Minnesota Prepaid Medical Assistance Project Plus (PMAP+)

Section 1115 Waiver No. 11-W-0039/5 Continuous Eligibility

Amendment Request
January 25, 2024

Submitted to:

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services

Submitted by:

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Attachments

1. Overview

The Minnesota Department of Human Services (DHS) is requesting an amendment to its Prepaid Medical Assistance Program Plus (PMAP+) waiver to expand and extend continuous eligibility for children. The amendment expands the 12-month continuous eligibility policy for children under 19 required under §1902(e)(12) and §2107(e)(1) of the Social Security Act to include 12-months of continuous eligibility for 19- and 20-year-olds, and continuous eligibility for eligible children up to age six.

Continuous eligibility for children is a long-standing health care coverage retention strategy used by states. Currently, 32 states offer 12-month continuous eligibility for children[1]. The Consolidated Appropriations Act (CAA) of 2023 requires all states, by January 2024, to provide 12-month of continuous eligibility for children from birth to under age 19, with some limited exceptions. Where the state refers to children from birth to age six, it includes infants under age one who, effective January 1, 2024, have 12-months of continuous eligibility under the Medicaid state plan[2]. This group does not require waiver authority.

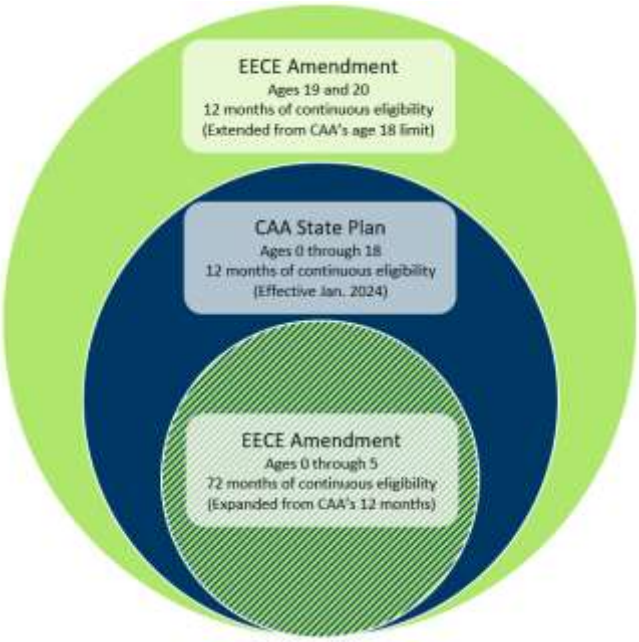
The goal of this amendment is to support on-going Medicaid and CHIP enrollment and improved access to health care for children. CMS' literature review for a presentation in 2023 included that "Research has shown that children who are disenrolled for all or part of the year are more likely to have fair or poor health care status compared to children who have health insurance continuously throughout the year.[3]" The amendment:

- Expands continuous eligibility for children up to age six; and
- Extends the 12-months of continuous eligibility to include young adults ages 19 and 20.

[1] Centers for Medicare and Medicaid Services presentation on June 29, 2023. 'Continuous Eligibility under the Consolidated Appropriations Act, 2023.'

[2] Minnesota plans to submit a Medicaid state plan amendment on or before March 30, 2024, providing 12-months of continuous coverage that includes children from birth to age 19.

[3] Brantley, E., & Ku, L. (2022). Continuous eligibility for Medicaid associated with improved child health outcomes. *Medical Care Research and Review*, *79*(3), 404-413.



CMS identified that continuous eligibility for children[4]:

- Reduces financial barriers to health care for low-income families;
- Promotes improved health outcomes; and
- Provides tools to hold health plans more accountable for quality care and improved health outcomes.

The amendment supports and broadens these benefits. Minnesota state law requires that DHS seek federal approval[5] for expanded and extended coverage. Extending and expanding continuous coverage policies prevents disruptions to continuity of care or delays in receiving needed services and reduces administrative burden for families. The amendment simplifies eligibility processes for all children and 19- and 20-year-olds enrolled in Medicaid and the Children's Health Insurance Program (CHIP) and will reduce churn off and back on the respective program when temporary changes occur, such as fluctuations in family size or household income. Churn is used to describe the temporary loss and return to health care coverage that is often caused by missing paperwork or eligibility process and policy issues. Studies suggest that roughly one in ten[6] Medicaid beneficiaries that lose eligibility return to the program within one year, and many are disenrolled for procedural reasons.

Providing continuous eligibility for children under age six supports early brain development during the first five years of life and supports continued access to well child and preventive

[4] CMS presentation, June 29, 2023 "Continuous Eligibility under the Consolidated appropriations Act, 2023." Slide deck.
[5] Minnesota Statutes, section 256B.056, subd. 7
[6] Kaiser Family Foundation, "Medicaid Enrollment Churn and Implications for Continuous Enrollment Policies", December 14, 2021. Accessed November 11, 2023, at https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/

health care including childhood immunizations. Extending continuous eligibility to young adults age 19 and 20 mitigates losses in coverage resulting from the lower income eligibility limit for that group and provides a bridge during the time many enrollees are transitioning from school to employment. For this group, the amendment supports the possibly of attaining health care coverage through an employer or having sufficient income to purchase coverage. Minnesota offers health care coverage options through MNsure,[7] including options for people with limited income, and supports continued access to extended coverage pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement including expanded mental health coverage.

A. Background

Over 650,000 Minnesota children are Medicaid and CHIP beneficiaries and Medicaid and CHIP cover 40% of all births in the state. Medicaid and CHIP eligibility is income-based. Yet, many families who meet the income thresholds face challenges in obtaining and maintaining Medicaid and CHIP coverage. People who live in poverty or deep poverty struggle on many levels. Understanding and completing Medicaid or CHIP eligibility paperwork for their child or children can be daunting.

Minnesota income data for 2021 identified 9% of state residents 11% of children were living in poverty. A family of three is in poverty if their household income is at or below $2,072 per month[8]. If it is under $1,036 per month, the family is in deep poverty. To provide context, the average size apartment in Minneapolis, MN is 777 square feet and the market rate rent average is $1,600 per month.[9]

Families in these economic conditions face unique stresses and challenges, and poverty and deep poverty are experienced across the state. For these families, their health and their children's health outcomes are adversely affected. A 2020 Minnesota Department of Human Services (DHS) report[10] found that children enrolled in Medicaid or the CHIP program who are living in deep poverty have mortality rates twice as high as children also on the program but who live at or above poverty. They are also less likely to receive preventative medical care.

In 2020, DHS embarked on an extensive study of racial disparities in public health care programs. The work culminated in a comprehensive report, Building Racial Equity into the Walls of Minnesota Medicaid published in February 2022 (referred to as the BREW report).[11] While the BREW report focused on racial equity, it offers considerable data and insights about the health coverage of all children enrolled in Medicaid and CHIP. The report collected and analyzed data from several sources, including health care service and eligibility data. The data,

[7] MNsure is Minnesota's marketplace for individuals and families to compare health care coverage options and costs and learn about health care options. Online applications submitted via the MNsure website determine whether the person may be eligible for Medicaid, CHIP, MinnesotaCare (Minnesota's Basic Health Program), or for enrollment in a Qualified Health Plan with or without an advance premium tax credit.

[8] Poverty Guidelines | ASPE (hhs.gov)

[9] RentCafe website 8/4/23

[10] The worry is always there: Improving the health of people living in deep poverty. Report, Dec 2020 issued by DHS. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG

[11] Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans (state.mn.us)

paired with broad public input sought through interview groups, townhall meetings, and talking with families and people who are (were) Medicaid and CHIP beneficiaries, identified health care access issues and offered suggested changes. The top two recommendations in the BREW report are to:

- Pursue continuous eligibility for children; and
- Simplify enrollment and renewal processes.

The obvious benefit of continuous eligibility is that it reduces the churn of children on and off Medicaid. One study found that for children on Medicaid, those who lived in states with continuous eligibility were less likely to have a gap in health insurance, were less likely to go without needed medical care, and their parents reported their health to be better than was the case for children in states without continuous eligibility.[12] The latter group were more likely to report problems with obtaining care. Continuous coverage is an important step toward ensuring that children have access to appropriate preventative and primary care, as well as treatment for acute and chronic conditions. Stable coverage also enables providers to develop relationships with children and their families.[13]

An analysis of 2017-18 American Community Survey (ACS) data by the State Health Access Data Assistance Center (SHADAC) shows that, in Minnesota, 64% of Black children, 54% of American Indian/Alaskan Native children, and 52% of Hispanic/Latino children receive their health care coverage through Medicaid, as compared to 17% of white children.[14]

Many parents with low wage jobs experience income volatility. They can have a temporary increase in income due to variable work time, overtime or during busy seasons.[15] This temporary income can be enough to lose their Medicaid coverage. When interviewing people living in deep poverty, one person shared:

> *"I work in the restaurant industry, that is a job where you go in at a certain time, and it could be that you work three hours, or you work five hours, or ten hours. You don't know. It's hard for me to determine how many hours a week I'll be working."*[16]

In addition to improving health care access, continuous eligibility promotes health equity. Black and Hispanic individuals are more likely to live in poverty as are American Indians.[17] Families

[12] Brantley, E. & Ku, Leighton. (2022). Continuous eligibility for Medicaid associated with improved child health outcomes. Medical Care Research and Review. Vol 79(3) 404-413.
[13] Ku, L., Steinmetz, E., & Bysshe, T. (2015). *Continuity of Medicaid Coverage in an Era of Transition*. The George Washington University.
[14] SHADAC analysis of the 2017-2018 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2017 and 2018 were combined to increase the sample size and improve the reliability of estimates among Minnesotans by race and ethnicity.
[15] Ku, L., Steinmetz, E., & Bysshe, T. (2015). *Continuity of Medicaid coverage in an era of transition*. The George Washington University.
[16] "We definitely struggle… The worry is always there: Improving the health of people living in deep poverty." Report, Dec 2020 issued by DHS. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG
[17] "We definitely struggle… The worry is always there: Improving the health of people living in deep poverty." Report, Dec 2020 issued by DHS. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG

with inconsistent incomes are also more likely to experience other adverse situations such as food insecurity, unstable housing, greater parental stress, and reduced child academic attainment. Losing health care coverage, even temporarily, compounds the other challenges families in these situations encounter. Uninterrupted access to health care for their children can help mitigate these negative effects.

B. How the demonstration program furthers the objectives of Title XIX and/or Title XXI of the Social Security Act

The amendment supports the objectives of Titles XIX and XXI of the Social Security Act by broadening the coverage provided under the CAA which mandates states to provide continuous eligibility in Medicaid and CHIP for children from birth through age 18 (with some limited exceptions) by January 1, 2024.

The limited exceptions to continuous eligibility under the amendment parallel those in the CAA. In addition to death, an enrollee may lose waiver eligibility if one of the following occur[18]:

- The child or the child's representative requests a voluntary termination of eligibility;
- The child ceases to be a resident of Minnesota; or
- The agency determines that the child's eligibility was erroneously granted.

For purposes of the amendment, use of the term "continuous eligibility" includes these exceptions and it applies to the Medicaid Expenditure Groups defined in the amendment.

C. Description of the hypotheses

Hypotheses

The amendment will improve access to health care for children enrolled in Medicaid and CHIP.

The Medicaid Expenditure Groups (MEGs)

Two MEGs would be added to the waiver. One for enrollees ages one to six[19] and the second for enrollees ages 19 and 20. The table shows how each would be identified by data source for purposes of budget neutrality reporting.

MEG	Data Source	Explanation
One to six year olds	Allocation of 2.2% of total expenditures and member months for MA children ages one to six years old.[20]	This represents the expansion group covered under the waiver.
19 and 20 year olds	Allocation of 2.2% of total expenditures and member months for MA 19 and 20 year olds.	This represents the expansion group covered under the waiver.

[18] Additional reasons a child or young adult may not be eligible for waiver coverage include fraud and other exclusions provided in CMS regulations or sub-regulatory direction.
[19] Infants under age one have continuous eligibility for 12-months under the Medicaid State Plan Amendment.
[20] This allocation excludes the one-year olds covered as a waiver population in the approved PMAP+ waiver.

A CHIP allocation form is not necessary because the impacted population at 2.2% of CHIP one-year-olds expenditures would be insignificant (less than five children). When turning age two, the CHIP Medicaid expansion infants will become Medicaid children with uninterrupted continuous eligibility through this waiver amendment.

D. Regions of the state covered by the demonstration

The amendment applies statewide for the identified MEGs. The eligibility groups are identified in Section 3.

2. Impact of Amendment on Beneficiaries

Children enrolled in Medicaid and CHIP will have uninterrupted health care coverage for longer periods of time resulting in improved access to health care and treatment follow-up. Measurable outcomes include increased use of well-child and preventive care as mentioned above.

Additional secondary benefits are expected; however, because measuring these outcomes require access to educational records and/or to many years of health care data, they are not included in the evaluation of the amendment.

Despite challenges in measuring the secondary benefits, it is of value to note that the state anticipates the amendment will positively impact long-term health outcomes through early diagnosis and treatment of chronic conditions, improved educational performance, and increased engagement of the child's eligible family members in Minnesota's public health care programs. Additionally, families and parents will be supported by minimizing worries related to their children's health care coverage.

For example, parents living in poverty face challenges such as managing the chronic financial stress of trying to meet day-to-day needs. This can take a toll both on them and on their ability to care for children to the best of their ability. Continuous eligibility can reduce the stress of their children's health care coverage by preventing an unexpected loss of coverage and reducing some of the paperwork they must complete. The deep poverty report describes the impact of chronic stress as described by a social service provider in a predominantly White rural community in Minnesota.

> *"Stress can be a huge barrier on their health. If you and I are worried how we're going to make ends meet and that stress on your heart and blood pressure… Do I pay my rent this month or do I pay my electric? This can have a cyclical impact. The anxiety can lead to greater mental health breakdowns, which can then impact functioning. We see this a lot in our community." P.38-39* [21]

[21] "We definitely struggle… The worry is always there: Improving the health of people living in deep poverty." Report, Dec 2020 issued by DHS. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG

3. Beneficiaries Affected by the Demonstration

The waiver amendment affects eligibility for children enrolled in Medicaid or CHIP who are ages one to six and ages 19 and 20. Children will have continuous eligibility until age six and those between age six to 21 will have 12-months of continuous eligibility.[22]

Eligibility

Included

The following eligibility charts identify the Medicaid and CHIP mandatory, optional, and expansion groups covered by the amendment. The waiver covers:

- Enrollees up to age six who will have continuous Medicaid or CHIP eligibility from the time of enrollment.
- Enrollees ages 19- and 20-years-old who will have 12-months of continuous Medicaid eligibility.

Not Included

The four groups listed below are not included in this amendment.

- Infants from birth to age one; they have 12-months of continuous eligibility under the Medicaid state plan (effective January 2024).
- Children from age six through age 18; they have 12-months of continuous eligibility under the Medicaid state plan (effective January 2024).
- Young adults over the age of 21 who are not transitioning from foster care.
- Young adults from age 18 to age 26 when transitioning from foster care to the former foster care youth group; they have eligibility without an income or asset test as former foster care youth through age 25, under the Medicaid state plan or under section 1115 waiver authority.[23]

Throughout the amendment, where birthdate is used as an eligibility criterion, the month of the person's birthdate is used rather than the specific date. For example, if an individual turns 21 on February 10, the person remains eligible through February, the month of their birthday.

[22] Through the PMAP+ amendment and Minnesota Medicaid state plan.

[23] Minnesota is submitting a separate waiver amendment for PMAP+ (in January 2024) to provide coverage for children who resided in foster care and turned age 18 before January 1, 2023, regardless of the state in which they aged out of foster care. Those who turned 18 after January 1, 2023, will be covered by Medicaid as required under the CAA of 2023.

Eligibility Charts

Mandatory State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Auto newborn (child born to person enrolled in Medicaid)	§1902(e)(4) 42 CFR §435.117	N/A (for the child)
Child with IV-E Foster Care or Adoption Assistance	§1902(a)(10)(A)(i)(I) and §473(b)(3) 42 CFR §435.145	N/A
Child certified blind or disabled	§1902(f) and §1902(a)(10)(A)(ii)(I) and §1905(a) 42 CFR §435.121	100% FPL
Child who is a parent	§1931 42 CFR §435.110	133% FPL
Pregnant person, who is a child under 21	§1902(a)(10)(A)(III) and (IV) 42 CFR §435.116 and §435.170	278% FPL
Poverty level infant, birth to age two	§1902(a)(10)(A)(i)(IV) and §1902(l)((1)(ii) Infant (child 0-1) 42 CFR §435.118 and §435.4 Section 1115 waiver authorizes coverage of one-year olds as infants for purposes of Medicaid and CHIP	Medicaid, 278% FPL
Poverty level children from age 2 through age 18	§1902(a)(10)(A)(i) (VI), and (VII) 42 CFR §435.118	275% FPL
Former Foster Care Children through age 25	§1902(a)(10)(A)(i)(IX) 42 CFR §435.150	N/A
Medicaid Savings Plan (MSP) eligibility (QMB, SLMB, QI)	§1902(a)(10)(E) and §1905(p)	QMB – 100% FPL SLMB – 120% FPL QI – 135% FPL

Optional State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Child in State-funded Foster Care	§1902(a)(10)(A)(ii) and §1905(a)(i)	N/A
Child with Minnesota Adoption Assistance	§1902(a)(10)(A)(ii)(VIII) 42 CFR §435.145	N/A
CHIP for Medicaid Expansion Group	§1902(a)(10)(A)(ii)(XIV), and §1905(u)(2)(B) 42 CFR §435.229 and §435.4	283% FPL*
Child age 19 and 20	§1902(a)(10)(A)(ii), §1905(a)(i) 42 CFR §435.222	133% FPL
Disabled child age 19 and 20	§1902(a)(10)(A)(ii)(I) and (IV); and §1905(a)(i)	100% FPL
Child enrolled under the TEFRA; and reasonable classification of TEFRA children	§1902(e)(3), §1905(a)(i) 42 CFR §435.225	100% FPL**
Reasonable classification for child enrolled in HCBS	§1902(a)(10)(A)(ii) and §1905(a)(i)	N/A
BBA group for employed persons with disabilities	§1902(a)(ii)(XIII)	N/A

* A 5% disregard for this group, making the total income level 288% FPL.
** Child is counted as a household of one for income determination.

Expansion Populations

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Infants given continuous enrollment from age one through age five with income exceeding the limit: MA infants enrolled before age two, with income above 278%; and CHIP Medicaid expansion infants with insurance enrolled before age two with income between 278% and 283%.	§1902(a)(10)(A)(i)(IV) and §1902(l)(1)(ii) §1902(a)(10)(A)(ii)(XIV)	Medicaid above 278% FPL CHIP above 283% FPL*
Infants given continuous enrollment from age one through age five with income exceeding the limit: CHIP Medicaid expansion infants enrolled before reaching age two with income between 278% and 283% FPL.	§1902(a)(10)(A)(ii)(XIV), and §1905(u)(2)(B) 42 CFR §435.229 and §435.4	CHIP above 283% FPL*

Children ages three, four and five in MAGI-based group	§1902(a)(10)(A)(i)(I), (III), (IV), (VI)	Medicaid above 275% FPL
Children ages one through five in a Medicaid non-MAGI group	§1902(f), §1902(e)(3), §1902(a)(10)(A)(i), (ii), and §1905(a)(i)	Medicaid above 100% FPL
Enrolled children ages 19 and 20	§1902(f), §1902(a)(10)(A)(ii)(I), (IV) and §1905(a)(i)	Medicaid income above MAGI-based 133% FPL or disabled child income of 100% FPL

* A 5% disregard for this group, making the total income level 288% FPL.

A. Eligibility determinations, if different from State plan

Eligibility determination processes are not changed and will follow the approved Medicaid state plan.

DHS oversees eligibility processes and delegates initial Medicaid and CHIP determinations and redeterminations to counties. DHS also has agreements with some tribal human service agencies for these functions. These tribal human service agencies and counties enter information into DHS developed and managed technology systems. Enrollees receive eligibility determinations and status updates from DHS through those systems. For tribal members whose tribal health care agency does not have an agreement with DHS, eligibility determinations are made by the county in which the person resides.

Specific policy, operational, and IT systems changes will be consistent with those for the continuous eligibility required under the CAA and the sub-regulatory guidance provided in CMS' State Health Official letter (#23-004), dated September 29, 2023.

Additionally, families with children will be reminded to continue to report changes in circumstances that may affect their child's Medicaid or CHIP eligibility. DHS' eligibility IT systems will be programmed to apply only those adverse changes that constitute the exceptions to continuous eligibility (e.g., death, no longer a Minnesota resident) to children covered under the waiver.

Notwithstanding the exceptions to continuous eligibility, a child under age six who would otherwise be determined ineligible for Medicaid or CHIP will remain eligible under the waiver. Young adults19 and 20 years old who would otherwise be determined ineligible for Medicaid, between annual renewals, will remain eligible for Medicaid under the waiver.

B. Enrollment limits

No enrollment limits apply.

C. Projected number of individuals

The following table shows the projected waiver enrollment for each MEG by demonstration years (DY) from 2025 through 2028.

MEG	DY31 (2025)	DY32 (2026)	DY33 (2027)	DY34 (2028)
One to six year olds	3,014	2,977	2,989	2,999
19 and 20 year olds	996	984	988	991

D. Post eligibility of income for long term care services and supports

Post-eligibility is not changed for the MEG groups covered by this amendment. Minnesota applies a household size of one for children under age 21 who meet the eligibility requirements for section 1915(c) home and community-based services, nursing facility care, or Intermediate Care Facility for people with Developmental Disabilities services.

4. Impact of Amendment on Demonstration Reporting, Quality and Evaluation Plans

The state's demonstration hypothesis is that expanded and extended continuous eligibility provided by the amendment will improve access to health care for children enrolled in Medicaid and CHIP. To evaluate this the state will measure:

- ✓ Churn rates
  - The churn from Medicaid and CHIP are expected to decrease.
  - This will be measured by an analysis of Medicaid and CHIP enrollment data.

- ✓ Receipt of recommended health care services
  - Children enrolled in Medicaid and CHIP will have an increased use of well-child and preventive care.
  - This will be measured by utilization of preventative care as recommended by the American Academy of Pediatrics.

To measure churn, DHS will compare pre-pandemic churn rates to evaluate whether (and potentially how much) continuous eligibility starting in 2024 impacts the rate children lose and regain their coverage within a six-month period.

To measure utilization of recommended care, DHS will use HEDIS measures. This provides the state with critical information about whether children access needed health care, whether they are accessing the preventive care, and whether they are screened for conditions where early detection can lead to better outcomes. For these analyses, DHS will use HEDIS measures as a foundation for the analysis but change the denominator to fit our investigation. DHS will compare these rates from before the pandemic to 2024 and later. Most of these measures are age-specific, as recommended care varies by the age of the child or youth. When the measures apply to children in both age groups, DHS will report it both for those age one through five years old and those age 19 and 20 years old. The state will report on some or all of these measures:

- Well-child visits in the first 15 months of life
- Child and adolescent well-care visits
- Annual dental visit / oral evaluation, dental services
- Childhood immunization status
- Immunizations for adolescents

The specific metrics would be included in updated the PMAP+ quality and evaluation plans. The state will also measure health care expenditures. This is discussed in the budget neutrality section of the waiver request.

5. Impact of Amendment on Budget Neutrality Agreement

The budget neutrality projections using the hypothetical model for the two MEGs, including member months and per member per month (PMPM) costs for each waiver demonstration year (DY), are provided in the two tables below. The state used the 2.2% allocation methodology as suggested by CMS. The state used the President's Budget Trend Rate of 5.2% to calculate the Without Waiver PMPM starting in DY31 through the end of the current approved waiver period. The cost history, trends, and calculations are provided in the budget neutrality workbook. See Attachment A.

Table 1. Projections for Hypothetical Population 1: One to six year olds

	DY31	DY32	DY33	DY34
Eligible member months	36,165	35,718	35,863	35,982
PMPM costs	$418.66	$440.43	$463.33	$487.42
Total Expenditure	$15,140,967	$15,731,408	$16,616,283	$17,538,349

Table 2. Projections for Hypothetical Population 2: 19 and 20 year olds

	DY31	DY32	DY33	DY34
Eligible member months	11,951	11,803	11,851	11,891
PMPM costs	$767.23	$807.13	$849.10	$893.25
Total Expenditure	$9,169,212	$9,526,860	$10,062,768	$10,621,191

6. Public Notice & Process for Comment

A. Start and end dates of the state's public comment period

The 30-day comment period was from December 18, 2023 to January 18, 2024. Additionally, public hearings on continuous eligibility were held during the 2023 Minnesota legislative session.

B. Certification that the state provided required public notice of the application

The demonstration project was authorized by the 2023 Minnesota legislature. It was included in the proposals brought forward by Governor Walz. As part of the legislative process there were

several public hearings. The authorizing law was enacted in Minnesota Session Law, Chapter 70, Art. 16, sec. 11. Information about the waiver amendment was shared at the Medicaid Services Advisory Committee on to the public on September 26, 2023, with discussion and feedback welcomed.

A notice requesting public comment on the waiver amendment was published in the Minnesota State Register on December 18, 2023. The notice provided information about the 30-day comment period from December 18, 2023 to January 18, 2024, and a link to the DHS website with more information. A copy of the notice is provided as Attachment B.

An electronic copy of the waiver request was posted on the DHS website on December 18, 2023. The webpage is updated on a regular basis and includes information about the public notice process, opportunities for public input, and provides a link to the waiver amendment. The main page of the DHS public website supports a search function to help people quickly move to the federal waiver page that identifies open comment periods.

C. Electronic mailing list

The GovDelivery[24] email list was used to notify subscribers and applicable state legislative committee chairs and county agencies of the amendment. The GovDelivery email with links to the DHS web page with waiver comment period information was sent on December 18, 2023. See Attachment C.

7. Tribal Consultation

There are eleven Tribal Nations in Minnesota, seven Ojibwe reservations and four Dakota (Sioux) communities. The seven Ojibwe reservations are: Grand Portage located in the northeast corner of the state; Bois Forte located in far northern Minnesota; Red Lake located in northern Minnesota west of Bois Forte; White Earth located in northwestern Minnesota; Leech Lake located in the north central portion of the state; Fond du Lac located in northeastern Minnesota west of Duluth; and Mille Lacs Band of Ojibwe located south of Brainerd in the central part of the state. The four Dakota communities are: Shakopee Mdewakanton Sioux located south of the Twin Cities near Prior Lake; Prairie Island Indian Community located near Red Wing; Lower Sioux Community located near Redwood Falls; and Upper Sioux Community whose lands are near the city of Granite Falls.

While these eleven Tribal Nations frequently collaborate on issues of mutual benefit, each operates independently as a separate and sovereign entity government – a state within a state or nation within a nation. Recognizing American Indian tribes as sovereign nations, each with distinct and independent governing structures, is critical to the work of DHS. DHS recognizes each American Indian tribe as a sovereign nation with distinct and independent governing structures. It is vital for the state to have strong collaborative relationships with tribal governments. To support this for health and human services programs, DHS has a designated

[24] GovDelivery is a subscription-based email system used by Minnesota state government to share information with the public. It is also sent to specific provider and stakeholder groups as applicable.

staff liaison in the Medicaid Director's office who is responsible to inform and, as applicable, coordinate Medicaid issues with the eleven Tribal Nations. Furthermore, Minnesota Executive Order 19-24 affirms the Government-to-Government Relationship between the State of Minnesota and Minnesota Tribal Nations.

The Tribal and Urban Health Directors Work Group was formed to address the need for a regular forum for formal consultation between tribes and state staff. Work group attendees include Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, and the DHS liaison. Other DHS leaders often participate in the meetings. The Native American Consultant from CMS and state agency staff attend as necessary depending on the topics covered. The DHS liaison attends all Tribal and Urban Health Directors Work Group meetings and provides updates on state and federal activities. The liaison arranges for appropriate DHS policy staff to attend the meetings to receive input from Tribal representatives and to answer questions.

Notice of the amendment was provided during Tribal and Urban Indian Health Director's meeting on November 16, 2023, Attachment D. Additionally, a letter was sent on December 18, 2023 to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic informing them of the state's intent to submit the amendment and inviting feedback and comment. The letter also informed Tribal leaders of the public input process and provided a link to the amendment. Please refer to Attachment E for a copy of the letter.

DHS did not receive any feedback.

8. Public Comment

During the public comment period from December 18, 2023 to January 18, 2024, DHS received three letters of support from organizations representing health plans and medical providers. See attachment F. DHS did not receive any suggested changes or questions.

9. State Contact

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