DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

December 21, 2022

Ms. Cynthia MacDonald
Assistant Commissioner and Medicaid
Director Health Care Administration
State of Minnesota, Department of Human Services
540 Cedar Street PO Box 64983
St. Paul, MN 55167-0983

Dear Ms. MacDonald:

Your Basic Health Program (BHP) Blueprint revision MN-22-0001, submitted on October 13, 2022, has been approved. This revision has an effective date of March 20, 2020.

Through revision MN-22-0001, CMS grants Minnesota flexibility in meeting the timeliness standards for processing annual recertifications in response to the COVID-19 public health emergency (PHE). The state will follow CMS-issued guidance regarding resuming the timely processing of recertifications.

Your BHP Project Officer is Carrie Grubert. Carrie is available to answer your questions concerning this revision and other BHP-related matters. Carrie's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8319
E-mail: carrie.grubert@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

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 https://www.medicaid.gov/basic-health-program/index.html.

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: Patrick Hultman
Title: Deputy Medicaid Director
Phone: 651-431-4133
Email: patrick.hultman@state.mn.us

Requested Initial Interim Certification Date (if applicable): Pick date.

Requested Initial Full Certification Date: 3/20/2020

Requested Initial Program Effective Date: 3/20/2020

Blueprint Revisions:

Revision number	Summary	Effective date	Certification date
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Administrative agency responsible for BHP ("BHP Administering Agency"):

Minnesota Department of Human Services

BHP State Administrative Officers:

Position	Title	Location (Agency)	Responsible for:
Jodi Harpstead	Commissioner MN Dept. of Human Services	DHS, St. Paul, MN	Management Oversight Implementation
Cynthia MacDonald	Assistant Commissioner of Health Care Administration and Medicaid Director	DHS, St. Paul, MN	Management Oversight Implementation Administration
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Program Administration: (Management, Policy, Oversight)

Position	Title	Location (Agency)	Responsible for:
Cynthia MacDonald	Assistant Commissioner of Health Care Administration and Medicaid Director	DHS, St. Paul, MN	Signs MCO Contracts
Julie Marquardt	Director, Benefits and Service Delivery	DHS, St. Paul, MN	Service Delivery and Benefits Policy

Program Administration: (Contracting, Eligibility Appeals, Coverage Appeals)

Position	Title	Location (Agency)	Responsible for:
P.J. Weiner	Manager, Contract Management and Compliance	DHS, St. Paul, MN	Contracting Negotiations
Karen Gibson	Director, Health Care Eligibility and Access	DHS, St. Paul, MN	Eligibility Policy
Tamara Smith	Director, Health Care Eligibility Operations	DHS, St. Paul, MN	Operations and Administration
John Freeman	Director, Appeals Division	DHS, St. Paul, MN	Appeals

Finance: (Budget, Payments)

Position	Title	Location (Agency)	Responsible for:
Margaret Kelly	State Budget Officer MN Management and Budget	MMB, St. Paul, MN	Budget
Angela Vogt	MN Management and Budget	MMB, St. Paul, MN	Budget
Shawn Welch	Reports and Forecasts	DHS, St. Paul, MN	Budget
Marty Cammack	Director Financial Operation Division	DHS, St. Paul, MN	Budget Management Payments
Christopher Ricker	Manager Financial Management	DHS, St. Paul, MN	Payments Accounting
Ahna Minge	Chief Financial Officer	DHS, St. Paul, MN	Budget

Governor or Designee: Patrick Hultman

Signature: Patrick Hultman

Date of Official Submission: November 17, 2022

Section 2: Public Input

This section of the Blueprint records the state's method for meeting the public comment process required for Blueprint submission. This section applies only to the current Blueprint submission.

Date public comment period opened: Select date

Date public comment period closed: Select date

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

We did not post this amendment for public comment because it is not required for changes related to COVID-19.

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

Click or tap here to enter text.

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 (Indicate with an "X" if input was solicited)	Input received (Indicate with an "X" if input was solicited)
Bois Forte Band of Chippewa	☐	☐
Fond du Lac Band of Lake Superior Chippewa	☐	☐
Grand Portage Band of Chippewa	☐	☐
Leech Lake Band of Ojibwe	☐	☐
Lower Sioux Community	☐	☐
Mille Lacs Band of Ojibwe	☐	☐
Prairie Island Indian Community	☐	☐
Red Lake Band of Ojibwe	☐	☐
Shakopee-Mdewakanton Sioux (Dakota) Community	☐	☐
Upper Sioux Community Pejuhutazzi Oyate	☐	☐

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

Click or tap here to enter text.

Section 3: Trust Fund

Please provide the BHP Trust Fund location and relevant account information.

Institution:

Minnesota Department of Human Services

Address:

540 Cedar Street, St. Paul, MN 55101

Phone Number:

651-431-3545

Account Name:

BHP Grants

Account Number:

Fund: 3000 APID: 1615 APFD: 11269 ALFD: 22750 EBFD: 32750 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.

Trustees

Name	Organization	Title	May authorize withdrawals? (Indicate with an "X" if named individual can authorize withdrawals)
Jodi Harpstead	Department of Human Services	Commissioner	☒
Jim Schowalter	Minnesota Management and Budget	Commissioner	☒
Ahna Minge	Department of Human Services	Chief Financial Officer	☒
Marty Cammack	Department of Human Services	Financial Operations CFO	☒
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	☐

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

No

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

Name	Organization	Title
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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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.

Name	Organization	Title	Contact
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

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: 651-431-3742

CMS Primary Contact Email: 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?

Yes

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.** (Indicate with an "X" to signal attestation.)	**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.	☒	Click or tap to enter a date.
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).	☒	Click or tap to enter a date.
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.	☒	Click or tap to enter a date.

Trust Fund Attestation	Attest that the Agency is immediately ready and able. (Indicate with an "X" to signal attestation.)	Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)
600.710(d) Publish annual reports on the use of funds within 10 days of approval by the trustees.	☒	Click or tap to enter a date.
600.710(e) Establish and maintain BHP Trust Fund restitution procedures.	☒	Click or tap to enter a date.
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.	☒	Click or tap to enter a date.

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.

Please name the agency with primary responsibility for the function of performing eligibility determinations:

Attestation	Completed (Indicate with an "X" to signal completion)	If No, Expected Completion Date (mm/dd/yyyy)	Marketplace Policy (Indicate with an "X" if Marketplace Policy applies)	Medicaid Policy (Indicate with an "X" if Medicaid Policy applies)
Eligibility Standards				
The state can enroll an individual in a Standard Health Plan who meets ALL of the following standards.	☒	Click or tap to enter a date.	N/A	N/A
305(a)(1) Resident of the State.	N/A	N/A	N/A	N/A
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.	N/A	N/A	N/A	N/A
305(a)(3) Not eligible to enroll in MEC or affordable ESI.	N/A	N/A	N/A	N/A
305(a)(4) Less than 65 years old.	N/A	N/A	N/A	N/A
305(a)(6) Not incarcerated other than during disposition of charges.	N/A	N/A	N/A	N/A
Application Activities				
310(a) Single streamlined application includes relevant BHP information.	☒	Click or tap to enter a date.	N/A	N/A
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.	☒	Click or tap to enter a date.	N/A	N/A
310(c) State is permitting authorized representatives; indicate which standards will be used.	☒	Click or tap to enter a date.	☐	☒
315 State is using certified application counselors; indicate which standards will be used.	☒	Click or tap to enter a date.	☐	☒

Attestation	**Completed** (Indicate with an "X" to signal completion)	**If No, Expected Completion Date (mm/dd/yyyy)**	**Marketplace Policy** (Indicate with an "X" if Marketplace Policy applies)	**Medicaid Policy** (Indicate with an "X" if Medicaid Policy applies)
Eligibility Determinations and Enrollment				
320(c) Indicate the standard used to determine the effective date for eligibility.	☐	Click or tap to enter a date.	☐	☒
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).	☐	Click or tap to enter a date.	☐	☒
335(b) Indicate the standard used for applicants to appeal an eligibility determination.	☐	Click or tap to enter a date.	☐	☒
340(c) Indicate the standard used to redetermine BHP eligibility.	☐	Click or tap to enter a date.	☐	☒
345 Indicate the standard to verify the eligibility of applicants for BHP.	☐	Click or tap to enter a date.	☒	☐

Note: N/A = Not applicable; indicates that there are no choices available.

1. Please indicate whether the state will implement continuous eligibility and redetermine enrollees every 12 months as long as enrollees are under 65, not enrolled in alternative MEC and remain state residents.

   No

   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, Minnesota continues to elect the Medicaid redetermination and verification processes set forth in 42 C.F.R. § 435.916(a) and §§ 435.945 through 435.956.

   Due to the declared emergency for COVID-19, enrollees' eligibility will be maintained regardless of nonpayment of premiums or changes in circumstances that would cause ineligibility, with the exception of:

   • becoming age 65;

   • becoming incarcerated after disposition of charges;

   • enrolling in minimum essential coverage; or

   • becoming a resident of another state;

   • invalid enrollment as the result of agency error or enrollee fraud or abuse (effective February 1, 2021);

• voluntary requests from enrollees to terminate coverage; or

• death.

In order to respond to the COVID-19 PHE, the state is granted temporary flexibility in meeting the timeliness standards for processing annual recertifications. BHP eligibility is redetermined for all enrollees in the fall, with a new eligibility period beginning January 1 of the following year. During the fall of 2022, the state will complete ex parte renewals for all BHP enrollees and renew those who can have their eligibility confirmed. The state will delay sending pre-populated renewal forms to enrollees who cannot automatically renew and will temporarily extend their eligibility into 2023. The state will follow CMS-issued guidance regarding resuming the timely processing of recertifications.

During the COVID-19 PHE, coverage will be maintained for enrollees who do not respond to a request for verification within the reasonable opportunity period if the individual is making a good faith effort to obtain the documentation. This provision is effective March 20, 2020.

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 must be complete. All verifications for MinnesotaCare cases are post-eligibility verifications. Applicants are given at least 90 days to supply the requested information. Supplement 2 contains the verification plan.

Minnesota also accepts paper applications. 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 a request for 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 time-frames 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 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 MA for families with children, adults under age 65 and former foster care youth, MinnesotaCare, qualified health plans, 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 MMIS incorporates automated processes for generating client notices and information packets in those instances in which 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. 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.

4. Once eligibility for Medical Assistance is determined, an eligibility notice indicating approval of Medical Assistance eligibility is mailed to the individual.

5. 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.

6. The eligibility system sends Medical Assistance eligibility data to MMIS.

7. Medical Assistance eligibility begins on the first day of the month the individual meets Medical Assistance eligibility factors based on the reported change, but no earlier than three months prior to the month in which the change is reported.

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.

Click or tap here to enter text.

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 assure that standard health plans from at least two offerors are available to enrollees. ☒

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

   Click or tap here to enter text.

3. If the state is not able to assure choice of at least two standard health plan offerors as described in question 1, 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).

   Click or tap here to enter text.

4. Is the state participating in a regional compact?

   No

   IF YES, please answer questions 5 - 9. If no, please skip questions 5 - 9.

5. Please indicate the other states participating in the regional compact.

   Click or tap here to enter text.

6. Are there specific areas within the participating states that the standard health plans will operate? If yes, please describe.

   Click or tap here to enter text.

7. 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.

   Click or tap here to enter text.

8. Please assure that the regional compact's competitive contracting process complies with the requirements set forth in 42 CFR 600.410. ☐

9. 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.

Click or tap here to enter text.

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:

(These are mandatory elements. Each box below must be checked to approve Blueprint.)

	Assurance: (Indicate with an "X" to signal assurance)
Conducted the contracting process in a manner providing full and open competition including:	
45 CFR 92.36(b) Following its own procurement standards in conformance with applicable federal law.	☒
45 CFR 92.36(c) Conducting the procurement in a manner providing full and open competition.	☒
45 CFR 92.36(d) Using permitted methods of procurement.	☒
45 CFR 92.36(e) Contracting with small, minority and women owned firms to the greatest extent possible.	☒
45 CFR 92.36(f) Providing a cost or price analysis in connection with every procurement action.	☒
45 CFR 92.36(g) Making available the Technical specifications for review.	☒
45 CFR 92.36(h) Following policies for minimum bonding requirements.	☒
45 CFR 92.36(i) Including all the required contract terms in all executed contracts.	☒
Included a negotiation of the following elements:	
Premiums and cost sharing.	☒
Benefits.	☒
Innovative features, such as:	
– Care coordination and care management	☒
– Incentives for the use of preventive services	☒
– Maximization of patient involvement in health care decision making	☒
– Other (specify below) Click or tap here to enter text.	☐
Meeting health care needs of enrollees.	☒
Included criteria in the competitive process to ensure:	
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.	☒

	Assurance: (Indicate with an "X" to signal assurance)
Use of managed care or a similar process to improve the quality accessibility, appropriate utilization and efficiency of services provided to enrollees.	☒
Development and use of performance measures and standards.	☒
Coordination between other Insurance Affordability Programs.	☒
Measures to address fraud, waste and abuse and ensure consumer protections.	☒
Established protections against discrimination including:	
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.	
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 reusing 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.

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 are modeled on standard Medicaid contracting requirements. The "safe harbor" provision in the Federal Register notice (see 78 Fed. Reg. 59130-59131 [September 25, 2013]) 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 continues the application of the safe harbor provision.

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.

DHS contracts for MinnesotaCare require 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.

For clients moving from 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.

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):

☒ 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.

☒ 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.

☒ 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, including any variation by FPL, and the applicable 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% FPL

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, online, 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.

Enrollees who do not pay their premium by the due date are disenrolled 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 2020 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's coverage continues through June, as this is a grace month. John has not paid his June premium by the last working day in June.

• John is disenrolled from his health plan effective June 30, 2020.

• 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.

Cost-Sharing

Cost-Sharing Assurances

The State assures that (check all that apply):

☒ 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).

☒ Cost sharing for Indians meets the standards of 45 CFR 156.420(b)(1) and (d).

☒ The State has not imposed cost sharing for preventive health services or items as defined in accordance with 45 CFR 147.130.

☒ 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.

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.

2. All copayments, co-insurance, and deductibles, by service.

MinnesotaCare enrollees (with the exception of the populations described above) are subject to the following cost sharing:

-$75 copay for ER visits that do not lead to an inpatient admission

-$25 copay for non-preventive visits; no copay for mental health visits

-$250 per inpatient hospital admission

-$100 ambulatory surgery

-$25 copay for eyeglasses

-$7 (generic) or $25 (brand) copay for prescription drugs up to $70 per month; no copay for some mental health drugs

-$40 per visit for radiology services

-$15 per visit for non-routine dental services

-10 percent co-insurance for durable medical equipment

Mental health services are not subject to copayments.

Services related to the testing, diagnosis, and treatment of COVID-19 are not subject to copayments during the federally declared public health emergency for COVID-19.

3. 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 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 420?

No

If yes, check the box on the right to indicate 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, check the box on the right to indicate 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). ☒

If the state is offering continuous enrollment and is imposing a premium lock-out period, the lock-out period in number of days is:

Please see our description of grace months on p. 25 above.

Section 7: Operational Assessment

The State assures that it can or will be able to:

	Full Assurance (Indicate with an "X" to signal assurance)	**Contingent Assurance** (Indicate with an "X" to signal assurance)
Eligibility and Renewals		
Accept an application online, via paper and via phone and provide in alternative formats in accordance with 42 CFR §600.310(b).	☐	☒
Return an accurate and timely eligibility result for all BHP eligible applicants.	☒	☐
Process a reported change and redetermine eligibility.	☒	☐
Comply with the ex-parte renewal process.	☒	☐
Issue an eligibility notice and share such notice with CMS.	☒	☐
Issue a renewal notice and share such notice with CMS.	☒	☐
Ability to terminate/disenroll from BHP for a variety of reasons, such as reaching age 65, obtaining MEC.	☒	☐
Issue termination/disenrollment notice to enrollees.	☒	☐
Benefits and Cost-Sharing		
Exempt American Indians from Cost-sharing.	☒	☐
Apply appropriate cost-sharing amounts to enrollees subject to cost-sharing limits.	☒	☐
Premium Payment and Plan Enrollment		
Issue an accurate and timely premium invoice.	☒	☐

Receipt and apply the premium payment correctly.	☒	☐
Notify enrollee of health plan choices and complete plan enrollment.	☒	☐
Issue a health plan disenrollment notice.	☒	☐
Coordinate enrollment with other Insurance Affordability Programs		
Transfer accounts and provide notification in accordance with 42 CFR 600.330(c) through (e).	☒	☐

Contingency Descriptions

Please describe the contingency or dependency that limit full assurance.

Accepting Applications – DHS can 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. We are planning to roll out a 6-month pilot for accepting applications via phone in February 2020. After six months, we will review the results of the pilot and make changes as needed. 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

This final section of the BHP Blueprint is a benefits description 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 benefits description below maps the base-benchmark plan to the EHB categories.

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

Standard Health Plan

State Name: Minnesota

Transmittal Number: Click or tap here to enter text.

Benefits description

The state is proposing to use a CMS approved EHB based plan.

No

Section 9: Secretarial Certification

Interim Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Official Interim Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.

Full Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Official Full Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.

Revised Certification:

Secretary/Secretary's Designee

Click or tap here to enter text.

Director
Center for Medicaid and CHIP services

Date of Revised Certification: Click or tap to enter a date.

Implementation Date: Click or tap to enter a date.

Section 9: Secretarial Certification

Interim Certification:

Secretary/Secretary's Designee

_____

Sarah deLone, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Date of Interim Certification (mm/dd/yyyy) Implementation Date (mm/dd/yyyy)

_____ _____

Full Certification:

Secretary/Secretary's Designee

_____

Sarah deLone, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Date of Full Certification (mm/dd/yyyy) Implementation Date (mm/dd/yyyy)

_____ _____

Revised Certification:

Secretary/Secretary's Designee
/Signed by Sarah deLone/

_____

Sarah deLone, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Date of Revised Certification (mm/dd/yyyy) Implementation Date (mm/dd/yyyy)

12/21/22 03/20/2020