

Health Care Eligibility and Access

Karen Gibson, Director



Minnesota Department of **Human Services**

Minnesota Health Care Programs

- Minnesota has a large and complex array of public health care programs funded either jointly with the federal government or solely by the state.
- Collectively these are referred to as the Minnesota Health Care Programs (MHCP) and include:
 - Medical Assistance (MA)
 - MinnesotaCare
 - General Assistance Medical Care (GAMC)
- Under these programs there are a variety of different populations served with different program eligibility requirements.
- There are also some specialty programs such as the Minnesota Family Planning Program.



Medical Assistance (MA)

- MA is funded through a combination of
 - State payments from the general fund
 - Federal funding received under Medicaid and Children’s Health Insurance Plan (CHIP)
- MA populations with joint federal and state funding:
 - Children under 21
 - Pregnant women
 - Parents
 - Aged, blind and disabled
 - Disabled children
 - TEFRA option for disabled children
 - MA for Employed Persons with Disabilities (MA-EPD)
 - Spenddown
 - Emergency Medical Assistance for non-citizens who have a medical emergency
- MA populations that are fully state-funded:
 - Certain residents of Institutions for Mental Diseases (IMDs)
 - Lawfully present non-citizens who qualify for federally funded MA due to immigration status
 - Center for Victims of Torture
- Refugee Medical Assistance is fully federally funded



MinnesotaCare

- MinnesotaCare is funded through a combination of:
 - State payments from the health care access fund
 - Enrollee premiums
 - Federal funding received under the Prepaid Medical Assistance Project Plus (PMAP+) waiver and CHIP
- MinnesotaCare populations with joint federal and state funding:
 - Children under 21
 - Pregnant women
 - Parents
- MinnesotaCare populations that are fully state-funded :
 - Adults without children
 - Lawfully present non-citizen children, pregnant women and parents who do not qualify for federally-funded MinnesotaCare due to immigration status
 - Legal guardians and foster parents



General Assistance Medical Care (GAMC)

- GAMC is fully state-funded program for low-income adults, ages 21-64, who have no dependent children living with them and who do not qualify for federally funded health care programs.
- Beginning June 1, 2010, most services for GAMC clients are provided through coordinated care delivery systems (CCDS). GAMC clients may choose to enroll in any CCDS that is accepting new patients.





Minnesota Department of Human Services

Federal Poverty Guidelines for Minnesota Health Care Programs

50% or 65% Represents FFP (Federal Financial Participation from Medicaid or CHIP)¹
90% Represents FFP for Family Planning
 0% Represents Fully State-Funded
 100% Represents FFP for QI

FPG	Families and children			Adults without children		Aged, blind and disabled	
	Medical Assistance ²	MinnesotaCare		MA ³	GAMC	MinnesotaCare	Medical Assistance
300	No coverage	No coverage				No coverage	MA-EPD
275	Infants ⁴ 0-2 280%					No coverage	
250	Pregnant Women ⁵ and Infants 275%	Children 275%	Parents ⁶ 275%				
225							
200							
175	Additional match from CHIP for children above 133% FPG	Additional match from CHIP for children above 133% FPG			No coverage	MinnesotaCare 250%	
150							
133	Children 2-18 150%						
125							
100	Children 19-20 100%						
75	Parents 100%						
50							
25							
0							

¹ Enhanced FFP available under the American Recovery and Reinvestment Act (ARRA) (as extended by P.L. 111-226)

² If income exceeds limit, may spenddown to 100% FPG to qualify for MA

³ The Minnesota Family Planning Program is a Medicaid Section 1115 Demonstration Project

⁴ CHIP funds infants 0-2 from 275-280% FPG

⁵ CHIP funds unborn children of pregnant women ineligible for federally funded Medicaid

⁶ Parents not eligible for MinnesotaCare if annual income exceeds the lesser of 275% FPG or \$50,000

⁷ MC = Medicare

⁸ If income exceeds limit, may spenddown to 75% FPG to qualify for MA





Minnesota Department of Human Services

Minnesota Health Care Programs (MHCP)

Effective January 1, 2011

This is only a summary. For details about covered services, you can:

- call your worker
- call your health plan or provider
- call your CCDS if you have GAMC.

If you are not in a health plan, call the MHCP Member Help Desk at (651) 431-2670 or (800) 657-3739.

Your provider must get approval for some services before you get them. They must be medically necessary.

MinnesotaCare Expanded

Pregnant women and children under 21

There are no copays or coverage limits.

- Alcohol and drug treatment
- Chiropractic care
- Dental care
- Doctor/clinic visits
- Emergency room care (ER)
- Eyeglasses
- Family planning services
- Hearing aids
- Home care
- Hospice care
- Hospital services (inpatient and outpatient)
- Immunizations and vaccines
- Interpreter services
- Lab and X-ray
- Licensed birth center services (upon federal approval)
- Medical equipment and supplies
- Medical transportation (access, ambulance and special)
- Mental health care
- Outpatient surgery
- Prescriptions and Medication Therapy Management
- Rehabilitative therapy

MinnesotaCare Basic Plus

Parents (income limits apply)

Same as MinnesotaCare Expanded except:

- Medical transportation (emergency only)
- Limited dental care

Copays and limits:

- \$3 copay on nonpreventive visits; no copay for mental health visits
- \$3.50 copay on nonemergency ER visits
- \$25 copay on eyeglasses
- \$3 copay on prescription drugs
- Inpatient hospital stays
 - \$10,000 yearly limit
 - You are responsible for any costs over \$10,000.

If you are unable to pay the copay, your provider still has to serve you. Providers must take your word that you cannot pay the copay. Providers cannot ask for proof that you cannot pay.

MinnesotaCare Basic Plus Two

Parents (income limits apply)

Same as MinnesotaCare Expanded except:

- Medical transportation (emergency only)
- Limited dental care

Copays:

- \$3 copay on nonpreventive visits; no copay for mental health visits

- \$3.50 copay on nonemergency ER visits
- \$25 copay on eyeglasses
- \$3 copay on prescription drugs

If you are unable to pay the copay, your provider still has to serve you. Providers must take your word that you cannot pay the copay. Providers cannot ask for proof that you cannot pay.

MinnesotaCare Basic Plus One

Adults without children

Same as MinnesotaCare Expanded except:

- Medical transportation (emergency only)
- Limited dental care

Copays and limits:

- \$3 copay on nonpreventive visits; no copay for mental health visits
- \$3.50 copay on nonemergency ER visits
- \$25 copay on eyeglasses
- \$3 copay on prescription drugs
- Inpatient hospital stays
 - \$10,000 yearly limit with 10% copay (up to \$1,000)
 - You are responsible for your copay and any costs over \$10,000.

The first time you are not able to pay a copay, your provider still has to serve you. Providers must take your word that you cannot pay the copay. Providers cannot ask for proof that you cannot pay. However, that provider does not have to serve you again if your copay is still not paid.

If you get MinnesotaCare, you will enroll in a health plan. The plan will mail you information about covered services. If you are in the hospital on the day your MinnesotaCare begins, MinnesotaCare will not pay the hospital bill or for any services related to the hospital stay.



Medical Assistance (MA)

Some people on MA enroll in health plans.

- Alcohol and drug treatment
- Chiropractic care
- Dental care (limited for non-pregnant adults)
- Doctor/clinic visits
- Emergency room care (ER)
- Eyeglasses
- Family planning services
- Hearing aids
- Home care
- Hospice care
- Hospital services (inpatient and outpatient)
- Immunizations and vaccines
- Interpreter services
- Lab and X-ray
- Licensed birth center services (upon federal approval)
- Medical equipment and supplies
- Medical transportation (access, ambulance and special)
- Mental health care
- Nursing homes and ICF-MR facilities
- Outpatient surgery
- Prescriptions and Medication Therapy Management
- Rehabilitative therapy
- Urgent care

Coverage for some long-term care services, including nursing homes, may require a separate application to determine if MA can pay for it. Ask your worker for more information.

Copays:

Adults age 21 or older (except pregnant women, people in hospice care, Refugee MA enrollees and people in nursing homes or ICF-MRs) have:

- \$3.50 copay on nonemergency ER visits
- \$3 or \$1 copay on prescription drugs up to \$7 per month; no copay on some mental health drugs

Monthly copays are limited to 5 percent of family income for adults with income at or below 100 percent of federal poverty guidelines.

If you are not able to pay a copay, your provider still has to serve you. Providers must take your word that you cannot pay the copay. Providers cannot ask for proof that you cannot pay.

If you have Medicare: Minnesota Health Care Programs cannot pay for any drugs in the Medicare prescription drug benefit. If you have Medicare, you can get Part D drug coverage. Prescriptions under Part D may have different copays.

General Assistance Medical Care (GAMC)

Services that are covered for everyone on GAMC:

- Outpatient prescription drugs
- Medication Therapy Management Services
- Alcohol and drug treatment through your county

For more services, you can enroll in a coordinated care delivery system (CCDS). All CCDSs provide:

- Inpatient and outpatient hospital
- Doctor/clinic visits
- Emergency room care (ER)
- Medical transportation (ambulance)
- Mental health services

Additional services may vary by CCDS. You can choose any CCDS that is taking new patients. Some or all CCDSs may not be taking new patients. For a list of CCDSs that you can choose from, look online at www.dhs.state.mn.us/GAMC or ask your worker.

If you do not enroll in a CCDS, you may be able to get care at your local hospital or community clinic.

Copays:

- \$25 copay on nonemergency ER visits
- \$3 or \$1 copay on prescription drugs up to \$7 per month; no copay on some mental health drugs

If you are not able to pay a copay, your provider still has to serve you. Providers must take your word that you cannot pay the copay. Providers cannot ask for proof that you cannot pay.

Emergency Medical Assistance (EMA)

EMA is fee-for-service and covers only short-term, emergency or ongoing chronic conditions.*

- Alcohol and drug treatment
- Care of chronic conditions
- Chiropractic care
- Dental care (limited)
- Doctor/clinic visits
- Emergency room care (ER)
- Inpatient hospital
- Interpreter services
- Lab and X-ray
- Labor and delivery
- Medical equipment
- Medical transportation (access, ambulance and special)
- Mental health care
- Nursing home
- Outpatient surgery
- Some prescription drugs
- Rehabilitative therapy

Copays:

- \$3.50 copay on nonemergency ER visits
- \$3 or \$1 copay on prescription drugs up to \$7 per month; no copay on some mental health drugs

Monthly copays are limited to 5 percent of family income for adults with income at or below 100 percent of federal poverty guidelines.

If you are not able to pay a copay, your provider still has to serve you. Providers must take your word that you cannot pay the copay. Providers cannot ask for proof that you cannot pay.

*EMA does not cover preventive care, family planning, immunizations, prenatal services, certain prescription drugs, eyeglasses, hearing aids, organ transplants or waiver services.

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.



Other programs

- Medicare Savings Programs
 - Medicare Savings Programs pay part or all of Medicare premiums/copays/deductibles for eligible individuals
 - Funded through a combination of federal and state funding
- Minnesota Family Planning Program (joint federal and state funding)



Eligibility for MHCP

- Eligibility for MHCP is determined on a variety of financial and non-financial factors such as;
 - Income
 - assets
 - basis of eligibility
 - citizenship or immigration status
 - Social Security number
 - disability status
 - state residence
 - living arrangement
 - household composition
 - enrollment in certain cash assistance programs
 - other health care coverage
 - need for long-term care services including a home and community-based waiver program.
- Individuals may be eligible for more than one MHCP and a program hierarchy is considered in determining which health care program is best for each applicant.



Size and scope of MHCP

- State Fiscal Year 2010
 - Average monthly enrollment of 776,000
 - Medical Assistance – 609,000 people
 - Families and children average monthly enrollment: 439,000
 - Elderly and persons with disabilities average monthly enrollment: 168,000
 - Expenditures - \$7.2 billion
 - MinnesotaCare – 132,000 people
 - Expenditures - \$666 million
 - GAMC – 35,000 people
 - Expenditures - \$296 million



Administration

- HCEA is divided into two main areas:
Administrative and Operations
 - Administrative is responsible for administration of Minnesota Health Care Program eligibility functions
 - 74.5 FTE
 - Operations is responsible for MinnesotaCare eligibility processing
 - 229 FTE



HCEA Administrative Responsibilities

- Customer service and community support for MHCP
- Design, development, and maintenance of program eligibility policies
- Training and support to processing entities (counties, tribes, and MinnesotaCare Operations)
- Oversight of eligibility administration across processing entities
- Responding to MHCP eligibility-related litigation



HCEA Operations

HCEA Operations provides capacity for eligibility processing for MinnesotaCare and the Minnesota Family Planning Program in St. Paul and Brainerd

- In 2010 HCEA operations:
 - processed over 90,000 MinnesotaCare applications
 - responded to over 272,000 phone calls
 - provided in-person assistance to over 46,300 people



Health Services Medical Management

Jeff Schiff MD MBA, Medical
Director

Julie Marquardt, Deputy Director



Minnesota Department of **Human Services**

Population and Budget

- \$1.6 billion / year
- 47 FTEs
- Budget \$8.06 million/ \$4.14 as salary
- Primarily disabled population
 - 106,000
- Transient population coming on the program
 - 100,000



Business Areas

- Contracts
 - authorization, evidence, care design
- Grant and program awards
 - Medicare participation in Health Care Home, child health quality measure development
- Benefit Policy
- Appeals
- State Medical review team
- Ambulatory rate policy
- Pharmacy services
- Care Delivery Reform



Functions

- Set benefit coverage policy for fee for service Medicaid
 - Mandatory services
 - Optional services (adult dental, pharmacy, therapies)
- Set rates for ambulatory services –
 - Providers
 - Resource Based Relative Value System (RBRVS) implementation
- Set pharmacy policy
 - Preferred drug list/ authorization
 - Rebates
 - Utilization review



Functions (cont.)

- Care delivery design
 - Implement Health Care Home
 - Implement ACO/ risk sharing
- State medical review team
 - Disability determinations



Health Care Operations

Adriann Alexander, Director



Minnesota Department of **Human Services**

Mission

To provide the technical and support services necessary to administer Minnesota Health Care Programs (MHCP) – the combined publicly funded health care programs by DHS.

- Maintain the operation components of the state's largest health plan (MHCP);
- Work to ensure the appropriate benefits are delivered to correct MHCP clients;
- Claims for these health care services result in accurate payments to providers.



Supporting DHS Priorities

- Integrated services
- Improving health care quality, access, etc.
- Improving service delivery through
- organization effectiveness and employee engagement



Functions

Operations

- Claims processing
- Operations data integrity
 - ensure claims are process within guidelines of policy requirement; ensure edits provide appropriate payment and prevent overpayments
- Benefit recovery
 - Cost Avoidance: ensures MHCP is the payor of last resort
- Recoveries
 - Liens, Tort, estate recoveries, etc.
- Provider relations
 - enrollment, call center, training/communications
- Respond to calls from enrolled providers, providing training/updates on MHCP requirements, MN-ITS support for provider portal, etc.



Functions (cont.)

Business Planning & Development

- Project Management
 - manage MMIS policy activities to ensure business and technical needs are met; ensure projects meet SDLC process delivery standards
- Encounter data quality assurance

Business Solutions

- Business analysis and solutions
 - ensure compliance with federal and state requirements
- Portfolio Management
 - administer databases that are used for MMIS Change Requests, problem logs and time tracking
- Electronic document management
 - scanning, proofing, indexing of paper documents related to claims processing



Functions (cont.)

Technology

- MMIS Mainframe system administration – mainframe system that pays medical bills and managed care capitation payments
- System/application design, development, testing, maintenance, & technical support
- Delivery of ecommerce solutions (MN-ITS) – enable providers to do business with DHS
- Application security administration
- Database administration, design, & maintenance
- System architecture & planning (EA)

Financial

- Budget planning, forecasting, and reporting – prep and reconciliation of MMIS budget accounts
- Premium program & surcharge billing – update, reconcile and prepare bills for various programs; process surcharge information



Functions (cont.)

Legal

- Legislative review of proposed bills, laws, and regulations to determine impacts and costs of MMIS
- Contracting
- Support lawsuits and appeals, including litigation hold process for health care administration
- Federal contact for submissions regarding MMIS



Administration

- 247 FTEs
- Annual budget - \$39 Million
 - 65% FFP

Fiscal Year 2010

- MMIS processed over 60 million claims transactions
- MMIS processed an average of 120,000 claims per day
- Over 411,000 providers calls were answered (avg. 1557 per day)
- \$409 Million in collections through May, 2010
- Just under 1000 formal system change requests were completed
- Over 11,000 enrollment applications were processed for new providers



Managed Care Purchasing and Payment Policy

Karen Peed, Director



Minnesota Department of **Human Services**

Primary Functions

- Managed Care Contract Arrangements
- CCDS Arrangements
- ACOs
- Rates Development
 - Hospital Payments, including DSH and DRGs, Rebasing
 - FQHCs and RHCs
 - School-based Services
 - Managed Care Organizations



Primary Responsibilities and Purposes

- Administration of health care purchasing arrangements
- Oversight of county and MinnesotaCare managed care enrollment
- Assure coordination with federal Medicare policies for integrated programs for dually eligible individuals.
- Administration of Medicare enrollment TPA contract
- Oversight of CCDS enrollment
- Rate setting
 - Hospitals
 - federally qualified health centers and rural health centers
 - Individual Education Plan services for school districts
 - managed care contracts.
- Assure compliance with federal requirements



Functions: Administration

- Development of Policies and procedures for administration of health care purchasing arrangements
- Solicitation and procurement for purchasing arrangements
- Development of payment structures, contract language, compliance requirements, withholds and incentives
- Negotiation of Contracts
 - Assure that contracts comply with applicable state and federal laws, rules and regulations
 - Comply with state and federal audits on managed care
 - Coordination with DHS policy divisions, other state agencies and federal agencies when appropriate
- Resolution of coverage and payment issues
- Assure compliance of contractors with terms of contract
- Develop standards to enhance encounter data quality



Functions: Oversight of enrollment in managed care organizations and CCDSs

- Provide training and technical assistance for county workers regarding enrollment, entry of CCDS enrollment into MMIS
- Respond to enrollment questions from counties, MinnesotaCare and MCOs
- Assure accurate and timely payment for contractors, including payment of incentive and return of payment withholds.
- Process capitation adjustments and update MMIS to correctly pay MCOs according to contract requirements



Functions: Special Needs Purchasing

- Provide special focus on the health care needs of special needs populations groups (persons with disabilities, and seniors) and develop contract provisions and polices that reflect these needs
- Develop rates policy for special needs purchasing contracts
- Develop and implement risk adjustment strategies for special needs populations
- Coordinate policy for health care purchasing for dual eligibles with CMS Medicare Special Needs Purchasing Policy



Functions: Administration of Medicare Enrollment Third Party Administrator Contracts

- Verify eligibility and application data for Medicare/Medicaid eligibles for integrated products (MSHO, SNBC)
- Issue required notices, including enrollment and disenrollment notices
- Reconcile Medicaid/Medicare enrollments and prepare required reports
- Prepare and provide quarterly reports to MCOs
- Comply with audits



Functions: Rates and Payment Policy

- Establishment of payment policy and calculation of rates
 - inpatient hospital services
 - outpatient critical access hospital services
 - school-based services
 - Indian health services
 - hospice services
 - federally qualified health center services
 - rural health center services.
- Establishment of rates for managed care with actuaries and management of risk adjustment mechanisms.
- Ensuring federal compliance
- Developing financing parameters for medical education payments.
- Actuary, disproportionate share hospital and children's hospital audit contracts.



Administration

- Contracts with 8 managed care organizations
- Capitation payments
 - SFY 2009 totaled \$2.9 billion dollars
- Enrollment
 - As of January 1, 2011: 555,302
- Contracts with 4 coordinated care delivery systems
 - Enrollment for January 1, 2011: 12,289
- DSH payments
 - FFY 2009 Hospital specific fee for service payment: \$25.5 million in federal payments.
 - Federal matching payment on inpatient and outpatient GAMC fee-for-service payments: \$31.5 million in federal payments.
- Monthly processing of supplemental payments for 56 FQHCS and 88 RHCs
- Payments IEP services Payments (approximately 361 schools)
 - SFY 08: approx. \$48.5 million.



Performance Measurement and Quality Improvement

Vicki Kunerth, Director



Minnesota Department of **Human Services**

Administration

- 60 FTE
- \$8 Million/year
- Approximately 60% of expenditures are studies, audits and surveys with 50-100% federal dollars (FFP dependent on the study).



Ombudsman Office for State Managed Health Care Programs

- The Ombudsman Office assists enrollees in MHCP who are enrolled in an MCO or a Coordinated Care Delivery System (CCDS) hospital.
- The Ombudsman works with enrollees to resolve access, service and billing issues to ensure that medically appropriate services are provided. Disputes and complaints are resolved through mediation, negotiation, education or referral to appropriate county, state or federal agencies or legal services. Each year, there are over 1,000 cases.
- The Office monitors the managed care state fair hearings and attempts to resolve issues before a hearing. In 2009, the office intervened in 30% of cases to resolve the issues before it went to a hearing, saving both time and money for all parties.



Member Help Desk

- **Provides** Information and Referral services to all fee-for-service and managed care enrollees of MHCP. It is the mission of the Member Helpdesk to provide consistent, reliable information about Minnesota's public health care program benefits or referral services depending on the needs of the caller.
- In 2010, the Member Help Desk handled over 79,000 calls (just over 80% of calls received).



Maternal and Child Health Assurance

Responsible for child health benefit policy and program activities for children enrolled in Minnesota Health Care Programs. This includes children's preventive services, immunizations, school-based special education services, and child welfare targeted case management, as well as quality monitoring and measurement compliance and quality. Major responsibilities include:

- **Child and Teen Checkups (C&TC)**, Minnesota's name for the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. Federal law requires that states work to achieve a screening participation rate of 80 percent or higher for all enrolled children through age 20 according to the recommended schedule.
- **Individual Education Plan (IEP) benefit policy** guides Minnesota school districts in maximizing federal Medicaid funding for qualifying special education services provided to Medical Assistance and MinnesotaCare enrollees.
 - IEP services are physical, occupational and speech therapy, Mental Health Services, Nursing, Personal Care Assistance, Assistive Technology, special transportation and interpreters. More than 17,000 Medicaid children are receiving these services in support of their education.

There are over 400,000 children enrolled in MCHP and this business area manages \$40 million in IEP services and \$10 million in county public health/tribal federal C&TC outreach and education requirements.



Health Program Quality

A variety of oversight and monitoring activities are conducted on the quality of health care services purchased through managed care for Minnesota health Care Program (MHCP) enrollees.

Responsibilities include:

- Develop and apply performance measures on access to services, quality of care, and timeliness of services.
- Conduct audits and studies on managed care provision of services, access policies, quality of care, and compliance with contract provisions.
- Conduct consumer surveys on satisfaction and choices to change enrollment in health plans.
- Oversight of quality assurance and improvement standards for health care purchasing.
- Analyses of health care quality and utilization data.



Surveillance and Integrity Review Section (SIRS)

As the state Medicaid agency, DHS is federally mandated to implement a statewide surveillance and utilization control program on the providers that bill DHS. SIRS does this by conducting post-payment reviews and monitoring the delivery of health services by vendors/providers and the use of health services by clients.

SIRS responsibilities include:

- Identify, investigate, and prevent suspected provider fraud, theft and abuse of MHCP
- Recover overpayments due to error, abuse or fraud
- Suspend or terminate participation of health care providers in MHCP when appropriate
- Facilitate prosecution of health care fraud by the Minnesota Office of the Attorney General
- Administer the MHCP Restricted Recipient Program (MRRP)
- Report professional misconduct
- Oversee the integrity activities of managed health care organizations that contract with DHS
- Regularly propose new edits for MMIS payment system to prevent billing errors, overpayments and fraud



SIRS (cont.)

- Over the last five years, SIRS has averaged over \$7 million/year in recoveries. 50% is returned to the General Fund. In 2010 DHS participated in 23 global pharmacy settlements for an additional \$14 million returned to the General Fund.
- The SIRS Hotline is a major source of problem identification. About 300 hotline calls are received each month from providers, clients, neighbors and employees. About 20-30% become investigation cases.
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- Started in 2010 and continuing into 2011, SIRS is implementing two new ongoing federal audits focused on inappropriate and excess payments.



Federal Relations Unit

Ann Berg, Director



Minnesota Department of **Human Services**

Mission

- Ensure that Minnesota is in compliance with Medicaid and Children's Health Insurance Program (CHIP) laws and rules and makes maximum use of available federal funding.



Functions

- **Compliance** - Assist policymakers on federal Medicaid and CHIP laws, regulations and policy to:
 - ensure federal funding
 - avoid financial sanctions
- **Federal authorities.** Manage the various federal Medicaid and CHIP authorities that are required for receipt of federal matching funds
 - State plan
 - -Federal waivers
 - -Other related reports and reviews



Functions (Cont.)

- **Information and Advocacy.** Operate as liaison to CMS for the Medicaid and CHIP programs in Minnesota.
 - respond to requests from the congressional delegation
 - respond to CMS requests for input/rulemaking
 - work with NASMD, NAMD, and other states
- **Contracts.** Manage the legal work for health care programs contracts--drafting, negotiating and executing of the managed care contracts.
- **Tribal Relations.** Liaison for health care to the seven American Indian tribes in Minnesota.



Maintenance of Effort Requirement (MOE)

- Section 2001 of the Affordable Care Act, paraphrased:

During the period that begins on the date of enactment and ends on the date the Exchange is operational states cannot have eligibility standards, methodologies or procedures that are more restrictive than those in effect on the date of enactment. This applies to waiver programs as well as the standard Medicaid program. For children, this requirement continues in effect until October 1, 2019.

Compliance with this requirement is a condition of receipt of any FFP under the Medicaid program. There is an exception for adults with income above 133%, where the state certifies that it has a budget deficit or a projected budget deficit. Once the certification is submitted, the exemption remains in effect for the remainder of the MOE period.



Maintenance of Effort (cont.)

- No CMS guidance issued, except for temporary MOE in the American Recovery and Reinvestment Act (ARRA)
- Penalty is all federal match, not just enhanced FFP
- In guidance on the MOE in the ARRA, CMS prohibited the following activities:
 - increasing premiums if failing to pay restricts, limits or delays eligibility
 - more restrictive income or asset methodologies than those in place on March 23, 2010
 - reducing income or asset standards
 - adding verification requirements unless necessary to comply with federal requirements
 - shortening the frequency of eligibility determinations
 - eliminate an eligibility group or subgroup
 - use of a more restrictive definition of disability
 - use of a more restrictive definition of institutional level of care, if it affects eligibility for Medicaid
 - reducing capacity in the home and community-based waiver programs
 - The exemption does not apply to pregnant women and individuals with disabilities.

