Change Item Title: Redesign Outreach Activities for Child and Teen Checkup Program

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	(802)	(1,603)	(1,603)	(1,603)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(802)	(1,603)	(1,603)	(1,603)
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor proposes to redesign outreach services to children and families to ensure more children are accessing critical preventative health care services within the Medical Assistance program. This proposal reduces General Fund expenditures by $2.4 million in the FY 2022-2023 biennium and by $3.2 million in the FY 2024-2025 biennium.

Rationale/Background:
Child and Teen Checkups (C&TC) is Minnesota's version of the federally required Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. The program is aimed at identifying and addressing early issues that may impact a child's overall health and development, with well-child checkups being the foundation of the program.

A critical component of the C&TC program is child and family outreach to notify them of upcoming well-child visits and to provide resources to support attending those appointments, such as interpreter and transportation services. Minnesota's participation rate at C&TC appointments has remained steady for years and trends below national standards. Department of Human Services (DHS) data also shows that the current outreach model executed under contract by counties and tribes lags in timing and may not be the most effective way to reach families.

Proposal:
This proposal would add the C&TC outreach activities to the Integrated Health Partnership (IHPs) contracts, which serve nearly 50 percent of children on Medical Assistance. The IHP model aims to reach better health outcomes for enrollees by aligning the many incentives for providers and having them be responsible for the health outcomes of their patients. Given the alignment of the goals between IHPs and the C&TC program, this proposal will make IHPs responsible for the outreach for this critical preventative health benefit. To support the IHPs in this responsibility, they will receive enhancements to the existing data and reports they are already receiving, as well as an enhanced population-based payment of $12 annually per child. IHPs will also be held to enhanced accountability metrics for the children and teens attributed to them. These additional costs are offset by expenditure reductions for the current contracts with counties to conduct this work.

Impact on Children and Families:
This change will enhance children's participation in critical well-child visits. Having the IHP responsible for outreach means that the provider picked by the patient will be the one reaching out to remind them of upcoming appointments and emphasize the importance of these preventative visits. In the current model,

counties and tribes perform the outreach, entities that patients are not necessarily familiar with. Additionally, some providers already report performing independent outreach to their patients and patients' families currently.

Equity and Inclusion:

Well-child visits are a critical preventative health service which are important for all kids, but especially for communities of color, which are known to experience greater health disparities. Having the provider entity that the child/family picked to serve them, where an established relationship already exists, will yield better outreach results. This model has the added benefit of allowing the provider, who has an established relationship with the family, to tailor their message using consistent clinic messaging and allowing for more culturally competent outreach.

IT Related Proposals:

This proposal does not require IT systems changes.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 22	FY 23	FY 22-23	FY 24	FY 25	FY 24-25
General Fund			(802)	(1,603)	(2,405)	(1,603)	(1,603)	(3,206)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(802)	(1,603)	(2,405)	(1,603)	(1,603)	(3,206)
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**
GF	33FC	MA Grants	(802)	(1,603)	(2,405)	(1,603)	(1,603)	(3,206)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**

Statutory Change(s):

Minnesota Statutes § 256B.0755; 256B.0625, subd. 58

Federal law or regulation to which this proposal complies:

NA

Change Item Title: Compliance with Interoperability and Patient Access Regulations

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	402	100	25	25
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	402	100	25	25
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends funding resources to meet requirements of the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Rule. This federal regulation finalizes new policies that require Medicaid payers to make it easier for patients to access and share their own health information via application programming interfaces (APIs) on internet enabled devices of their choice (such as smartphones) and moves the healthcare system toward greater interoperability. Complying with the CMS requirements requires a General Fund investment of $502 thousand in the FY2022-2023 biennium and an investment of $50 thousand in the FY2024-2025 biennium.

Rationale/Background:
Lack of seamless data exchange in healthcare has historically detracted from patient care, leading to poor health outcomes and higher costs. CMS published the Interoperability and Patient Access Rule to establish policies that break down barriers in the nation's health system to enable better patient access to their health information, improve interoperability, and promote innovation, while reducing the burden on payers and providers. By ensuring systems can communicate in a more seamless and consistent manner, patients and their healthcare providers will have the opportunity to be more informed, enabling better care and spending less in the long term on complex processes to integrate and communicate information. In a future where data flows freely and securely between payers, providers, and patients, the health care system can achieve truly coordinated care, improved health outcomes, and reduced costs.

The changes called for by the new rule aim to make it easier for clients to access their own health information, which will require DHS to adopt new technologies and data-sharing standards to adapt to the new digital world. The CMS rule focuses on requirements for organizations that provide products for CMS sponsored programs including Medicare, Medicaid, and the Affordable Care Act plans on the federal exchange. The CMS rule makes reference to standards and requirements established in the Health and Human Services Office of the National Coordinator for Health Information Technology (ONC) 21st Century Cures Act: Interoperability, Information Blocking rule.

Proposal:
This proposal implements the system changes required to comply with the new federal regulations on interoperability standards which enable DHS to improve the delivery of health information to patients and providers and moves the healthcare system toward greater interoperability. This includes:

- *Patient Access*: Provide patients secure and easy access to their claims and encounter information, including cost, as well as a defined subset of their clinical information through third-party applications of

their choice. Claims data, used in conjunction with clinical data, can offer a broader and more holistic understanding of an individual's interactions with the health care system, leading to better decision-making and better health outcomes.

- *Provider Directory*: Make provider directory information publicly available. Making this information broadly available will encourage innovation by allowing third-party application developers to access information so they can create services that help patients find providers for care and treatment, as well as help clinicians find other providers for care coordination, in the most user-friendly and intuitive ways possible. Making this information more widely accessible is also a driver for improving the quality, accuracy, and timeliness of this information.
- *Payer-to-Payer Data Exchange*: CMS-regulated payers are required to exchange certain patient clinical data at the patient's request, allowing the patient to take their information with them as they move from payer to payer over time to help create a cumulative health record with their current payer. Having a patient's health information in one place will facilitate informed decision-making, efficient care, and, ultimately, can lead to better health outcomes.
- *Improving the Dually Eligible Experience*: Update reporting requirements and the frequency of Federal-State Data Exchanges of certain enrollee data for individuals dually eligible for both Medicare and Medicaid, from a monthly to a daily exchange to improve the dual eligible beneficiary experience, ensuring beneficiaries are getting access to appropriate services and that these services are billed appropriately the first time, eliminating waste and burden.

DHS and MNIT are in the process of creating a plan for addressing the requirements in the rule for submission to CMS. This includes identification of potentially overlapping projects and possible options for meeting the requirements in the most efficient way. This will include coordination with DHS's Medicaid Managed Care Organizations, MNsure, and the Minnesota Department of Health.

Effective dates within the rule vary by component beginning January 1, 2021 with enforcement starting July 1, 2021. Given the extent of changes required, it is expected to take greater than 6 months to achieve basic compliance with the earliest components.

While the specific IT solution to come into compliance with this rule is still being explored, DHS anticipates that funds will be used to complete the following work:

- Create a secure, standards-based API that allows patients to easily access their claims and encounter information, including cost, as well as formulary information;
- Make standardized, web-enabled information about provider networks available;
- Update the frequency of exchange of data with Medicare for individuals dually eligible for Medicare and Medicaid from monthly to daily to ensure beneficiaries are getting access to appropriate services and that these services are billed appropriately the first time, eliminating waste and administrative burden;
- Review and identify other impacts of the rule and the companion Information-Blocking provisions in the CURES Act rule on existing DHS policies, processes, and contracts.

Implementing these components will require DHS and MNIT staff to analyze and identify impacts, plan for implementation, and operationalize the new policies. It will also require system architects, security analysts, and data architects to learn the new standards, facilitate mapping of required data components, and establish or contract with eligible vendors for mechanisms to authenticate and respond to API requests.

The systems changes that MNIT will complete are estimated to require 13,022 hours of work, take approximately 24 months to complete, and cost a total of $1,273,801 for initial development. An additional $375,000 in state funds will be directed for work at DHS to engage a vendor in policy and process development as well as requirements for service delivery transformation efforts that are need in preparation and throughout implementation of the revised policies. Both MNIT and DHS vendor costs will draw down a 90 percent federal

funds match. CMS has indicated states are eligible for enhanced matching dollars when following established interface guides and security standards, which DHS intends to do.

Equity and Inclusion:
All enrollees will be positively impacted by these proposed changes. Compliance with this rule furthers DHS's efforts at achieving a business model that includes racially and culturally appropriate considerations to support an equitable service delivery system, utilizing a person-centered framework, using the social determinants of health to identify root causes of an individual or family's need for services, and using a multi-generational approach which takes into account the needs of the whole family. In developing that new business model, stakeholder feedback was gathered from representatives of historically marginalized groups of people. In addition, the new business model's ongoing development and implementation will be intentionally inclusive and offer opportunities for broad stakeholder input and collaboration, including people served and advocates. Overall, the change to the business model will reduce or eliminate disparities for all groups.

Impact on Children and Families:
This proposal accelerates efforts of other initiatives and innovations that require the connection and coordination of health services. Families with children who have special health needs will especially benefit because of the many health providers and payers involved in the person's care. Making it easier for individuals to have a longitudinal record of important health history is particularly helpful for families who make transitions between providers or payers as they move and age.

IT Related Proposals:
The necessary systems changes are estimated to require 13,022 hours of work, take approximately 24 months to complete, and cost of a total of $1,273,801 for initial development.

Results:
The primary result of the proposal is compliance with new regulations because enforcement carries potential penalties of up $1 million per violation for failing to share the required patient requested data.

While the extent to which beneficiaries will take advantage of being able to access their data under the new policies is unknown, tracking of which APIs and volume of request is required. This will allow evaluating how often we are satisfying patient data requests, and the extent to which the health outcomes for those patients may differ from those who do not.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of requests received and fulfilled by patients for their own data	0	0	2020
Equity	Rate of requests by persons living with a disability, by ethnicity group, and geographic region is proportionate to population in order to identify needed outreach or communication about availability of the APIs	0	0	2020

Fiscal Tracking:

Net Impact by Fund (dollars in thousands)			FY 22	FY 23	FY 22-23	FY 24	FY 25	FY 24-25
General Fund			402	100	502	25	25	50
HCAF								
Federal TANF								
Other Fund								
Total All Funds			402	100	502	25	25	50
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**
GF	11	State Share of Systems Costs (APD @ 90%)	127	0	127	25	25	50
GF	11	HCA Admin (Contract)	275	100	375	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**

Statutory Change(s):

Rider

Federal Citation:

42 CFR 431.60
85 FR 25642, 25642-25961

Change Item Title: Expand Use of Encounter Alerting System

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	(1,616)	(1,345)	(1,301)	(1,258)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(1,616)	(1,345)	(1,301)	(1,258)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends expanding the Minnesota Encounter Alerting Service to improve care and lower the health care costs of Minnesota Health Care Program enrollees. This reduces General Fund expenditures by $3.0 million in the FY 2022-2023 biennium and by $2.6 million in the FY 2024-2025 biennium. This proposal assumes the net general fund savings in FY 2022-23 is applied against the $100 million Blue Ribbon Commission (BRC) reduction target enacted in 2019.

Rationale/Background:

Fragmented care is expensive; the sooner a provider who is accountable for coordinating a person's care can be informed of a health event, the more effectively they can support recovery, transitions between care settings, and avoid re-hospitalization. This proposal expands efforts to implement more timely communication from an emergency room, hospital, or long-term care facility to a person's care team.

This is a cost savings strategy which would expand participation in the Minnesota Encounter Alerting Service (MN EAS) so that more Minnesota Health Care Program enrollees have improved access to coordinated care. Participation in the MN EAS was piloted by providers participating in accountable care arrangements and has been a critical tool for timely coordination of transitions of care. Notifications from 171 sources result in the successful delivery of over 100,000 alerts per month. The Department of Human Services (DHS) contributes attributed patient panels for Integrated Health Partnerships (IHPs), and providers who perform care coordination can upload additional consenting panels.

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC) recently published companion rules which impact policies around the interoperability of health information. Under the new rule, hospitals are required to send event notifications as a condition of provider participation in Medicare and Medicaid. The Minnesota Encounter Alerting Service will make it easier for hospitals to meet this requirement. The new ONC rule includes a definition of a health information network, which would include the MN EAS because it facilitates the sharing of information between unaffiliated providers.

Proposal:

This proposal expands onboarding efforts to additional Medicaid providers, encourages participation of other payer panels, and ensures sustainable funding of the MN EAS system. While a majority of the hospitals in the state are now sending notifications to the service, work remains to connect additional community providers to the service. On average, one-quarter (25 percent) of the notices generated can be matched and delivered to a

subscribing participant's care coordination panel. Expanding the service to additional care coordination panels would extend the benefit realized by IHPs and existing participants to additional providers.

The expansion to additional providers and payer panels also makes it easier for providers to use consistent workflows and the alerts for Medicaid and Medicare consumers can be matched at a higher rate to the appropriate care team. Basic onboarding of new providers typically takes three weeks and requires minimal time of staff for review of agreements and training and workflow discussions. For systems desiring deeper integration into existing infrastructure and workflow tools, the resources required may be higher. As a result, savings can be realized within a short time after bringing on additional providers.

In addition to expanding onboarding efforts, this proposal funds work necessary to maintain and expand the Encounter Alerting Service, and clarifies authority for DHS to operate the service to ensure providers have a cost-effective option for satisfying the hospital alerting requirement in the CMS Interoperability Rule.

This proposal is estimated to generate savings of $4.5 million total dollars in the next biennium. These savings would be realized through expected reductions in readmissions as a result of care teams receiving notifications of adverse events in a timely fashion so that appropriate transitions of care occur for patients with complex medical conditions.

Medicare beneficiaries who had transitional case management following a discharge had a significantly lower overall mean cost ($3,358 vs. $3,033).[1] Minnesota has relatively low rates of using that service[2] and a functioning Admission/Discharge/Transfer system would aid and enable this. Studies indicate that if the necessary follow-up is not provided after an ER visit or hospitalization, recovering patients are more susceptible to complications and illness, resulting in worse health outcomes and costly readmissions (Kirsch, Kothari, Ausloos, Gundrum & Kallies, 2015). Also, people who are not seen by their primary provider within 30 days of an ER or hospital admission have a 10x greater risk of readmission (Moran, Davis, Moran, Newman, & Mauldin, 2012).

Impact on Children and Families:

The strategy applies to persons covered by Minnesota Health Care Programs who receive treatment in an emergency room, hospital, or long-term care (LTC) facility and the providers who serve them. For a consumer, health care is more cohesive, and the support needed during a care setting transition can be arranged sooner. This impact can be experienced immediately as evidenced by family and patient stories shared by participants who describe a sense of relief or re-assurance that their care team was on the same page and knew about an event so they could help with follow-up. For health care providers in hospital or ER settings, the service reduces administrative burden (i.e., phoning/faxing) and allows for critical health event information to be communicated seamlessly to a patient's primary provider.

The service ensures that the provider can receive the information securely even if they are not on the same electronic health record (EHR) system or part of the same health system. For primary care providers or other care coordination staff, less time is spent searching and seeking updated clinical information and there are improved health outcomes because the critical information was pushed to them right away when there was still time to intervene. For providers who have traditionally not been able to participate in e-health exchange, this service provides a low cost, high value way to receive necessary notifications.

Equity and Inclusion:

The service promotes cohesive and supportive health care for the enrollee, while promoting a reduction in cost, administrative burden, and time for individuals covered by Medical Assistance or Medicare receiving treatment in an emergency room, hospital, or long-term care facility. Populations that benefit most from this strategy are

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6583218/

[2] https://data.cms.gov/Medicare-Physician-Supplier/Medicare-ProviderUtilization-and-Payment-Data-Phy/fs4p-t5eq/data

those who experience high use of the emergency room as their main source of care, including persons who are homeless and persons with mental illness. The availability of this care coordination tool allows provider systems who disproportionately serve these populations to receive these important event notifications.

IT Related Proposals:

Systems modifications are not needed for this proposal.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 22	FY 23	FY 22-23	FY 24	FY 25	FY 24-25
General Fund			(1,616)	(1,345)	(2,961)	(1,301)	(1,258)	(2,559)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(1,616)	(1,345)	(2,961)	(1,301)	(1,258)	(2,559)
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**
GF	33AD	MA Grants	(2,289)	(2,243)	(4,532)	(2,199)	(2,156)	(4,355)
GF	13	HCA Admin (Contract)	990	1,320	2,310	1,320	1,320	2,640
GF	REV1	FFP @ 32%	(317)	(422)	(739)	(422)	(422)	(844)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**

Statutory Change(s):

Minnesota Statutes §256.01, subd. 28

Federal law or regulation to which this proposal complies:

CMS Interoperability and Patient Access final rule (CMS-9115-F)

21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program, 45 CFR 170 and 171

Change Item Title: Align Asset Limits for Medicare Savings Programs

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2021, the Governor recommends indexing the Medicare Savings Programs (MSP) asset limits to align with the Medicare Part D Low-Income Subsidy (LIS) as required by federal law. This proposal is budget neutral in the current biennium.

Rationale/Background:

Medicare Savings Programs are federal and state-funded programs that assist people on Medicare who have limited income and assets by paying some Medicare expenses, such as premiums, deductibles, and coinsurance. The three types of MSP are Qualified Medicare Beneficiary (QMB), Service Limited Medicare Beneficiary (SLMB), and Qualified Individual (QI).[1] To qualify for QMB, SLMB, or QI, a person must have assets of no more than $10,000 for a household of one or $18,000 for a household of two or more (Minnesota Statutes § 256B.057, subd. 3).

Federal law requires that a state's MSP cannot have an asset limit that is lower than the maximum asset level allowed for the LIS.[2] The 2020 asset limit for a single individual is $7,860 and $11,800 for a married couple.

An analysis of the actual annual increases in the LIS asset limits using the average dollar increase per year since 2006 ($189) shows that the amounts are projected to exceed the MSP asset limits in 2032. The same analysis using the average adjustment factor change from year to year (1.61 percent) shows that the amounts are projected to exceed the MSP asset limits in 2036.

States are not permitted to apply asset limits for their Medicare Savings Programs that are more restrictive than the federal Medicare Part D LIS asset limits. Although Minnesota's MSP asset limits are currently less restrictive than the LIS asset limits, the MSP asset limits are fixed amounts in Minnesota statute, while the LIS asset limits index annually. Eventually, the LIS asset limits will reach and exceed Minnesota's MSP asset limits, making the

[1] The Qualified Working Disabled (QWD) MSP has asset limits of $4,000 for a household of one, and $6,000 for a household of two or more. Federal and state QWD asset limits do not increase annually, and therefore the QWD MSP is excluded from this proposal.

[2] The LIS asset limits for single individuals and married couples are based on three times the Supplemental Security Income (SSI) resource standard increased by the annual percentage increase in the consumer price index as of September of the previous year.

MSP asset limits more restrictive. The LIS asset limits are estimated to reach the MSP asset limits currently set in statute between 2032 and 2036.

Proposal:
This proposal provides the state law authority to index the MSP asset limits annually to correspond to the LIS resource limits, when the LIS asset limits reach or exceed the amounts currently set out in state law.

No fiscal impact is projected during this biennium or during the out years. However, providing the requirement in state law will result in a fiscal impact in future years (2032-2036).

Impact on Children and Families:
This proposal is a technical change required for future federal compliance. The proposed change will impact dual eligible Medicare/Medicaid enrollees, who are low-income people age 65 or older, or who are blind or have a disability. This proposal will not directly impact children, youth, and families or address the administration's priorities for these groups.

Equity and Inclusion:
This proposal is a technical change and does not impact equity outcomes in the short or long term. However, the population impacted by this proposal are dual eligibles, meaning low-income seniors or people with disabilities who qualify for benefits under both Medicare and Medical Assistance. Dual eligibles typically have higher rates of chronic illnesses, dementia and other forms of cognitive impairment, physical and developmental disabilities, and/or mental illnesses. Dual eligible beneficiaries are more likely to have functional limitations and require long-term care services than non-dual eligible Medicare beneficiaries. Dual eligible enrollees may experience beneficial changes due to increased MSP asset limits at the point the indexed limits begin (around 2032-2036).

IT Related Proposals:
No IT systems work needs to be completed related to this proposal.

Fiscal Detail:
None

Statutory Change(s):
Minnesota Statutes § 256B.057, subd. 3.

Federal law or regulation to which this proposal complies:
42 U.S.C. § 1396d(p)

Change Item Title: Realigning MinnesotaCare Statute with Federal Requirements

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends repealing legislation passed in 2016 that required the Department of Human Services (DHS) to stagger MinnesotaCare renewals throughout the year. DHS lacks federal approval to implement the change. This proposal is budget neutral.

Rationale/Background:

Under the 2016 legislative change, state law requires MinnesotaCare eligibility to be renewed once every 12 months based on the enrollee's month of application, rather than the current MinnesotaCare renewal schedule that requires all enrollees to renew each January. These changes also directed DHS to use current income to determine eligibility rather than projected annual income, and annual indexing of the Federal Poverty Guidelines was changed to occur each July rather than January.

DHS has been unable to implement these changes because the Centers of Medicare and Medicaid Services (CMS) has not approved the use of current income instead of calendar year projected annual income for MinnesotaCare financial eligibility outlined in the Basic Health Program Blue Print. In addition, CMS did not approve the DHS proposal to redistribute renewal dates for the current MinnesotaCare caseload throughout the year. DHS has been in regular communication with MNsure and the navigator organizations to determine opportunities to address issues this legislation intended to solve. For example, DHS is working to establish a triage system for navigators when a renewal case requires immediate attention to ensure a timely response, is providing additional training for call center staff to ensure renewals are processed more effectively and efficiently during open enrollment season, and has made improvements to METS, the IT system used to determine eligibility, to address common issues in the renewal process.

Proposal:

This proposal repeals legislative changes to the MinnesotaCare statute that authorized:

- Staggering renewals;
- Using current income for financial eligibility; and
- Changing the timeline for annual updates to the federal poverty guidelines to July instead of January.

Impact on Children and Families:

Repealing the statute to stagger MinnesotaCare renewals throughout the year will not adversely impact children or families. Enrollees will not experience a noteable change in their renewals as a result of the repeal, as staggered renewals for MinnesotaCare has not been implemented.

Equity and Inclusion:
Repealing the 2016 legislation that authorized staggered renewals would not disproportionally affect a specific racial or social group enrolled in MinnesotaCare. Enrollees will not experience a noteable change in their renewals as a result of the repeal, as staggered renewals for MinnesotaCare has not been implemented.

IT Related Proposals:
No IT changes are necessary to implement this proposal.

Fiscal Detail:
None.

Statutory Change(s):
Minnesota Statutes §§ 256L.01; 256L.04; and 256L.05.

Change Item Title: Modify the Window for Information Gathering for Inpatient Rate Setting

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends expanding the time period during which hospitals may appeal and/or correct the information the Department of Human Services (DHS) uses to set both the rates and the overall budget pool for inpatient hospital services. The proposal is budget neutral.

Rationale/Background:

Prior to 2014, the rate methodology for inpatient hospital services was specific to each hospital and was based only on the historical costs and services delivered by each individual hospital. Under this older rate setting method, hospitals could amend and correct the information used to set the rates well after the rates had gone into effect.

The current rate methodology for inpatient hospital services, implemented in November 2014, sets statewide base rates that are targeted to an overall budget pool. Under this methodology, any change in rates for one hospital will result in a change in the rates paid to all other hospitals.

Given the interrelated nature of the new hospital rates, changes were needed to address the time period during which hospitals could appeal their rates. During the 2017 legislative session, a language change was enacted to restrict the time period of the information DHS would consider in an appeal to ensure that all of the information used in the rate setting process was available in its final and correct form prior to DHS beginning the rate setting process. Amended hospital cost reports or reported Medicaid days would not be considered in the appeal if the amended information was not available prior to December 31st of the year that followed the base year for the rate setting. This one year window seemed reasonable at the time the legislative change was enacted. However, based on experience to date, DHS believes the appeals window can be extended to 18 months, giving hospitals more time to correct any errors in their cost reports.

Proposal:

This proposal directs DHS to expand the window for hospitals to correct the information used to compute inpatient hospital payment rates from 12 months to 18 months. This is a technical change to extend the timeframe during which a hospital can correct errors in their cost reports. It does not change the methodology used to calculate rates or the overall budget pool for inpatient hospital services and is, therefore, budget neutral.

Impact on Children and Families:

Families and children served by the Medical Assistance and MinnesotaCare programs are best served when providers are paid a fair and accurate rate. This proposal ensures that the rates paid to hospitals are calculated using the most up to date information.

Equity and Inclusion:

Enrollees and providers benefit when the rate setting process is fair and transparent. This change maximizes the window provided to hospitals to correct any errors in the information used to compute payment rates.

IT Related Proposals:

This proposal will not require and changes to DHS IT systems.

Fiscal Detail:

None.

Statutory Change(s):

Minnesota Statutes § 256.9695, subd. 1

Federal law or regulation to which this proposal complies:

NA

Change Item Title: Updating Rate Methodology Description for Outpatient Hospital Services

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends amending state statute to more clearly describe the rate methodology the Department of Human Services (DHS) uses to set payment rates for outpatient hospitals. This proposal is budget neutral.

Rationale/Background:
DHS uses Medicare's Ambulatory Payment Classification (APC) system to set outpatient hospital rates for most hospitals. This is not clear in the statutory language which instead describes the pricing data CMS used to develop the APC methodology over twenty years ago. The intent of the current language is that DHS will adopt Medicare's payment methodologies, as they are regularly updated, but that intent is not clear. DHS will amend the statute in a manner that will clarify the intent and continue to allow DHS to adopt Medicare's updates without the need for additional statutory changes.

Proposal:
This proposal amends statute to more clearly describe the rate methodology used to set payment rates for outpatient hospital services. This change is budget neutral. This proposal does not change current rate setting methodology; it only seeks to make the methodology clearer in statute.

Impact on Children and Families:
All providers and enrollees benefit when payment rates are fair and transparent. New providers will also have enough information to make an informed decision as to whether or not they want to participate in Minnesota Health Care Programs. Minnesota Health Care Program enrollees benefit when more hospitals accept the program's rates.

Equity and Inclusion:
All providers and enrollees benefit when payment rates are fair and transparent. New providers will also have enough information to make an informed decision as to whether or not they want to participate in Minnesota Health Care Programs. Minnesota Health Care Program enrollees benefit when more hospitals accept the program's rates.

IT Related Proposals:
There are no IT changes associated with this proposal.

Fiscal Detail:
None.

Statutory Change(s):
Minnesota Statutes § 256B