the MinnesotaCare enrollees who 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 - DHS can correctly compute premiums for MinnesotaCare enrollees and issue premium invoices. As noted in Section 6 above, we have not been able to prioritize improvements in the premium collection function of the financial management module that would allow for the accurate and timely processing of premium payments. Consequently, we are moving the premium collection process back to the legacy system (MMIS) in January, to be effective for coverage in the spring of 2016.

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. When an enrollee needs to move between public and Marketplace programs, we use the manual enrollment process described in other sections of this document.

Please describe any mitigation steps that will be in place and the date by which a full assurance will be possible.

These are included in the descriptions above.

Section 8: Standard Health Plan

The final section of the BHP Blueprint is an attachment that allows a state to define the standard health plan(s) that will be offered under the BHP. The standard health plan is the set of benefits, including limitations on those benefits for which a state will contract. States are required by statute to offer the Essential Health Benefits (EHB) that are equally required in the Marketplace. States are also required to define those benefits using any of the base-benchmark or reference plans set forth at 45 CFR 156.100 (which could be a different base-benchmark or reference plan than is used for Marketplace or for Medicaid purposes).

The Blueprint will not be a complete submission without the attachment defining the standard health plan offered under BHP.

The MinnesotaCare benefit set complies with the Essential Health Benefits requirements using the Federal Employee Health Benefit Plan (Basic Option) as the reference benchmark plan. MinnesotaCare enrollees under age 21 receive the full Medicaid state plan benefit set as set forth in Minnesota's approved Medicaid State Plan. Adults receive Medicaid state plan benefits with exclusions and limitations. Benefits for all MinnesotaCare enrollees are documented in the attached benefit comparison tool (Supplement 3).

Supplement 1: Basic Health Program- Encounter Data Collection

This supplement to the Minnesota Basic Health Program Blueprint is dedicated to a description of the encounter data that will be collected from Standard Health Plans for administering the program, implementing risk adjustment between health plans, and calculating the Population Health Adjustment Factor in the Basic Health Program Payment Notice.

Data Collected

Minnesota will require all Standard Health Plans and other service delivery mechanisms that deliver health care services to MinnesotaCare enrollees to submit encounter data to DHS. Minnesota currently collects encounter data from managed care organizations for its Medical Assistance and MinnesotaCare enrollees. Specifically, managed care organizations are contractually required to submit:

- Individual enrollee-specific, claim-level encounter data for services provided by the managed care organization to enrollees detailing all medical and dental diagnostic and treatment encounters, all pharmaceuticals, supplies and medical equipment dispensed to Enrollees.
- Encounter data that includes all paid lines associated with the claims.

The contractual encounter data reporting requirements currently used for MinnesotaCare are provided in Exhibit 5 of this document.

Data Format and Standards

DHS requires all encounter claims to be submitted electronically. DHS data reporting requires the use of standard transactions. Specifically, encounter data must be reported to DHS using the following claim transaction formats:

- The X12 837 standard format for physician, professional services and physician-dispensed pharmaceuticals (837P), for inpatient and outpatient hospital services (837I) and for dental services (837D)
- The NCPDP Batch 1.2/D.0 for pharmacy services and for non-durable medical supplies which have an NDC code

DHS has based the encounter data submissions on the X12 and NCPDP standards and generally require the submissions to meet all state and federal requirements, including the federal Implementation Guides. However, because DHS does not follow the HIPAA transaction standards exactly, we have developed two

companion guides to clearly articulate the submission requirements: the *DHS 837 Encounter Companion Guide for Professional, Institutional and Dental Claims*, and the *Pharmacy Encounter Claims Guide*.

DHS requires that all encounter data be submitted no later than thirty days after the date a managed care organization adjudicates the claim, including submission of all claim adjustments by voiding out the original claim and submitting a new claim. DHS requires encounter data submissions for each transaction format at least bi-weekly. When DHS returns or rejects a file of claims, a managed care organization has twenty calendar days to resubmit the file with all of the required data elements in the correct file format.

If a managed care organization is unable to make a submission during a certain month, the managed care organization is required to notify DHS of the delay, provide a reason for the delay, and provide an estimated date when DHS can expect the submission.

When DHS receives an encounter data submission, it is evaluated for compliance with the data submission requirements, including format and content requirements. The data submission is checked against a set of criteria known as edits that verify that the submission meets the published data standards. DHS provides managed care organizations a remittance advice, which indicates which of the claims were accepted and those that were rejected because of errors. The remittance advice is provided in the form of the X12 835 transaction. In an effort to make the feedback through the remittance advice more meaningful and actionable, DHS has replaced the usual HIPAA denial remark codes with a more detailed and clear set of denial remark codes. The remark codes are provided in Exhibit 7 of this document.

Data Quality Assurance

Minnesota conducts a variety of quality assurance activities to ensure that encounter data submissions are timely, complete, accurate, and consistent across submissions. DHS has an Encounter Data Quality Unit, which consists of a supervisor, a team lead, 3 data analysts, and 3 claims analysts who evaluate managed care data and create data quality improvement projects for the data.

The Encounter Data Quality Unit monitors the encounter data submissions to identify, research, and correct data quality problems. The Encounter Data Quality Unit pays special attention to the submission of “paid amounts” within the claims. The Unit is currently developing a control report and reconciliation process to better confirm accuracy and consistency of paid amounts on each claim. When problems are identified with a managed care organization’s data submissions, the managed care organization is required to develop a correction plan.

In an effort to ensure that encounter data is submitted accurately and consistently, the Encounter Data Quality Unit holds regular meetings with the managed care organizations. DHS and the managed care organizations meet as a collective group quarterly to discuss encounter data submissions. DHS meets with individual organizations between quarterly meetings, particularly if an organization is working on a correction plan.

The Encounter Data Quality Unit is currently working on a new effort called the Quality Assurance Project. The goal of the project is to develop enhanced quality assurance protocols to ensure that managed care organizations are submitting timely, complete, consistent, and accurate data, which reflect the claims that their providers have submitted. The Encounter Data Quality Unit is working with a

contractor to determine a set of best practices and protocols for organizations to follow as they adjudicate claims and create encounter files for DHS. The contractor will suggest quality assurance protocols that DHS and data submitters will implement to enhance the timeliness, completeness, accuracy, and consistency of encounter data submissions.

Supplement 2: Verification Plan

This supplement to the Minnesota Basic Health Program Blueprint is dedicated to a description of the data sources and procedures the state will use to verify application eligibility data.

MinnesotaCare will follow the processes for verifying applicant information established in 45 CFR 155.315, 45 CFR 155.320 and 45 CFR 350(c) of the Exchange final rule. In general, these provisions maximize the use of available electronic data, and allow a reasonable period of time for obtaining further information from applicants. **For factors that require verification that is not available from electronic sources in the federal hub, the state will accept self-attestation and verify during post-eligibility. Applicants will have a reasonable period of 90 days.**

Verification Procedures

The following table summarizes the verification procedures that MinnesotaCare will use to support eligibility determinations for enrollment in the Basic Health Program.

Category of Information	MinnesotaCare Verification Procedures
Citizenship	Federal Data Hub match in real time with SSA will be used for electronic verification of citizenship or status as a national with a Social Security number. If the real time verification is not successful we will request and adjudicate paper documentation.
Immigration Status	Department of Homeland Security data match via the Federal Data Hub; if DHS cannot verify immigration status, request and adjudicate paper documentation.
Residency	Accept self-attestation without further verification.
Age	Accept self-attestation without further verification.

Household /Family Size and Household Composition	Accept self-attestation without further verification if tax data match via the federal data hub represent accurate projection of family size. If data are unavailable or not an accurate projection, accept attestation unless not reasonably compatible with information provided on the application or in the records available to the agency, with the exception of tax data. Adjudication of paper documentation, as necessary.
American Indian / Alaska Native Status ¹	Accept self-attestation without further verification.
Membership in a Federally-recognized Tribe	Data match with any electronic data sources available to the agency that have been approved by HHS for this purpose. Adjudication of paper documentation if no data sources are available, or as necessary to resolve inconsistencies.
Income	Data match on Projected Annual Income with IRS data, SSA Title II, TALX, PRISM (state child support data based for alimony income) and DEED quarterly wage and unemployment date (PRISM and DEED are applicant only). Assessment of reasonable compatibility and adjudication of paper documentation when necessary.
Incarceration	Data match with SSA Prisoner Update Processing System via the Federal Data Hub. Adjudication of paper documentation, as necessary.
Public Minimum Essential Coverage (MEC)	Data match with Federal agencies via the Federal Data Hub.
Enrollment in Employer-Sponsored Minimum Essential Coverage	Accept self-attestation without further verification.
Eligibility for Employer-Sponsored Minimum Essential Coverage	Accept self-attestation without further verification.

¹ Under state law American Indians and their household members are exempt from MinnesotaCare premiums.

Additional Information on Income Verification Procedures

Minnesota primarily relies on federal tax information (FTI) obtained from the Federal Data Hub to verify an applicant’s projected annual income. When FTI or other electronic sources are unavailable or if the amount that the applicant self-attests to is not reasonably compatible with electronic sources, applicants must provide other documentation to verify income or a reasonable explanation of the discrepancy. Minnesota follows the verification procedures listed below for each individual component of the projected annual income if the individual components align with the projected annual income. When further verification is needed, the applicant self-attestation is accepted, and verification obtained post-eligibility-

Income Source	Verification Procedure
Wages	Accept self-attestation if reasonably compatible with the following electronic data sources (in hierarchy order). Adjudication of paper documentation, as necessary. <ol style="list-style-type: none"> 1. FTI 2. Online Payroll Verification Tool (TALX.) 3. Minnesota Department of Employment and Economic Development (DEED) Quarterly Wage Data (applicants only)
Interest/Dividends	Accept self-attestation if reasonably compatible. Adjudication of paper documentation, as necessary.
Alimony	Accept self-attestation if reasonably compatible with amount received from PRISM. Adjudication of paper documentation, as necessary.
Social Security (Title II Benefits)	Accept self-attestation if reasonably compatible with benefit information received from SSA via the Federal Data Hub . Adjudication of paper documentation, as necessary.
Self-Employment	Accept self-attestation if reasonably compatible. Adjudication of paper documentation, as necessary.
Unemployment Compensation	Accept self-attestation if reasonably compatible with benefit information received from the Minnesota Department of Employment and Economic Development (DEED) . Adjudication of paper documentation, as necessary.
Taxable Scholarships, Awards and Grants	Accept self-attestation if reasonably compatible. Adjudication of paper documentation, as necessary.
Taxable Lump Sum Payments	Accept self-attestation if reasonably compatible. Adjudication of paper documentation, as necessary.
Other Taxable Income	Accept self-attestation if reasonably compatible. Adjudication of paper documentation, as necessary.

Endnotes

¹ 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 is generally limited to children aged 19 and 20, parents and childless adults with incomes between 133% and 200% FPL, non-citizen parents and adults, or other applicants with incomes below 200% FPL who meet the BHP eligibility rules and who are not eligible for MA.

² Minnesota interprets 42 CFR 600.305(a)(3) to exclude eligibility to purchase individual coverage in the private market from the definition of MEC since applicants for all of the insurance affordability programs are eligible to purchase private market coverage without a subsidy.

³ Eligibility is determined in the month of application. The effective date of coverage is 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 determination.

⁴ DHS does not propose to alter the current process for handling appeals. Minnesota continues to follow Medicaid appeals rules. Timelines for requesting, hearing, and deciding appeals remain the same and state Human Services judges continue to hear all MinnesotaCare appeals. No appeals to the federal Department of Health and Human Services are offered for MinnesotaCare appeals.

⁵ The ceiling 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 participating providers cannot exceed the statutory requirements for cost-sharing in MinnesotaCare. Plans are given the opportunity to offer cost-sharing that is lower than the statutory required amounts.

⁶ 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 2016 coverage year.

⁷ Capitation rates were developed to achieve a Medical Loss Ratio that is higher than 85%.

⁸ 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 is eliminated for enrollees with incomes below 35% FPL effective January 1, 2015.

⁹ The copay for emergency room visits does not apply to visits that lead to an inpatient visit.

¹⁰ The following non-mental health/chemical dependency services are assessed this copay: advanced practice nurse, audiologist, chiropractor, nurse midwife, optician, optometrist, physician, physician ancillary, and podiatrist.

¹¹ DHS and the Marketplace use a single shared eligibility system. Therefore, accounts do not need to be transferred between systems. When clients move between public and Marketplace programs, the system creates notifications to workers at the sending and receiving agencies notifying them that responsibility for the case has been transferred.

Section 9: Secretarial Certification

Interim Certification:

Secretary/Secretary's Designee

Vikki Wachino, Director
Center for Medicaid and CHIP Services

Date of Interim Certification (mm/dd/yyyy)

Implementation Date (mm/dd/yyyy)

Full Certification:

Secretary/Secretary's Designee

Vikki Wachino, Director
Center for Medicaid and CHIP Services

Date of Full Certification (mm/dd/yyyy)

Implementation Date (mm/dd/yyyy)

Revised Certification:

Secretary/Secretary's Designee

Vikki Wachino, Director
Center for Medicaid and CHIP Services

Date of Revised Certification (mm/dd/yyyy)

Implementation Date (mm/dd/yyyy)

MAR 30 2016

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