

Minnesota Department of Human Services

Comprehensive Quality Strategy

Minnesota Department of Human Services

February 2015

For More Information Contact:

Ann Berg, Deputy Medicaid Director
Minnesota Department of Human Services
Elmer L. Andersen Human Services Building
P.O. Box 64983
St. Paul, MN 55164-0983
Telephone: 651-431-2193
Email: ann.berg@state.mn.us

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I. Introduction, Overview and History

A. Introduction

This draft comprehensive quality strategy provides an overview of the Minnesota Medicaid program and its objectives, the state's methods of assessing program performance, improvement activities and results, and achievements and opportunities. While the state has continuously engaged in quality improvement initiatives for different components of the Medicaid program, the state is in the process of transitioning to a more comprehensive quality strategy.

The draft strategy is made up of multiple primary elements: the comprehensive managed care quality strategy, the HCBS waiver program quality framework, and the evaluation of Minnesota's three section 1115 demonstration waivers. Each of these elements has been developed with public input.

This comprehensive strategy provides an opportunity to gather and enumerate the numerous health quality improvement efforts occurring through the department and to move toward coordination of all the initiatives. The next submission of Minnesota's comprehensive quality strategy will include descriptions of and reports on progress on the health quality improvement efforts throughout the department. We will review and update the comprehensive quality strategy annually. DHS is establishing a standing advisory group to formally review the strategy before submission. Comments from the general public will also be solicited.

The managed care quality strategy incorporates elements of current DHS contract requirements, HMO licensing requirements and federal requirements. Annually, DHS assesses the quality and appropriateness of health care services delivered under managed care, monitors and evaluates MCO's compliance with state and federal Medicaid and Medicare managed care requirements. DHS also imposes corrective actions and sanctions if MCOs are not in compliance with these requirements and standards. DHS emphasizes compliance with state and federal requirements, enrollee satisfaction, and demonstrated improvements in the care and services provided to all enrollees.

In addition to the managed care quality strategy, compliance, oversight and improvement activities for long-term care services provided under fee-for-service are conducted in a comprehensive manner across all HCBS waiver programs and Alternative Care. Minnesota has five home and community-based services waivers: Developmental Disability (DD), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Brain Injury (BI) and Elderly Waiver (EW). In addition, Minnesota's Alternative Care program provides home and community-based services to seniors whose incomes are too high to qualify for full Medicaid benefits but who need a nursing facility level of care and who have combined income and assets that would allow them to spend down to Medicaid levels within 135 days if they were to move to a nursing facility.

HCBS waiver compliance, oversight and improvement activities are conducted in a comprehensive manner across all HCBS waiver programs and Alternative Care. These activities

are not segregated by waiver. Minnesota has a county-based, case management infrastructure. State law specifies that counties provide case management services. All counties are enrolled providers and have a Medicaid provider agreement with the Department. Federally recognized tribes that contract with the Department may also provide case management services. The tribes must be enrolled providers and have a Medicaid provider agreement with the Department.

Finally, the quality strategy also incorporates evaluation plans for Minnesota's three demonstration waivers: the Prepaid Medical Assistance Program Plus waiver, which authorizes the MinnesotaCare program for Medicaid expansion populations, the Minnesota Family Planning Program, and the Reform 2020 Waiver. The Reform 2020 demonstration allows the state to provide preventive services under the Alternative Care program to seniors who are likely to become eligible for Medicaid and who need an institutional level of care. Second, the demonstration supports the state's efforts to reform the personal care benefit.

B. Overview of Minnesota's Medicaid program

Through its Department of Human Services (DHS), Minnesota administers the Medical Assistance (MA) program under Title XIX and Title XXI of the Social Security Act. The state's Medicaid program, known in Minnesota as Medical Assistance (MA), is the largest of Minnesota's publicly funded health care programs. The program provides health care services that address acute, chronic and long-term care needs for over 700,000 Minnesotans each month. Three-fourths of those are children and families, pregnant women and adults without children. The others are people 65 or older and people who have disabilities.

Changes to federal law have allowed Minnesota to expand Medical Assistance to adults without children with incomes at or below 75% of the federal poverty level (FPL) in March 2011. In August of 2011, adults without children with incomes up to 250% FPL were added to the state's longstanding section 1115 expansion waiver. Many of these enrollees who were newly covered under Medicaid have complex and chronic health conditions that may result in disabilities. Their addition to Minnesota's federally-funded health care programs underscores the importance of supporting robust primary care, improving care coordination, and providing the necessary long-term services and supports to maintain independence, housing and employment. Investments in service delivery systems that integrate medical, behavioral and long-term care services in a patient-centered model of care, and modifications to long term care that provide flexibility to match services with participants' needs will profoundly impact the health of individuals, health care expenditures, and the fiscal sustainability of Medical Assistance into the future.

Most Medical Assistance recipients, including adults, parents, children, pregnant women and seniors, are served under a managed care delivery system. The fee-for-service delivery system serves those who are excluded from managed care and includes people with disabilities who have opted not to enroll in managed care. Minnesota's Medicaid Accountable Care Organization model (Integrated Health Partnerships or IHP) operates across both fee-for-services and managed care and was specifically designed to be flexible to accommodate multiple models, broader participation and encourage innovation. The model was designed to create multi-payer alignment for providers participating in Medicare Pioneer ACO and Shared Savings as well as private payer ACO/total cost of care models in the state.

In addition to Medicaid State Plan coverage, Minnesota has a longstanding Medicaid expansion program called MinnesotaCare. Prior to 2015, Minnesota received federal funding, or federal financial participation (FFP), for infants, children, pregnant women, adults, parents and caretaker adults enrolled in MinnesotaCare under the Prepaid Medical Assistance Plus (PMAP+) demonstration. The MinnesotaCare program will transition from Medicaid to Basic Health Plan authority in January of 2015.

Minnesota was one of the first states to receive a federal waiver to implement a mandatory managed care program for its Medicaid recipients, allowing for the purchase of a comprehensive array of health care services from MCOs on a prepaid capitated basis. Currently, many Medical Assistance recipients and all MinnesotaCare recipients are required to choose an MCO serving their geographic area and then receive all health care services through the selected MCO. In fiscal year 2013, approximately two thirds of MA recipients (501,000) were enrolled in managed care.

MCOs organize and coordinate care by using provider networks, having provider payment arrangements that incent quality, and implementing administrative and clinical systems for utilization review, quality improvement and enrollee services. Managed care also uses targeted care management for certain complex and high-cost health services.

The capitated amount paid to MCOs varies by characteristics of enrollees (e.g., age and gender) and by health care program. The total amount of capitation payments made in 2013 was a total of \$3.25 billion for MA and \$570 Million for Minnesota Care.

Fee-for-service (FFS) is the traditional payment system in which providers receive a payment for each unit of service they provide. The amount paid for services is typically based on rates that have been determined by a formula or funding levels. FFS payments are typically aligned with coding guidelines and rules (e.g. ICD-9, CPT and DRG) that define what can be paid and billed for. Medicaid FFS consumers can access services through any Medicaid certified provider of their choice. Enrolled Medicaid providers bill DHS directly for the services that each individual Medicaid enrollee receives. Claims are adjudicated and paid through the Medicaid Management Information System (MMIS). The provider may only bill the client for any co-payment that Medicaid has established for that service. Approximately 238,000 individuals are served in FFS Medicaid. Many of these individuals are people with disabilities who utilize Minnesota's long-term care services and supports.

C. History of Minnesota's Medicaid Program

In 1985, DHS began to contract with MCOs on a prepaid, capitated basis through an initiative known as the Prepaid Medical Assistance Program, or PMAP. Originally, PMAP included Medical Assistance recipients in three Minnesota counties.

In 1992, MinnesotaCare was established. In 1995, Minnesota received a federal waiver to require most Medical Assistance recipients and all MinnesotaCare recipients to receive health care services through MCOs. Now managed care has expanded to all Minnesota counties.

In 1997, the Minnesota Legislature enacted a law allowing county-based purchasing entities, or CBPs, to contract with DHS to provide Medical Assistance services. In 2000 and 2002, Minnesota received a federal waiver that allowed South Country Health Alliance and PrimeWest Health System to be MCOs as county-based purchasing entities and to provide Medical Assistance health care services on a prepaid, capitated basis.

Dual Eligibles

Since 1985, Minnesota seniors (age 65 and older) who meet eligibility criteria for Medical Assistance have been covered under managed care. However, 95 percent of these seniors are dually eligible for both Medicare and Medicaid. For dual eligible Minnesotans, Medicare covers the individual's preventive and acute care; and Medicaid covers Medicare deductibles, copayments, and any additional Medicaid services including most long-term care services.

Programs for Seniors (MSHO/SNPs/MSC+)

In the early 1990s, a law was enacted that provided authority for the development of integrated Medicare and Medicaid programs for dually eligible people to better coordinate care and reduce conflicting financial incentives between the two programs. In 1995, the Centers for Medicare and Medicaid Services (CMS) gave Minnesota approval for a dual eligible demonstration program called Minnesota Senior Health Options (MSHO) for Minnesota seniors in PMAP. In 1997, MSHO was implemented in the seven-county Twin Cities metro area. CMS and DHS had joint contracts with three managed care organizations to provide all Medicare and Medicaid services. Enrollment in MSHO was a voluntary alternative to enrollment in PMAP for Medicaid seniors.

In 2005 and 2006, as part of implementing the Medicare Part D pharmacy benefits, CMS transitioned the MSHO managed care organizations to Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). During this time, MSHO also expanded to all 87 Minnesota counties. At the same time, Minnesota received federal waiver authority to transition seniors from the PMAP+ demonstration to into a new program called Minnesota Senior Care Plus (MSC+) authorized under a section 1915(b) waiver, which includes long-term services and supports. The change to MSC+ was phased in over several years and was fully implemented statewide in all 87 counties by 2009.

Currently, seven MCOs participate in the MSHO and MSC+ programs. These two programs serve approximately 48,498 of Minnesota's 55,000 seniors in Medicaid. The other 6,502 are served in fee-for-service because of various managed care exclusions. Minnesota seniors on Medical Assistance are required to enroll in MSC+ either through an MCO, or the fee-for-service program. Approximately 35,000 seniors have voluntarily enrolled in MSHO as an alternative to MSC+. Medicaid benefits in MSHO and MSC+ are the same for both programs. The primary difference between MSHO and MSC+ is that MSHO provides all Medicare and Medicaid services through a single managed care organization, whereas, MSC+ provides Medicare services through CMS' fee-for-service program and separate Medicare Part D drug plans. A significant feature of both programs is the provision of care coordination. Each enrollee is assigned a care coordinator during initial enrollment. Care coordinators assess enrollees' health; assist enrollees in navigating the health care system and work with enrollees to ensure that care is provided in appropriate settings.

Program for People with Disabilities (SNBC)

In 2006, a law was enacted for an integrated Medicare and Medicaid managed care program for people age 18 to 64 with disabilities. The new program, called the Special Needs Basic Care (SNBC), was implemented in 2008 and was offered by eight SNPs in all 87 counties. Enrollment in SNBC was voluntary. The program initially integrated Medicare and Medicaid through state contracts with MCO SNPs. However, between 2010 and 2011, several SNBC plans dropped out of Medicare Advantage. Currently, SNBC is provided through five health plans in 87 counties. However, only two of the health plans are Medicare SNPs. Most SNBC enrollees are only enrolled in managed care for Medicaid services. Medicare services are largely provided through CMS' fee-for-service and separate Medicare Part D plans.

In 2011, a law was enacted that requires people with disabilities receiving Medical Assistance to be assigned to an SNBC health plan unless an individual chooses to opt out of SNBC enrollment and remain in MA fee-for-service. Beginning January 1, 2012, people with disabilities under age 65 who had MA fee-for-service coverage were asked to enroll in a SNBC health plan. Enrollment of adults with disabilities into SNBC was phased in between January and August 2012; enrollment of children has not yet started. In December 2011, seven percent of the eligible adults, or 6,148 people, were enrolled in SNBC. Currently, 50 percent of the eligible adults, or 45,544 people, are enrolled in SNBC.

Authorities for Managed Care

State law authorizes the Department of Human Services to provide health care services through managed care for MA and MinnesotaCare, specifically:

Prepaid Medical Assistance Program (PMAP)

- Minnesota Statutes, § 256B.69
- Minnesota Rules, Parts 9500.1450 to 9500.1464

MinnesotaCare

- Minnesota Statutes, § 256L.12

Minnesota Senior Health Options (MSHO)

- Minnesota Statutes, § 256B.69, Subdivision 23

Special Needs Basic Care (SNBC)

- Minnesota Statutes, § 256B.69, Subdivision 28

Federal authority for Minnesota to operate its Medical Assistance and MinnesotaCare programs is in the Balanced Budget Act of 1997 implemented under the Medicaid Managed Care Regulations at 42 C.F.R. §438. Additionally, CMS has granted Minnesota waivers to some of the Medicaid requirements in Title XIX of the Social Security Act to allow the delivery of health care services through managed care.

Other Health Care Delivery Models

Patient Centered Medical Home

A Patient Centered Medical Home is a model of care delivery usually focused on treating individuals with chronic health conditions or disabilities. The medical home uses a team approach, coordinating primary and specialty care under one provider umbrella for individuals with specific conditions. Minnesota medical homes, called Health Care Homes, were developed as a result of the state's health reform legislation passed in 2008 and implemented in 2009. Minnesota currently has over 200 certified medical homes throughout the state.

Accountable Care Organization

Accountable Care Organizations (ACOs) are comprised of a group of health care providers who affiliate to coordinate patient care. The organization's payment is specifically tied to a financial benchmark that allows the ACO to share savings achieved through health care quality and efficiencies. This model was initially developed through Medicare. It is now expanding in many states to Medicaid and the private market. In 2010, the legislature authorized implementation of a demonstration testing alternative and innovative health care delivery systems, including accountable care organizations. Minnesota's recent Integrated Health Partnership demonstration is testing accountable care models, where DHS negotiates contracts directly with provider entities for a specified patient population according to agreed-upon risk and gain-sharing payment arrangements. In addition, DHS also contracts with an MCO, Hennepin Health, to serve adults without children residing in Hennepin County, as county-integrated safety net ACO model.

D. Strategy Objectives

The priority of the state is to ensure access to quality health care for all Medicaid recipients and to utilize partnerships between the Agency, its partner agencies (such as the Department of Health), enrollees, the state's external quality review organization (EQRO), MCOs, and the provider community to improve access, quality, and continuity of care. Minnesota's Department of Human Services supports the partnerships for quality improvement through regular meetings with stakeholders, including managed care organizations, advocacy groups, and enrollees.

Through the Comprehensive Quality Strategy, DHS strives for results in all of the following essential outcomes:

- Purchasing quality health care services,
- Protecting the health care interest of managed care enrollees through monitoring of care and services,
- Assisting in the development of affordable health care,
- Reviewing and realigning any DHS policies and procedures that act as unintended barriers to the effective and efficient delivery of health care services,
- Focusing health care improvements on enrollee demographics and cultural needs,
- Improving the health care delivery system's capacity to deliver desired medical care outcomes through process standardization, improvement, and innovation, and
- Strengthening the relationship between patients and health care providers.

II. Managed Care Introduction

A. Quality Strategy Program

The DHS Quality Strategy (Quality Strategy) was developed in accordance with Medicaid managed care regulations at 42 C.F.R. §438.202(a), which requires the state to have a written strategy for assessing and improving the quality of health care services offered by MCOs. The quality strategy encompasses oversight of the following managed care health care programs:

- PMAP (Prepaid Medical Assistance Program)
- MinnesotaCare
- MSHO (Minnesota Senior Health Options)
- MSC+ (Minnesota SeniorCare Plus)
- SNBC (Special Needs Basic Care)

The federally mandated regular reporting on the quality strategy's implementation, effectiveness and compliance with federal and state standards is addressed in the Annual Technical Report (ATR) produced by the External Quality Review Organization (EQRO) [42 C.F.R. §438.202(e), 438.364].

The quality strategy assesses the quality and appropriateness of care and service provided by MCOs for all managed care contracts, programs and enrollees, but in some areas there are additional or alternative Medicare Advantage benefits.

Compliance, oversight and improvement activities for all Minnesota managed health care programs are conducted in a comprehensive manner across all enrollees. These activities are not segregated by federal authority.

Components of the Quality Strategy

The quality strategy incorporates elements of current contract requirements, HMO licensing requirements and federal Medicaid managed care regulations. The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) is the core of DHS' responsibility to ensure the delivery of quality care and services in publicly funded managed health care programs. Annually, DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, impose corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcomes of DHS' quality improvement activities are included in the Annual Technical Report, which is posted on the DHS public website at the following link: <https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6888-ENG>

External Review Process

Each year the state Medicaid agency must conduct an external quality review of the managed care services. The purpose of the external quality review is to produce the Annual Technical Report that includes:

- 1) Determination of compliance with federal and state requirements;
- 2) Validation of performance measures, and performance improvement projects; and
- 3) An assessment of the quality, access, and timeliness of health care services provided under managed care.

Where there is a finding that a requirement is not met, the MCO is expected to take corrective action to come into compliance with the requirement. The External Quality Review Organization conducts an overall review of Minnesota's managed care system. The review organization's charge is to identify areas of strength and weakness and to make recommendations for change. Where the technical report describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's ATR. The technical report is published on the DHS website at: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6888-ENG>

Performance Improvement Projects

Managed care plans must conduct performance improvement projects designed to improve care and services provided to enrollees. A summary report is published on the DHS website at: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6646A-ENG>

B. Summary of Managed Care Contracts

Table A below provides a list of the current managed care organization contracts operated under the Minnesota Medicaid program during calendar year 2014.

2014 Minnesota MCO Contracts			
Program	Federal Authority	Number of MCO Contractors	Type of Contract
Prepaid Medical Assistance Program Plus (PMAP+)	State plan and 1115 PMAP+ waiver	8	Families & Children contract
MinnesotaCare	1115 PMAP+ waiver	8	Families & Children contract
MinnesotaSeniorCare Plus (MSC+)	1915(b) MSC+ waiver and 1915(c) HCBS waivers	8	Seniors contract
Minnesota Senior Health Options (MSHO)	State plan voluntary managed care	8	Seniors contract
Special Needs Basic Care (SNBC)	State plan voluntary managed care	5	SNBC contract

C. Summary of the PMAP+ Demonstration Waiver

Minnesota's section 1115 PMAP+ demonstration was initially approved and implemented in July 1995. Its original purpose was to enable the state to establish a prepaid, capitated managed care delivery model that operates statewide, and to provide federal support for the extension of health care coverage to additional populations through the MinnesotaCare program. The demonstration also has been used to test waivers and expenditure authorities that allow simplification and streamlining of Medicaid program administration, and for alternative funding and payment approaches to support graduate medical education (GME) through the Medical Education and Research Costs (MERC) fund.

In December 2013, Minnesota was granted a one-year temporary extension for PMAP+, with amendments to reflect new health care coverage options introduced in 2014 under Affordable Care Act. The extended demonstration continued MinnesotaCare coverage only for 19 and 20 year olds, caretakers adults, and adults without children with incomes above 133 and at or below 200 percent of the FPL, with the expectation that MinnesotaCare would eventually be transitioned to a Basic Health Plan (BHP) option for these groups in 2015. Other populations that participated in MinnesotaCare – pregnant women, children, foster care age outs, juvenile residential correctional facility post-release, and adults with incomes at or below 133 percent of the FPL – began receiving Medicaid coverage in 2014 under Minnesota's state plan, and MinnesotaCare adults with incomes above 200 percent of FPL were transitioned to subsidized qualified health plan coverage through Minnesota's new state-based Marketplace. Waiver and

expenditure authorities allowing streamlining benefit sets for pregnant women, GME funding through MERC, medical assistance for children ages 12 through 23 months with incomes at or below 283 percent of FPL, and mandatory managed care for population groups were continued in the extended demonstration. New authority was granted to provide Medical Assistance for caretaker adults who live with and are responsible for children age 18 who are not full time secondary school students.

In December 2014, another one-year extension was granted for PMAP+, for the period of January 1 through December 31, 2015. The PMAP+ demonstration in 2015 consists of the following:

- Medical assistance for groups not included in Minnesota's Medicaid state plan; specifically, children ages 12 through 23 months with incomes above 275 percent FPL and at or below 283 percent of the FPL, and parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18 year old who is not a full time secondary school student;
- Full Medical assistance benefits for pregnant women during their hospital presumptive eligibility period;
- Mandatory enrollment into prepaid managed care of certain groups that are excluded from such under section 1932 of the Act and;
- GME payments through the MERC fund.

D. Summary of MSC+ Waiver

Since 1995, Minnesota has covered seniors under the Minnesota SeniorCare waiver. This waiver, under section 1915(b) of the Social Security Act, allows mandatory managed care enrollment of seniors, including those dually eligible for both Medicaid and Medicare. In 2009, Minnesota SeniorCare Plus was implemented so that, for those seniors needing long term services and supports, the managed care organization would be responsible to coordinate of 1915(c) Elderly Waiver services and a portion of the nursing facility benefit.

Minnesota also continues to offer a voluntary option for seniors to enroll in Minnesota Senior Health Options (MSHO), an integrated Medicare/Medicaid product. MSHO plans are Medicare Advantage Special Needs Plans that coordinate Medicare and Medicaid benefits for enrollees. MSHO also provides managed long term services and supports through the Elderly Waiver and a portion of the nursing facility benefit. The managed care contracts for seniors combine the MSHO and MSC+ products. This has enabled the state to implement contract requirements specific to the needs of seniors and to increase the focus on best practices for geriatric care.

III. Outcomes and Assessment

A. Quality Improvement Principles

Quality improvement is dependent upon the integration of the following Continuous Quality Improvement (CQI) principles:

- **Continuity and Consistency of Purpose.** DHS must establish clear parameters and standards to guide clinical and service improvements that are systematic and focused. Improvements take time to evolve and mature. A measured, thoughtful, strategic and systematic patient-centered approach must be employed to achieve sustained improvement.
- **Accountability and Transparency.** As stewards of public funds, DHS must hold the MCOs accountable for the quality of the health care services provided. The quality strategy holds MCOs accountable through the use of consistent quality and performance measures reported to enrollees and public stakeholders. These measures review many aspects of care and service with a particular focus on the ability to obtain the greatest health improvement at the lowest cost, balanced by conformity with social and cultural preferences.
- **Value.** The worth of the quality and services provided will be determined in relation to long-term health care outcomes and satisfaction of principal consumers, the managed care enrollee population. The quality strategy will repeatedly ask and evaluate findings to the question; *“Did the delivery system provide care and services in the appropriate quantity, quality and timing to realize the maximum attainable health care improvement at the most advantageous balance between cost and benefit?”*
- **Consumer Informed Choice and Responsibility.** The most effective and efficient health care delivery system includes the enrollee/patient in the health care decision process. In order for the patient to participate, they must be provided with the prerequisite health care information. Informed consumer must also assume responsibility to make responsible choices and reduce high-risk behaviors in order to realize optimum outcomes.

The assessment of the quality strategy is not just in the measurement of compliance with state and federal requirements, but also in enrollee satisfaction and demonstrated improvements in the care and services provided to all enrollees. Improvements in care and services can also be assessed in the outcomes of the MCO’s annual performance improvement projects as required by 42 C.F.R. §438.240(1), which are summarized in an annual report available at the following link: <https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6646A-ENG>. In addition, the EQRO annual evaluation addresses all elements of the quality strategy and strives to provide effective recommendations for improvement.

B. Expected Managed Care Outcomes

The quality strategy puts into operation theories and precepts that influence the purchasing of managed health care services for managed care publicly funded programs. To achieve quality health care services there must be measurement of improvement in enrollee health outcomes and satisfaction to conceivably affect cost.¹ It is anticipated the quality strategy will result in seven essential outcomes, which include:

- Purchase of quality health care services;
- Protect the health care interest of managed care enrollees through monitoring of care and services;
- Assist in the development of affordable health care;
- Identify DHS policies and procedures which act as unintended barriers and realign;
- Focus on health care prevention and chronic disease improvements consistent with enrollee demographics and cultural needs;
- Improve the health care delivery system's capacity to deliver desired health care outcomes through process standardization, improvement and innovations; and
- Strengthen the relationship between the patients and health care providers.

IV. Federal BBA Managed Care Regulations

A. Compliance with Federal Regulation 42 CFR §438

DHS' quality strategy has been developed to incorporate federal regulation governing managed care at 42 C.F.R. §438.202. The DHS quality strategy:

- Acts as a written plan for assessing and improving the quality of managed care services offered by all MCOs;
- Solicits input of recipients, stakeholders and MCOs on the effectiveness of on the quality strategy;
- Ensures MCO compliance with state and federal law;
- Requires periodic reviews to evaluate strategy effectiveness, make revisions; and
- Results in regular internal and public reports on the implementation and effectiveness of the strategy.

DHS developed and published its initial written quality strategy in the State Register for public comment in June of 2003. The quality strategy is regularly reviewed and revised.

¹ Often in special needs populations improvement measurement focuses on maintenance or efforts to slow the decline in status which is a commonly expected outcome of a chronic condition.

B. Integration of Medicare and NCQA standards

To avoid duplication, the Quality Strategy assessment of mandatory activities includes information obtained from Medicare and private accreditation reviews in addition to Minnesota Department of Health's (MDH) triennial Quality Assurance Examination (QA Exam). DHS, MDH, MCOs and NCQA have spent considerable time meeting to determine how information gathered by NCQA and Medicare can be used to minimize the data collection burden and still provide the EQRO information to complete its assessment consistent with 42 C.F.R. §438.364. Discussions to identify additional opportunities to reduce the data collection burden through equivalency are ongoing.

Currently three MCOs are accredited by NCQA; if an NCQA accreditation review indicates the MCO did not obtain 100 percent compliance with a standard (or element), MDH completes the entire review of that standard during their triennial, on-site review. If the MCO is in 100 percent compliance with NCQA standards considered by DHS as equal or greater than state and federal requirements, MDH will not audit the applicable section. Likewise, equivalent CMS Medicare Audit Standards will be utilized to reduce the triennial audit data collection burden. Appendix A provides a current listing of the NCQA and CMS standards that are comparable.

DHS reviews the effectiveness of the Quality Strategy at least annually. Significant future modifications will be published in the State Register to obtain public comment, presented to the Medicaid Citizen's Advisory Committee and reported to CMS. The Quality Strategy is available on the DHS public website for all interested parties to review at <http://edocs.dhs.state.mn.us/lfserver/Public/DHS-4538A-ENG>.

V. State Managed Care Standards

A. Access, Structure/Operational, and Measurement/Improvement Standards

The Quality Strategy is organized to reflect the standards outlined in Subpart D of the Medicaid Managed Care Regulations. Subpart D is divided into three sections; Access, Structure/Operations, and Measurement/Improvement Standards. Each standard has multiple components as indicated in the following table.

1. Access Standards
438.206 Availability of services
438.207 Assurances of adequate capacity and services
438.208 Coordination and continuity of care
438.210 Coverage and authorization of services
2. Structure and Operational Standards
438.214 Provider selection
438.218 Enrollee information
438.224 Confidentiality
438.226 Enrollment and disenrollment
438.228 Grievance systems
438.230 Sub-contractual relationships and delegation
3. Measurement and Improvement Standards
438.236 Practice guidelines
438.240 Quality assessment and performance improvement program
438.242 Health information systems

Each of the standards is described in Appendix B, including the methods used to assess compliance with the standards. Appendix B also describes state and federal requirements in addition to 42 C.F.R. §438.

B. EQR Activities

States contracting with Medicaid Managed Care Organizations (MCO) are required to conduct an external quality review of each MCO. States may perform this review directly, or contract with independent accredited businesses called external quality review organizations (EQRO). States must also prepare an annual technical report and describe how the MCO delivers, quality, timeliness of and access to health care for all enrollees. Annually in the ATR the EQRO:

- Assesses each MCO's strengths and weaknesses with respect to quality, timeliness and access to health care services,
- Provides recommendations for improving quality of services furnished by each MCO,
- Provides appropriate comparative information about all MCOs,
- Assesses the degree to which each MCO has addressed problems and effected changes as previously identified by the State or as recommended by the EQRO,
- Evaluate the implementation and effectiveness of the Quality Strategy, and
- Advises DHS on opportunities for improvement.

VI. Quality Strategy Oversight

The Minnesota Department of Health regulates and licenses health maintenance organizations (HMOs) and county-based purchasing (CBP) entities doing business in Minnesota. MDH conducts a triennial quality assurance examination of all MCOs to monitor and assess compliance with state licensing regulations. While the primary purpose of the QA Exam is to monitor compliance with Minnesota's HMO licensing regulations, some of the information collected and assessed is used by the EQRO to assess DHS and CMS requirements.² DHS and MDH have worked collaboratively to assure that when possible, information collected for the Quality Assurance Examination includes information consistent with federal EQR requirements to avoid the duplication of mandatory data collection. This additional information not specifically outlined in state law but required by CMS is also collected and reported by MDH within the Triennial Compliance Assessment in addition to the QA Exam document. If MDH discovers a deficiency, a corrective action and mid-cycle follow-up review is required to ensure all deficiencies are resolved. The EQRO uses information from the QA Exam, TCA report, and follow-up deficiency audits to determine MCO compliance with DHS and CMS requirements. DHS also collects other contractually required reports directly from the MCO including the annual MCO Quality Work Plan and Evaluation. All information will be provided to the EQRO for its validation and evaluation, resulting in the detailed ATR.

A. Other DHS Quality Improvement Activities and Relevant Reports

1. Voluntary Changes in MCO Enrollment

DHS also conducts annual surveys of enrollees who voluntarily change from one managed care plan to another. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The annual survey results report is published annually on the DHS website at: <http://edocs.dhs.state.mn.us/lfserver/public/DHS-5875C-ENG>

2. Consumer Satisfaction

DHS sponsors an annual satisfaction survey of enrollees using the Consumer Assessment of Health Plans Survey (CAHPS®) instrument and methodology to assess and compare the satisfaction of enrollees with services and care provided by MCOs. The overall goal of the CAHPS project is to conduct an annual consumer satisfaction survey of access and quality of care provided by MCOs to Minnesota's publicly funded health care program enrollees. The CAHPS® 4.0 Adult Medicaid Core Questionnaire Module plus optional CAHPS® questions and supplemental DHS questions are incorporated with the core module to create the survey instrument. The survey is conducted using a four-wave mail plus telephone data collection method. The CAHPS vendor works toward the goal of collecting 300 completed questionnaires/interviews in each of approximately 28 cells defined by DHS, for a total of at

² Since calendar year 2007, MDH during the Quality Assurance Examination has collected additional compliance information for DHS public programs. Appendix C provides a detailed description of the additional compliance information MDH collects for DHS. Compliance information collected by MDH will be reviewed by DHS and corrective action will be taken as necessary.

least 8,400 completed interviews. Survey results are published on the DHS website at: <http://edocs.dhs.state.mn.us/lfserver/public/DHS-5541E-ENG>.

DHS also monitors consumer satisfaction via monthly surveys of enrollees who voluntarily change from one MCO to another. The one-page survey with a brief explanation of the purpose and the survey questions is mailed to the head of each household. The initial mailing is made early in the month that the change became effective. Three weeks later, a second survey is mailed to non-respondent households. The survey instrument is in English, with interpreter services available by telephone. DHS' expectation is that statewide change rates will vary over time, but remain below a 5% threshold.

3. Managed Care Grievance System Information Summary, DHS

DHS compiles an annual report summarizing data on enrollee grievances and appeals filed with managed care plans; notices of denial, termination or reduction (DTRs) sent by the plans; and managed care state fair hearings filed with DHS. The summary report is published on the DHS website at: <http://edocs.dhs.state.mn.us/lfserver/public/DHS-6178A-ENG>

4. MCO Internal Quality Improvement System

MCOs are required to have an internal quality improvement system that meets state and federal standards set forth in the contract between the MCO and DHS. These standards are consistent with those required under state health maintenance organization (HMO) licensure requirements.

The Minnesota Department of Health (MDH) conducts triennial audits of the HMO licensing requirements. The most recent results from examinations for each health plan are posted at the MDH website at : <http://www.health.state.mn.us/divs/hpsc/mcs/quality.htm>.

MDH also compiles an annual report using the Health Care Effectiveness Data Information Set (HEDIS) tool to compare how health plans perform in quality of care, access to care, and member satisfaction with the health plan and doctors. The reports are published on the MDH website at: <http://www.health.state.mn.us/divs/hpsc/mcs/hedis13.htm>

5. BBA managed care validation requirements

The scope of the EQRO activities is described in Subpart E of 42 C.F.R. §438. Annually, the State or the EQRO is required to conduct three mandatory activities and at the State's discretion, conduct five optional activities. The State must annually perform the following three mandatory activities:

- a. Validation of performance improvement projects,
- b. Validation of performance measures, and
- c. MCO compliance with State standards for access to care, structure and operations, and quality measurement and improvement.

6. University of Minnesota's State Health Access Data Assistance Center (SHADAC)

With full implementation of the Affordable Care Act's (ACA's) health insurance coverage provisions on January 1, 2014, there has been great interest in assessing the law's early impact

on health insurance coverage in Minnesota. At the request of Minnesota's Health Insurance Marketplace, MNsure, researchers from the University of Minnesota's State Health Access Data Assistance Center (SHADAC) compiled data from a variety of sources to analyze, at an aggregate level, the shifts in health insurance coverage that have taken place in Minnesota since the fall of 2013. Support for this work was provided through the Robert Wood Johnson Foundation's State Health Reform Assistance Network. The purpose of the SHADAC report is to estimate the early impact of the ACA on the number of uninsured in the state, and to show how the distribution of health insurance coverage has changed. The SHADAC report is included at Appendix G.

7. Report on the Value of Minnesota Health Care Programs (MHCP) Managed Care, as compared to Fee-for-service

The Minnesota Department of Human Services (DHS) contracted with Public Consulting Group (PCG) to author a report on the value of managed care for state public health care programs. Specifically, PCG was tasked with determining the value of managed care for Minnesota Health Care Programs (MHCP) in comparison with a Fee-For-Service (FFS) delivery system. The report is posted on the DHS public website here: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6787-ENG>

8. Self-reported MCO quality improvement initiatives

MCOs submit annual summaries of how their quality improvement program identifies, monitors and works to improve service and clinical quality issues relevant to the Minnesota Health Care Program (MHCP) enrollees. The reports are posted on the DHS public website at the links indicated below. Each MCO summary highlights what each MCO considers significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement.

- Quality Program Transparency and Accountability Blue Cross and Blue Shield:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742A-ENG>

- Quality Program Transparency and Accountability HealthPartners:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742B-ENG>

- Quality Program Transparency and Accountability Hennepin Health:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742C-ENG>

- Quality Program Transparency and Accountability IMCare:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742D-ENG>

- Quality Program Transparency and Accountability Medica:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742E-ENG>

- Quality Program Transparency and Accountability MHP:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742F-ENG>

- Quality Program Transparency and Accountability PrimeWest:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742G-ENG>

- Quality Program Transparency and Accountability SCHAs: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742H-ENG>

- Quality Program Transparency and Accountability UCare: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742I-ENG>

9. Annual Report of Managed Care in Minnesota Health Care Programs

A comprehensive report providing a summary of oversight activities of Minnesota's state managed care programs. <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742I-ENG>

10. Other DHS Quality Improvement Activities

In future years, depending on funding, clinical or non-clinical focus studies may be undertaken. As these focus studies are developed the MCOs will be consulted and may be requested to assist with operational efforts. When these optional activities are completed they will be included in the annual EQRO report. The attached appendixes provide additional details on DHS quality improvement activities

VII. Home and Community-Based Waiver Compliance, Oversight and Improvement

State law specifies that counties provide case management services. All counties are enrolled providers and have a Medicaid provider agreement with the Department. Federally recognized tribes who contract with the Department may also provide case management services. The tribes must be enrolled providers and have a Medicaid provider agreement with the Department.

The Department conducts triennial onsite reviews of counties and tribes to monitor their compliance with HCBS waiver policies and procedures. Minnesota has five home and community-based services waivers: Developmental Disability (DD), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Brain Injury (BI) and Elderly Waiver (EW). In addition, Minnesota's Alternative Care program provides home and community-based services to seniors whose incomes are too high to qualify for full Medicaid benefits but who need a nursing facility level of care and who have combined income and assets that would allow them to spend down to Medicaid levels within 135 days if they were to move to a nursing facility.

HCBS waiver compliance, oversight and improvement activities are described separately in each of the state's five section 1915(c) approved waivers, but county site reviews and oversight of long-term care services and supports is conducted in a comprehensive manner across all HCBS waiver programs and Alternative Care. These activities are not segregated by waiver. Minnesota has a county-based case management service infrastructure.

At the conclusion of the triennial site reviews of Minnesota's counties and tribes providing case management services, the Department issues a summary report that includes recommendations for program improvements (i.e., sharing best practice ideas) and corrective actions. Corrective

actions are issued if the county or tribe being reviewed is found to be out of compliance with waiver policies and procedures. The county or tribe is required to submit a corrective action plan and evidence of the correction. The Department evaluates whether the correction and evidence are sufficient to demonstrate that the corrective action was implemented.

The Department also monitors HCBS waiver and case management activities through quality assurance plans and MMIS subsystems. Counties and tribes are required to submit a quality assurance plan to the Department every one to two years. The plan is a self-assessment of compliance with waiver policies and procedures, some of which directly apply to case management activities. Our MMIS design supports HCBS waiver policies and procedures, including those related to case management. DHS uses data from MMIS to monitor case management activities. DHS reports on the quality assurance measures in accordance with the §1915(c) waiver requirements.

VIII. Other Demonstration Waivers

In addition to Minnesota's managed care waivers and the HCBS waivers Minnesota operates the Minnesota Family Planning Program waiver and the Reform 2020 waiver.

Family Planning

The purpose of the Minnesota Family Planning Program is to demonstrate positive health outcomes and cost savings by providing an accessible, preventive approach to family planning services for individuals who normally would not access such services. The waiver reduces gaps in coverage and increases the availability of pre-pregnancy family planning services. Family planning and child spacing promotes healthier pregnancy outcomes.

DHS began implementation of the Minnesota Family Planning Program (MFPP) section 1115 waiver on July 1, 2006. This program was initially approved by the Centers for Medicare & Medicaid Services (CMS) for a 5-year period, ending June 30, 2011. A three-year extension of the Minnesota Family Planning Program section 1115 waiver was approved by CMS on December 29, 2011 for the period July 1, 2011 through December 31, 2013. On December 31, 2012 the Department submitted an initial waiver extension request to continue operating MFPP for an additional three years. In June of 2013, CMS approved an extension of MFPP until December 31, 2014. In July of 2014, CMS granted an extension of MFPP waiver authority through December 31, 2015.

The MFPP demonstration expands the provision of family planning and family planning related services to men and women, age 15 to 50, who have family income at or below 200 percent of the FPL, and who are not enrolled in any other Minnesota Health Care Programs administered by DHS.

The demonstration allows Minnesota to provide family planning services to men and women who would not otherwise access such services in order to reduce the number of unintended pregnancies and births paid for by the Medical Assistance program.

Reform 2020

Minnesota is redesigning its personal care assistance benefit to expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after the Community First Choice Option. It will reduce pressure on the system as people use the service-option flexibility within CFSS instead of accessing the expanded service menu of one of the state's five home and community based services (HCBS) waivers to meet gaps in what they need.

The new CFSS service, with its focus on consumer direction, is designed to comply with the regulations regarding section 1915(k) of the Social Security Act. Minnesota has received partial federal approval under the Reform 2020 demonstration waiver to implement this new benefit. Minnesota is currently seeking additional federal authority under the 1915(i) and 1915(k) state plan amendments and has been advised that authority under §1915(b)(4) is also necessary to implement this benefit.

Under CFSS, people may use their service budget to directly employ and pay qualified support workers and/or to purchase goods or environmental modifications that relate to an assessed need identified in their service delivery plan. A financial management service contractor (FMS) will be the employer-agent assisting participant-employers to comply with employer regulations and requirements and for billing and making payments on behalf of participant-employers. In addition, participants will utilize a consultation services provider to learn about CFSS, select a service delivery model, develop a person-centered service delivery plan and budget and to obtain information and support about employing, training, supervising and dismissing support workers. Work is underway to define the responsibilities and qualifications of CFSS financial management services contractors and consultation services providers.

DHS will purchase FMS and consultation services via competitive procurement. Competitive procurement is appropriate for FMS and consultation services providers to ensure that only the most qualified providers are utilized and in order to allow DHS to concentrate provider training and monitoring efforts on a few highly qualified providers. FMS and consultation service providers will have a new and critical role in ensuring that participants learn how to use this self-directed option and experience expected outcomes, while funds are spent appropriately and participant's identified needs are met. To ensure smooth transition to this more flexible benefit, and to implement quality services, DHS will limit the pool of FMS and consultation services providers to a small number of qualified entities. In addition, selective contracting is particularly appropriate for FMS because other states offering participant-directed benefits have had success in purchasing financial management services and consultation services at a lower price when the number of contractors is limited so that the contractors have a sufficient volume of participants.

A. Expected Outcomes for Other Waivers

Family Planning

Under the demonstration Minnesota expects to achieve the following objectives:

- Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs (MHCP),
- Increase the proportion of men and women enrolled in MHCP who utilize family planning services,
- Increase the average age of mother at first birth among MHCP enrollees, and
- Reduce the teen birth rate among MHCP enrollees.

The hypotheses that will be tested during the demonstration renewal period, the program objectives, and associated indicators for measurement of progress toward those objectives, are summarized in Appendix F.³ The data sources and measurement period that will be used for each indicator are noted.

Reform 2020

The Reform 2020 demonstration will assist the state in its goals to:

- Achieve better health outcomes,
- Increase and support independence and recovery,
- Increase community integration,
- Reduce reliance on institutional care,
- Simplify the administration of the program and access to the program, and
- Create a program that is more fiscally sustainable.

B. Waiver Updates

Family Planning

The Minnesota Family Planning Program continues to provide coverage of family planning and related health care services for people who are not enrolled in any of the other public health care programs. The program increases access to family planning services for low-income Minnesotans and helps reduce the number of unintended pregnancies. In state fiscal year 2013, the program served approximately 35,000 people, with a monthly average enrollment of approximately 20,000. Total spending was nearly \$14.9 million.

Reform 2020

CMS approved Minnesota's section 1115 demonstration project, entitled Reform 2020 in October 2013. The five year demonstration provides federal support for the Alternative Care program, which provides supports to help seniors at risk of nursing home placement to stay in their homes. The Reform 2020 demonstration waiver will also provide access to expanded self-directed options under the Community First Services and Supports (CFSS) program for people who would not otherwise be eligible for these services. Implementation of this part of the demonstration is contingent upon federal approval of additional state plan and waiver authority.

³ Appendix F is an attachment from the Minnesota Family Planning Program section 1115 waiver renewal request, May 17, 2013 which outlines the evaluation plan objectives and indicators

IX. Review of Comprehensive Quality Strategy

A. Periodic Reviews of Quality Strategies by the State

DHS Health Care Administration will conduct an annual review of the effectiveness of its Comprehensive Quality Strategy at the end of each calendar year for submission by the end of the first quarter of the following year. The Agency will solicit input of the Comprehensive Quality Strategy Advisory Committee and other stakeholders annually through public meetings and posting a draft of the Comprehensive Quality Strategy document on its website for public review and comment each year. The feedback provided by stakeholders, including Medicaid recipients and their representatives, will be taken into consideration and incorporated into the Comprehensive Quality Strategy updates.

B. Definition of Significant Change to Quality Strategies

The factors requiring a review of the Comprehensive Quality Strategy that includes gathering stakeholder input are the following:

- A material change in the numbers, types, or timeframes of reporting,
- A pervasive pattern of quality deficiencies identified through analysis of the annual reporting data submitted by the MCOs, the quarterly grievance reports, the state's annual compliance on-site surveys and desk reviews, and the enrollee complaints filed with the state,
- Changes to quality standards resulting from regulatory authorities or legislation at the state or federal level, or
- A change in membership demographics or the provider network of 50 percent or greater within one year.

C. Timeframes for Updating Quality Strategies

DHS Health Care Administration will review and update the Comprehensive Quality Strategy annually. Each time the CQS is updated, it will be posted on the Agency's website and presented to the Comprehensive Quality Strategy Advisory Committee and other stakeholders for review and public comment. DHS will work with the CMS to ensure that the CQS and the state's submission process are compliant with Section 508 of the Rehabilitation Act. DHS will continue to comply with the reporting requirements of its approved waivers submitting quarterly and annual reports to CMS on the implementation and effectiveness of the waivers.

X. Next Steps

A. Stakeholder Input

DHS has numerous standing advisory groups and short term working groups composed of stakeholders providing input on health care program policy and administration issues. In the third quarter of 2014, DHS will establish a standing advisory group of stakeholders drawn from the current specialized groups. This group, the Comprehensive Quality Strategy Advisory Committee, will formally review the annual CQS before submission and their comments will be taken into account for the final report. While the CQS Advisory Committee will be a formal stakeholder input mechanism, in the interests of transparency and inclusiveness the draft report will be posted on the DHS public web site and comments from the general public will also be solicited.

B. Catalog of Health Care Program Improvement Efforts

Minnesota's DHS is the single state agency for the administration of Medical Assistance. However, the department is composed of several administrations and aspects of the Medical Assistance program are distributed among the administrations. The Comprehensive Quality Strategy provides an opportunity to investigate and enumerate the health quality improvement efforts occurring throughout the department. The next submission of Minnesota's Comprehensive Quality Strategy will include descriptions of and reports of progress on the health quality improvement efforts throughout the department.

C. Comprehensive Strategy

With the larger view of Medical Assistance program improvement efforts, the department will for the first time be in a position to assess the coordination of all the initiatives and prioritize its resources in the most effective way. Dialog around a potential new strategy from which to view the department's work on Medical Assistance program quality improvement will begin after the submission of the next submission of the Comprehensive Quality Strategy referenced in B above. The progress of this new strategy and continued updates of program improvement efforts will be included in the subsequent Comprehensive Quality Strategy.

XI. Appendices:

The attached appendices provide additional details on DHS quality improvement activities:

Appendix A: "Data Collection Burden Reduction" provides a summary of NCQA standards that are comparable and will be utilized by the EQRO to reduce the duplication of the data collection as required by 42 C.F.R. §438.360 (b)(4).

Appendix B: “Core Quality Strategy Components” provides a brief explanation of each core standard, MCO duties, oversight activities, and reporting requirements for the EQRO to use in its review and evaluation of MCO compliance with the standards.

Appendix C: DHS Triennial Compliance Assessment (TCA) provides a detailed listing of additional compliance information collected for DHS and provided to the EQRO to evaluate in the ATR.

Appendix D: PMAP+ Waiver Evaluation Proposal.

Appendix E: Reform 2020 Waiver Evaluation Proposal.

Appendix F: Family Planning Waiver Evaluation Proposal.

Appendix G: State Health Access Data Assistance Center Report: Early Impacts of the Affordable Care act on Health Insurance Coverage in Minnesota (June 2014).

Appendix A

Data Collection Burden Reduction

The following table provides private accreditation (NCQA) and Medicare standards that are comparable to BBA Managed Care standards (42 C.F.R. §438.360). Comparable information is used to reduce the data collection burden for MCOs. NCQA standards are reviewed and assessed on an ongoing basis to determine if any changes to the list are necessary.

Medicaid Regulation	NCQA Standard “100% Compliance” ¹
Utilization Review and Over/Under Utilization of Services 42 C.F.R. §438.240 (b)(3)	UM 1-4, UM 10- 15
Health Information Systems 42 C.F.R. §438.242	Annual NCQA Certified HEDIS Compliance Audit 1
Quality Assessment and Performance Improvement Program 42 C.F.R. §438.240 (e)(1-2)	QI 1, Element B
Clinical Practice Guidelines 42 C.F.R. §438.236 (b-d)	QI 9, Elements A
Case Management and Care Coordination 42 C.F.R. §438.208 (b)(1-3)	QI 4 Element B, QI 5
Access and Availability of Care and Services 42 C.F.R. §438.206	QI 3 Element A QI 4 Elements A-D, QI 5 Elements A-C RR 3 MED 1
Emergency Room and Post Stabilization Care 42 C.F.R. §438.114	UM 12
Confidentiality 42 C.F.R. §438.208 (b)(4), §438.224, and 45 C.F.R. Parts 160 and 164, Part 431, Subpart F	RR5, Elements A-G
Sub-contractual Relationships and Delegation 42 C.F.R. §438.230	QI 12 UM 15, CR 9, RR 7, MEM 9
Credentialing and Recredentialing 42 C.F.R. §438.214	CR 1 - 9, QI 4, QI 5

1. An MCO will be considered to have met the requirements in BBA 42 C.F.R. §438: if the previous three annual NCQA Certified HEDIS Compliance Audits indicate; a) all performance measures are reportable, and b) the MCO provides the audit reports from the previous three years for review.

2. DHS/MCO contract Section 7.3(A) Disease Management Program Standards. If the MCO has diabetes, asthma, and cardiac disease management programs that achieves 100 percent compliance with the NCQA QI 8, the MCO will not need to further demonstrate compliance.

¹ 2013 NCQA Standards and Guidelines for Accreditation of Health Plans, effective July 1, 2013.

Appendix B

Managed Care Core Quality Strategy Components

ACCESS STANDARDS

42 C.F.R. §438.206 Availability of services.

MCO Duties

In a managed care delivery system, the MCO agrees to provide all services to enrollees through its contract with the State. Any services or benefits provided under the State Plan that are not covered though the contract is identified in the MCO's evidence of coverage (EOC). The MCO must provide information to enrollees on how to access State Plan services not covered in the contract. Under the contract with the State, the MCO provides the same or equivalent services as provided in fee-for-service, or at its own expense, exceed the State limits provided through the fee-for-service (FFS) delivery system. The MCO may also provide additional or substitute services.

Enrollees receive information in the EOC regarding what services are covered and how to access those services through the MCO. Enrollees also receive information regarding their rights and responsibilities under managed care via a brochure issued by DHS. MCOs are required to make enrollment materials available in predominant languages and to translate any MCO specific information vital to an enrollees understanding of how to access necessary services. The requirements ensure that information regarding MCO services and enrollee rights are available to enrollees with limited English proficiency (LEP). These documents are updated on an annual basis. The brochures are available on the DHS public website.

Through the contract, the MCO agrees to provide services that are sufficient to meet the health care needs of enrollees such as physician services, inpatient and outpatient hospital services, dental services, behavioral health services, therapies, pharmacy, and home care services.

The MCO must meet the requirements of 42 C.F.R. §438.214 (b) for credentialing of its providers. For community-based special needs plan enrollees (MSHO, and SNBC), MCOs are also liable to provide a specified limited nursing facility benefit. All State Plan services not covered by the contract can be accessed through fee-for-service. The MCO must ensure that female enrollees have direct access to women's health specialists within the network, both for covered routine and preventive health care services. An OB/GYN may serve as a primary care provider. The MCO must provide for a second opinion from a qualified health care professional within its network or arrange to obtain one outside the network at no cost to the enrollee. If an MCO's provider network is unable to provide services required by an enrollee, the MCO must adequately and in a timely manner cover services outside the network for as long as the current MCO provider network is unable to provide the needed services.

The State offers a number of special needs programs that either integrates Medicaid and Medicare benefits and requirements or, combine Medicaid benefits with a Medicare Advantage Special Needs Plan (SNP) to serve persons with disabilities or persons age 65 years and older

who often have comorbid chronic care needs. Though these special needs plans enrollees have access to coordinated benefits and care, including Medicare pharmacy benefits, to meet their specific health care needs. The State's special needs programs are described below:

Minnesota Senior Health Options (MSHO): MSHO is a voluntary managed care program that integrates Medicare and Medicaid through State contracts with SNPs. MSHO operates under §1915(a) authority and provides eligible persons age 65 and older all Medicare benefits including Part D pharmacy benefits, Medicaid State Plan services, Elderly Waiver (EW) services (as permitted under a 1915(c) waiver), and the first 180 days of care in a nursing facility after which time coverage reverts to MA Fee-For-Service (FFS). The MCO agrees to provide EW services and must have a network of providers for home and community based services. A significant feature of the MSHO program is the provision of care coordination assigned to each MSHO enrollee upon initial enrollment. Each MSHO enrollee is assigned a care coordinator upon initial enrollment. Care coordinators assist enrollees in navigating the health care system and work with them to ensure that care is provided in appropriate settings. Enrollees must have both Medicare Parts A and B in addition to Medical Assistance (dual eligibility) to enroll in the MSHO program. Enrollment in MSHO is an alternative to mandatory enrollment in the MSC+ program.

Special Needs Basic Care (SNBC): SNBC is a voluntary managed care program for people age 18 to 64, who are certified disabled and eligible for Medical Assistance. SNBC incorporates Medicare Parts A, B and D for enrollees who qualify for that coverage. A care coordinator or navigator is assigned to each enrollee to help access health care and other support services. DHS contracts with five Medicare Advantage Special Needs Plans to provide SNBC. SNBC offers all medically necessary Medicaid State Plan Services with the exception of HCBS waivers, Personal Care Assistants, and private duty nursing (PDN). HCBS waiver services, PCA, and PDN services are paid by the MA fee-for-service program. If an enrollee is Medicare eligible, the MCO covers all Medicare services, including prescription drugs covered by Part D and any alternative services the MCO may choose to offer. The MCO pays for the first 100 days of nursing facility care for community enrollees who enter a nursing facility after enrollment. In 2013, the SNBC program expanded to serve over 35,000 enrollees. Blue Plus, HealthPartners, and Itasca Medical Care do not participate in the program.

Oversight Activities

An annual assessment of available services is based on a review of provider networks, including review of Provider Directories and Primary Care Network Lists (PCNLs), and an ongoing assessment of changes to MCO networks, the results of the MDH triennial Quality Assurance Examination, the DHS Triennial Compliance Assessment (TCA), and review of complaint data regarding access to services. DHS will also develop service utilization measures based on encounter data to aid in this assessment.

DHS uses specific protocols to review evidence of coverage (EOCs), PCNLs and provider directories. This includes review of information on what services may be accessed directly and services which require a referral. Availability of services are assessed including primary care, specialty care, women's health services, second opinions, access to out-of network services, and

transitional services. Other elements reviewed include limitation on cost-sharing not to exceed the in-network cost, and access to covered MA services not covered by the MCO contract.

DHS addresses provider payment issues on a case-by-case basis. Enrollee complaints regarding requests to pay for medically necessary services either in or out-of-network are brought to the attention of DHS contract managers or the DHS Managed Care Ombudsman's Office. DHS brings these matters to the MCO for investigation and appropriate action. MCOs must provide all required services.

DHS monitors patterns of written and oral grievance and appeals to determine whether there are specific concerns regarding availability of services, access to women's health services, second opinions or complaints about services in or out-of-network. Issues and trends are addressed at periodic meetings with the MCOs. Identified issues are referred to the MCO for correction.

MDH conducts its Quality Assurance Examination every three years. This includes a review of the MCO's policy and procedure for Grievance and Appeals and second opinions. DHS has also added an exam component for review of out-of-network care. The results of the MDH review are turned over to the EQRO for review. MDH will conduct follow-up as part of its mid-cycle review if deficiencies are identified.

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

MCOs are also expected to meet the service needs of specific enrollee populations. At the time of initial enrollment, the State provides the MCO with information about enrollee language and race/ethnicity, and whether an enrollee is pregnant. The MCO can use this information to help match an enrollee with appropriate medical and language services.

At the time an individual applies for Medical Assistance or other public health care programs, the county or MinnesotaCare financial worker collects information on each applicant's race, ethnicity and primary language spoken. There are fields in the State's information system to collect this data. Race categories mirror the United States Census categories. Ethnicity is collected based on the applicant's report. Primary language is also collected at the time of application and applicants are asked if they require an interpreter to access the health care system. DHS transfers race or ethnicity and language information to MCOs for new enrollees. Upon receipt of this enrollment information indicating the need for interpreter services the MCO contacts the enrollee by phone or mail in the appropriate language to inform the enrollee how to obtain primary health care services.

42 C.F.R. §438.207 Assurance of adequate capacity and services.

MCO Duties

In a managed care delivery system, the MCO, through its contract with DHS, assures the State that it has the capacity to provide all health care services identified in the contract to publicly

funded enrollees. The signed contract represents that assurance. The MCO also assures DHS that those services are sufficient to meet the health care needs of enrollees and have sufficient capacity to meet community standards.

The contract requires the MCO maintain an adequate number of hospitals, nursing facilities, health care professionals, and allied and paramedical personnel distributed across sufficient service sites for the provision of all covered services. The MCO's provider network must meet MDH requirements for distance or travel time, adequate resources, timely access, and reasonable appointment times.

On an annual basis the MCO is required by the contract to provide a complete list to DHS of participating providers. The MCO must furnish a complete provider directory including primary care, specialty care, dental, behavioral health, and hospital providers. In addition, the MCOs must provide primary care network lists (PCNLs) that include the names and locations of primary care providers, hospital affiliations, providers if the providers are accepting new patients, languages spoken in the clinics, how to access behavioral health services, and other important information. MCOs update PCNLs quarterly.

DHS requires MCOs to pay out-of-network providers for required services that the MCO is not able to provide within its own provider network. The MCO is required to provide enrollees with common carrier transportation to an out-of-network provider if necessary. If a particular specialty service is not available within the MCO's immediate service area, the MCO must provide transportation. Treatment and transportation are provided at no cost to the enrollee except for permitted cost sharing arrangements.

MCOs must submit provider network information to DHS at the time of their initial entry into a contract or new service area with DHS. MCOs must have service area approval from MDH before DHS will sign a contract.

The contract between the State and the MCO requires that all provider terminations are reported to the State, including the number of individuals who are affected by such terminations, the impact on the MCO's provider network and the resolution for enrollees affected by the termination. There are provisions in state law that covers continuity of care in the event of a provider termination. In the case of a "significant change" (material modification) in the provider network the MCO must notify the State as soon as the change is known. In the event of such a material modification, the enrollee has the right to change providers within the MCO or to change to another MCO. The MCO must notify affected enrollees in writing and give them the opportunity to change primary care providers from among the remaining choices or to change to another MCO.

Waiver Services Provider Networks for MSHO and SNBC. These special needs programs have relatively open networks for home and community-based services so that enrollees have sufficient access to providers for these services. Since these are voluntary products, enrollees can always disenroll from MSHO to MSC+ or to managed care/FFS from SNBC if necessary to access a certain HCBS provider.

Oversight Activities

MDH reviews and approves provider networks during the initial MCO licensure process and any service area expansion of an MCO. MDH also reviews MCO provider networks during the QA Exam conducted every three years. MDH will conduct a follow-up evaluation if deficiencies are identified. MDH reviews the impact of provider terminations on an MCO's provider network. MCO policies and procedures are reviewed for access requirements under Minnesota Statutes 62D (for HMOs). Minnesota access standards require that primary care providers are available within 30 minutes or 30 miles and specialty care within 60 minutes or 60 miles, unless there are no providers within those limits. In such cases, state law permits application of a community standard.

During clinic site visits, MDH assesses appointment availability and waiting times. Utilization management activities are also reviewed. Grievances are audited to determine if any patterns resulting from access issues can be identified. The results of the MDH assessments are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. Results of the MDH QA Exam are also made available to the EQRO for review.

At the time of initial entry of an MCO into a region for a DHS contract, DHS reviews the MCO's proposed provider network for completeness. MCOs must have service area approval from MDH before a contract can be signed. DHS works with local county agency staff to develop requests for proposals for each geographic region, including the identification of major providers, any gaps in the service area for potential responders to the Request for Proposal. County staff that have knowledge of recipient utilization and access patterns, also review initial provider network proposals and advise DHS of the relative strengths and weaknesses of the proposals. Minnesota Statutes 256B.69 states that local county boards may review proposed provider networks and make recommendations to DHS regarding the number of MCOs and which MCOs should receive contracts with DHS. In addition, the law also specifically provides that county boards may work with DHS to improve MCO networks until additional networks are available.

DHS reviews Provider Directories annually and PCNLs quarterly to assure that all geographic areas have adequate networks. This review uses a protocol to ensure completeness of information required by 42 CRF 438.207 (names, addresses, languages, providers that are closed and open to new enrollees). Materials provided to enrollees and potential enrollees by MCOs must be approved by DHS prior to distribution. MCOs are required to list a phone number in the materials so an enrollee or potential enrollee can get information on changes that occur after materials are printed. MCOs may also include this information on their websites. DHS also reviews and approves all MCO website content.

DHS periodically maps MCO provider networks to evaluate network accessibility. DHS reviews grievance and appeals, both written and oral, to determine if access to service is adequate, and identify problems and trends. DHS reviews and evaluates provider network changes in the event of a change in provider access including the closing or loss of a clinic, or a substantive change in the MCO provider network. If a provider network change results in a lack of adequate coverage, the MCO may be removed as an option for assignment, or the MCO contract in a particular

county may be terminated. A referral may be made to MDH to evaluate whether the MCO meets state standards.

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

42 C.F.R. §438.208 Coordination and continuity of care

MCO Duties

Under this section, MCOs are required to ensure coordination of all care provided to enrollees to promote continuity of care. This includes coordination of care and benefits when multiple providers, or provider systems or multiple payers are involved. DHS contracts with MCOs for a comprehensive range of Medical Assistance and MinnesotaCare benefits. DHS does not contract for partial benefit sets such as a behavioral health carve-out. In Minnesota, persons who have insurance coverage from a health maintenance organization (HMO) are excluded from enrollment unless they are covered by a HMO that contracts to provide services as an MCO under Minnesota Health Care Programs (MHCP). In such a case, the enrollee may voluntarily enroll in MHCP within the same MCO. The contracted MCO is required to coordinate care and benefits if there are any differences in benefits or networks. The MCO is required to have written procedures that ensure that each enrollee has an ongoing source of primary care appropriate for his or her needs and a provider formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

The MCO is responsible for the care management of all enrollees. The MCO's care management system must be designed to coordinate primary care and all other covered services to its enrollees and promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability. The MCO must also have procedures for an individual needs assessment, diagnostic assessment, the development of an individual treatment plan based on the needs assessment, the establishment of treatment goals and objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. There is also a strategy to ensure that all enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment if an enrollee requires a treatment plan for any condition, it is the responsibility of the enrollee's primary care provider to develop and periodically review the plan. The enrollee must be allowed to participate in the development and review of his or her plan to the extent possible according to the enrollee's health status.

MSHO and SNBC programs have "care coordinators," "health coordinators" "case managers or navigation assistants" whose role is to coordinate care for enrollees. Care coordination is required under the DHS/MCO contract Article 6. The MSHO and SNBC contract specify detailed care coordination requirements that hold the care coordinator/health coordinator/navigation assistant responsible for coordinating care including assurances that enrollees have an ongoing source of primary care. Under these programs a care plan is developed that combines the primary care, chronic disease management and long-term needs

including HCBS. Care plan development involves the enrollee's participation to the extent possible according to the enrollee's health status.

In MSHO and SNBC, dual-eligible enrollees get their Medical Assistance and Medicare services from the same MCO. On the other hand, MSC+ enrollees may receive their Medicare services from a Medicare FFS plan or by enrolling in a Medicare Advantage managed care plan different from their MSC+ MCO. The MSC+ MCO must coordinate services with the Medicare plan. However, most seniors required to enroll in MSC+ have chosen to enroll in MSHO where all their Medicare and Medical Assistance services are covered by one health plan. MCOs are expected to comply with requirements for care coordination and continuity of care, as stated in the MSHO/ MSC+ and SNBC contracts.

Oversight

DHS reviews the EOCs to assess each MCO's procedures for ensuring coordination and continuity of care and ensuring that each enrollee has access to a primary care provider. In addition, MSHO/ MSC+ MCOs are required to audit a sample of care plans of waiver enrollees to assess the implementation of care plan requirements for each care system and county care coordination system. The care plan audit examines evidence of comprehensive care planning as stipulated in the Comprehensive Care Plan Audit Protocol. DHS also reviews grievance and appeal data to identify whether access to primary care providers, care coordination or continuity of care are issues requiring systematic follow-up. In addition, DHS follows up on a case-by-case basis on specific grievance and appeals regarding coordination and continuity of care.

In the past the EQRO, conducted a triennial "look behind" audit of a sample of MSHO/ MSC+ MCO care plan audits to assess each MCO's compliance with the standard outlined in the Comprehensive Care Plan Audit Protocol to identify areas for a closer examination. This activity is now completed through an interagency agreement with MDH.

Special Health Care Needs

MCO Duties

According to their contract MCOs must identify enrollees, 18 years and older who may need additional health care services through method(s) approved by DHS. These methods must include analysis of claims data for diagnoses and utilization patterns (both under and over) to identify enrollees who may have special health care needs.

In addition to claims data, the MCO may use other data to identify enrollees with special health care needs such as health risk assessment surveys, performance measures, medical record reviews, and enrollees receiving personal care assistant (PCA) services, requests for pre-authorization of services and/or other methods developed by the MCO or its contracted providers.

The mechanisms implemented by the MCO must assess enrollees identified and monitor the treatment plan set forth by the treatment team. The assessment must utilize appropriate health care professionals to identify any ongoing special conditions of the enrollee that require specialized treatment or regular care monitoring. If the assessment determines the need for a

course of treatment or regular health care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist such as a standing referral or a pre-approved number of visits as appropriate for the enrollee's condition and identified needs.

MSHO/SNBC: The State has determined that all enrollees in MSHO and SNBC are considered to meet the requirements for enrollees with special health care needs. In MSHO and SNBC, all enrollees are screened and assessed to determine whether they have special needs. In MSHO, the MCO is required to have providers with geriatric expertise and to provide Elderly Waiver home and community based services to eligible individuals. In SNBC, the MCO must offer primary care providers with knowledge and interest in serving people with disabilities. The MCO must also provide Community Alternatives for Disabled Individuals (CADI) and Brain Injury (BI) waiver services to eligible individuals. Contracts with MCOs also require them to have mechanisms to pay for additional or substitute services.

Oversight

The MCO must submit to DHS a claims analysis to identify enrollees with special health care needs and include the following information:

- The annual number of enrollees identified for each ambulatory care sensitive condition (ACSC), and
- Annual number of assessments completed by the MCO or referrals for assessments completed.

MSHO: DHS staff review enrollee screening and assessment documents that are submitted by care coordinators for enrollees in need of home and community based services. EW services will be reviewed and evaluated by the State including the Care Plan, Case Management and Care System audit reports and audit protocols as required in contract Section 7.8.3

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

42 C.F.R. §438.210 Coverage and authorization of services.

MCO Duties

Article 6 of the F&C MA contract specifies which services must be provided and which services are not covered. Medical necessity is defined. The contract requires that all medically necessary

services¹ are covered unless specifically excluded from the contract. The MCO must have in place policies for authorization of services and inform enrollees how services may be accessed (whether direct access is permitted, when a referral is necessary, and from whom). In the contract, federal, and state laws specify time frames for decisions and whether standard or expedited. (See Grievances and Appeals in Article 8 of the contract) The EOC must inform enrollees how to access State Plan services not covered by the MCO's contract.

When a service is denied, terminated, or reduced, the MCO must give the enrollee a notice of action including a description of the enrollees' rights with respect to MCO appeals and State Fair Hearing process.

Oversight Activities

On a quarterly basis, MCOs submit specific information about each notice of action to the State Ombudsman Office. This office reviews the information and tracks trends in denial, termination and reduction of services.

Review of encounter data also provides information regarding coverage and authorization of services. DHS monitors enrollee grievances related to service access.

Every three years, MDH conducts an on-site Quality Assurance Examination. This audit includes a review of service authorization and utilization management activities of the MCO or its subcontractor(s). DHS works closely with MDH in preparing for these audits and has the opportunity to identify special areas of concern for review. MDH conducts a follow-up exam if deficiencies are identified. The results of this examination are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. The results of the MDH audit are also made available to the EQRO for review.

MSHO /SNBC: DHS has an interagency agreement with MDH for review of specified Medical Assistance requirements, including specific MSHO items. The MSHO contract requires that MCOs conduct on-site audits of provider care systems and provide information about care system performance at the State's annual site visit. DHS also reviews MSHO encounter data with comparisons to Families and Children MA and MA FFS. DHS developed a database combining Medical Assistance and Medicare data about dual-eligible enrollees to enable data analysis of the dual-eligible population. The State works with a collaborative created by MCOs participating in MSHO to track a core set of "Value Added" utilization measures.

¹ Medically necessary services-Those services which are in the opinion of the treating physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage, may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 CFR 440.230). Medicaid EPSDT coverage rules (42 USC §1396(r)(5) and 42 USC §1396 d(a)).

Implementation of SNBC began January 1, 2008 as well as analysis of utilization patterns of SNBC enrollees.

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

STRUCTURE AND OPERATIONAL STANDARDS

42 C.F.R. §438.214 Provider selection

MCO Duties

In a managed care delivery system, the MCO selects, reviews, and retains a network of providers that may not include all available providers. Since the MCO has a limited network of providers from which the enrollee may select, the MCO has a responsibility to monitor these providers for compliance with state licensing requirements and MCO operational policies and procedures.

The MCO is required to have an established Credentialing and Re-credentialing program that monitors and reviews the panel of providers for the quantity of provider types and the quality of providers offering care and service. The MCO's Credentialing and Re-credentialing program must follow National Committee for Quality Assurance (NCQA) standards.

The MCO is prohibited from discriminating against providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCO is prohibited from contracting with or employing providers that are excluded from participation in Federal Health Care programs.

Oversight Activities

At least once every three years, MDH conducts an audit of MCO compliance with state and federal requirements. The results of the MDH examination are reviewed by the EQRO. MDH will conduct a follow-up Mid-cycle Examination if deficiencies are identified.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO makes recommendations for improving the quality of health care services as necessary.

42 C.F.R. §438.218 Enrollee information

Enrollee information must meet the requirements of 438.10 (Information Requirements). There are specific requirements for current managed care enrollees and potential enrollees. In Minnesota, the State or the local agency provides most information to potential enrollees. Most, but not all enrollee information is provided by the MCOs.

MSHO/ SNBC: MCOs with Medicare Advantage SNPs are also subject to Medicare regulations, which permit and require MCOs to market to potential and current enrollees. Thus, MCOs in the MSHO/ SNBC programs market and provide most of the information to potential enrollees.

State Duties

DHS must ensure that enrollment notices, informational, instructional and marketing materials are provided at a 7th grade reading level. The State or local agency provides information to most potential enrollees through written enrollment materials. Potential enrollees may also choose to attend a presentation. This information is designed to help enrollees and potential enrollees understand the managed care program. The State must identify the prevalent non-English languages spoken throughout the state and make written information available in those languages. The State must make oral interpretation services available in any language and must provide information about how to access interpretation services. Information must be available in alternative formats to address special needs, such as hearing or visual impairment, and must inform enrollees and potential enrollees about how to access those formats.

MCO Duties

Enrollment notices, informational, instructional and marking materials, and notice of action, must be provided at a 7th grade reading level. The MCO must identify the prevalent non-English languages spoken within its service area throughout the state and take reasonable steps to ensure meaningful access to the MCO's programs and services by persons with Limited English Proficiency (LEP). The MCO must make oral interpretation services available in any language and must provide information about how to access interpretation services. Information must be available in alternative formats that take into account the enrollee's special needs, including those who are hearing impaired, visually impaired or have limited reading proficiency. The MCO must inform enrollees about how to access those formats.

Oversight Activities

The State provides enrollment materials, which meet the requirements above, to the local agency for distribution to all enrollees or potential enrollees. By contract, the State must review and approve all MCO notices and educational/enrollment materials prior to distribution to enrollees or potential enrollees. MCO enrollees receive a membership card and other materials, including a Provider Directory and the Evidence of Coverage upon enrollment. Providers use the enrollee's MCO member card to verify enrollment status through the Eligibility Verification System (EVS). If the provider finds a discrepancy between data provided by the MCO and the data available on EVS, the provider contacts the State provider help desk. The help desk verifies the system data and refers the problem to the enrollment coordinator group to resolve with the MCO.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO makes recommendations for improving the health care services furnished by each MCO.

The State will conduct site visits at the local agencies to monitor managed care presentations and review enrollment activities.

A. Information for Potential Enrollees

State Duties

The State or local agency must provide specific information to each potential enrollee who becomes eligible to enroll in a mandatory or voluntary Medical Assistance managed care program. The following information is provided within a timeframe (15 calendar days) that allows the potential enrollee to choose among available MCOs which includes:

- The basic features of managed care,
- Which populations are enrolled on a mandatory basis, populations excluded from enrollment or those free to enroll voluntarily,
- MCO responsibility for coordination of care,
- Summary information specific to each MCO operating in the potential enrollee's service area which includes benefits covered, cost sharing, service area, names, locations, and phone numbers of providers, primary care physicians, specialists, hospital affiliation, special services, evening or weekend hours, any non-English language spoken by providers, and providers not accepting new patients,
- A description of benefits available under the State Plan not covered by the MCO contract, and how and where enrollees may obtain those benefits,
- Cost sharing, and
- How transportation is provided.

MCO Duties

The MCO must provide PCNLS, which include summary information specific to each MCO operating in the potential enrollee's service area. The information must include names, locations, phone numbers, primary care physicians, specialists, hospital affiliation, special services, evening or weekend hours, non-English language spoken by providers, and providers not accepting new patients. MCOs are required to provide a telephone number for enrollees and potential enrollees to call to get information about changes that have occurred since the documents were printed. MCOs may also make this information available on their websites.

B. Information for Enrollees

State Duties

The State will notify all enrollees of their enrollment rights also referred to as open enrollment in September of each year to be effective January 1st of the following year. Each year during open enrollment, the State must provide the enrollees the opportunity to request specified information. This information includes:

- The basic features of managed care,
- Which populations are excluded from enrollment or are free to enroll voluntarily,
- MCO responsibility for coordination of care,
- Summary information specific to each MCO operating in the potential enrollee's service area, which includes benefits covered, cost sharing, service area, names, locations, phone

- numbers of providers, any non-English language spoken by providers, providers not accepting new patients, and
- Benefits available under the State Plan, which are not covered under the contract. The information includes how and where enrollees may obtain those benefits,
- Cost sharing, and
- How transportation is provided.

The State must notify enrollees about their rights and responsibilities, including information on grievance, appeal, and State Fair Hearing procedures. Annually, and upon request, each enrollee will receive information within a specific timeframe in a comparative chart-like format which includes, the MCOs service areas, benefits covered under the contract, cost sharing and quality and performance indicators including enrollee satisfaction. Each enrollee must also receive a written notice of any network change that the State defines as significant.

MCO Duties

MCOs furnish enrollment materials to each enrollee within a reasonable time (15 days) after the MCO receives notice of the recipient's enrollment from the State. Each enrollee must receive a written notice of any information change that the State defines as significant and any restrictions on the enrollee's freedom of choice among network providers. The MCO must provide each enrollee with specific information. This includes how to access services, services that may be accessed directly or require a referral, and how an enrollee may choose a primary care provider. This information is included in the Evidence of Coverage (EOC), Primary Care Network List (PCNLs) and Provider Directory.

Oversight Activities

The State provides the MCO with a model EOC. The MCO must submit its EOC for approval to DHS and MDH prior to distribution. The State provides requirements and guidelines for information to be included in PCNLs and Provider Directories. This information includes use of the language block and submission of the results of a test for readability of the document. The MCO's PCNL and Provider Directory must be approved by DHS prior to use. Protocols are used for review of all of these documents.

MSHO/ SNBC: These programs utilize integrated Medicare and Medical Assistance materials. The State develops model materials for this purpose whenever possible, incorporating both Medicare and Medical Assistance requirements. Informational material, enrollment material, websites and other recipient information containing statements about the benefit package are subject to review and approval by the State and the CMS Medicare Regional Office. Consumer Advisory Committees for these programs also provide input and review of enrollment processes and materials. DHS plays a significant role in working with the MCO and county staff in assisting potential and current enrollees with eligibility issues. DHS also follows up on complaints about the enrollment process.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO may make recommendations for improving the health care services furnished by each MCO.

42 C.F.R. §438.224 Confidentiality

MCO Duties

All managed care contracts require MCOs to comply with 45 C.F.R. parts 160 and 164, subparts A and E to the extent that these requirements are applicable, and expects MCOs comply with subpart F of Section 42 C.F.R. §431.

Oversight Activities

The State has incorporated the requirements of 45 C.F.R. parts 160 and 164, subparts A and E into its contracts with MCOs. The State monitors MCO compliance with all applicable confidentiality requirements.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO may make recommendations for improving the MCO's assurance of confidentiality.

42 C.F.R. §438.226 Enrollment and disenrollment

Provisions for enrollment and disenrollment must meet the requirements of 42 C.F.R. §438.56. Disenrollment provisions apply to all enrollees whether the enrollment is mandatory or voluntary. Enrollees may request disenrollment either orally or in writing from the State or local agency. Enrollees may request disenrollment:

- If they move out of the MCO's service area,
- If they need related services to a procedure performed at the same time when all services are not available within the MCO's network and the PCP or another provider determines that receiving the service separately would cause undue risk,
- If they have other reasons including but not limited to poor quality of care, lack of access to services or lack of access to providers experienced in dealing with the enrollee's health care needs,
- For cause at any time,
- Once during the first year of enrollment, and without cause at least once every twelve months,
- During the 90 days following the date of the recipient's initial enrollment with the MCO, or the date the State sends the recipient notice of the enrollment, whichever is later,
- Upon automatic reenrollment if the loss of eligibility has caused the recipient to miss the annual open enrollment opportunity, or
- When the State imposes intermediate sanctions.

MSHO/SNBC: Enrollment and disenrollment functions for Medical Assistance are performed by the State rather than through the local agency or the MCO. For Medicare enrollment and disenrollment, most MCOs have contracted with the State to serve as a Third-Party-Administrator. Enrollees in these voluntary programs are permitted to disenroll at any time, with

or without cause, with the disenrollment usually effective in the next month according to Medicare timelines.

State Duties

A determination for disenrollment must be made no later than the first day of the second month following the month in which the enrollee requests disenrollment or the request is considered approved. Automatic reenrollment in the same MCO is provided if the disenrollment period is for a period of two months or less, if the enrollee establishes eligibility within two months or less.

MCO Duties

MCOs are precluded by the DHS/MCO contract from requesting that an enrollee be disenrolled from MHCP for any reason. MCOs must refer any requests for disenrollment to the State or local agency. MCOs are permitted to request that an enrollee be disenrolled only if the enrollee becomes ineligible for Medical Assistance, moves out of the service area, or engages in disruptive behavior as specified in 42 C.F.R. §422.74.

Oversight Activities

The State monitors all requests for disenrollment.

Enrollees have access to information, about their right to disenroll, from county staff MCO staff and care coordinators. The information is provided in managed care program brochures, the Evidence of Coverage, and Notice of Rights and Responsibilities brochure mailed to enrollees by the State. State staff also monitor disenrollment through grievance and appeals, disenrollment surveys (enrollees who change MCOs or disenroll from MSHO), disenrollment statistics, and frequent communications with MCO staff and care coordinators.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and evaluates each MCO's compliance with this standard. The EQRO will make recommendations for improving the health care services furnished by each MCO.

42 C.F.R. §438.228 Grievance system

MCO Duties

A grievance system provides an opportunity for managed care enrollees to express dissatisfaction with health care services provided. The MCO and DHS grievance and appeal process ensures that enrollees and providers have input into the health care decision-making process. The following are grievance system required elements:

- MCOs are required to have a Grievance System which includes an oral and written grievance process, an oral and written appeal process, and access to the State Fair Hearing system. The process must allow a provider to act on behalf of the enrollee with the enrollee's written permission.

- The MCO must assist enrollees, as needed, in completing forms and navigating the grievance and appeal process. The appeal process must provide that oral inquiries seeking to appeal an action be treated as an appeal with the opportunity to present evidence in person as well as in writing.
- The MCO must dispose of each grievance and resolve each appeal, whether orally or in writing, and provide notice, as expeditiously as the enrollee's health condition requires, but no later than the timeframes established by state and federal laws, and that are specified in the contract.
- A State Fair Hearing must be permitted as specified by the State. The MCO must be a party to the State Fair Hearing and comply with hearing decisions promptly and expeditiously.
- The MCO must send a notice of action to each enrollee when it denies, terminates, or reduces a service or when it denies payment for a service. The notice must state the action taken; the type of service or claim that is being denied, terminated, or reduced; the reason for the action; and the rules or policies which support the action. The notice must include a rights notice, explaining the enrollee's right to appeal the action. The MCO must continue to provide previously authorized benefits when an enrollee appeals the denial, termination, or reduction of those benefits and the timelines and other conditions for continuation of benefits are met, as specified in Section 8 of the contract.
- The MCO must maintain grievance and appeal records, and provide notification to the State, as specified in the contract.

MSHO/ SNBC: Enrollees of these programs also have access to Medicare grievance and appeals processes. In order to simplify access to both the Medicare and Medical Assistance grievance systems, the State has developed an integrated process in conjunction with CMS that allows the MCO to make integrated coverage decisions for both Medicare and Medical Assistance. Enrollees continue to have access to grievance and appeal procedures under both programs.

Oversight Activities

On a quarterly basis, the MCO must report specified information about each notice of action to the state Managed Care Ombudsman Office. This office reviews this information and tracks trends in the MCO's Grievance System.

DHS integrates data provided by MDH through the Quality Assurance Examination with the data collected directly from MCOs by DHS in order to analyze appeal and grievance procedures, timelines, and outcomes of grievances, appeals, and State Fair Hearings.

At least once every three years, MDH audits MCO compliance with state and federal grievance and appeal requirements. The results of the MDH audit are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. The results of the MDH audit are also reviewed by the EQRO. MDH will conduct a follow-up examination if deficiencies are identified.

Reporting and Evaluation

Data collected from DHS and MDH grievance and appeal investigations are integrated to provide feedback on the grievance system and serve as a basis for recommending policy changes.

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

42 C.F.R. §38.230 Sub-contractual relationships and delegation

MCO Duties

The MCO may choose to delegate certain health care services or functions (e.g., dental, chiropractic, mental health services) to another organization with greater expertise for efficiency or convenience, but the MCO retains the responsibility and accountability for the function(s). The MCO is required to evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. When the MCO delegates a function to another organization, the MCO must do the following:

- Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function,
- Have a written agreement with the delegate identifying specific activities and reporting responsibilities and how sanctions/revocation will be managed if the delegate's performance is not adequate,
- Annually monitor the delegates' performance,
- In the event the MCO identifies deficiencies or areas for improvement, the MCO/delegate must take corrective action, and
- Provide to the State an annual schedule identifying subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed.

MSHO/ SNBC: MCOs are also required to audit their care systems annually.

Oversight Activities

At least once every three years, MDH audits MCO compliance with state and federal requirements in a review of delegated activities. MDH will conduct a follow-up review if deficiencies or mandatory improvements are identified. The results of the MDH audit are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. The results of the MDH audit are also reviewed by the EQRO.

MCOs annually monitor the subcontractor's ability to perform the delegated functions. The results of the review are provided to the EQRO for evaluation. If an MCO identifies deficiencies or mandatory improvements, the MCO will inform DHS of the corrective action. Corrective action information will be provided to the EQRO to be included in its evaluation.

MSHO/ SNBC: MDH QA Exam reviews MCO subcontracts for compliance with contract requirements.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information submitted to DHS and assess each MCO's compliance with this standard. The EQRO may make recommendations for improving the quality of health care services furnished by each MCO.

MEASUREMENT AND IMPROVEMENT STANDARDS

42 C.F.R. §438.236 Practice guidelines

MCO Duties

Adoption and application of practice guidelines are essential to encourage appropriate provision of health care services and promote prevention and early detection of illness and disease.² Providers that agree and follow guidelines based upon current clinical evidence have the potential to identify and change undesirable health care processes and reduce practice variation.

MCOs are required to adopt, disseminate and apply practice guidelines. The guidelines must be evidence based, consider the needs of enrollees and be adopted in consultation with providers. The guidelines must be reviewed and updated periodically to remain in concurrence with new medical research findings and recommended practices. The MCO must apply the guidelines in utilization decisions, enrollee education and coverage of services. All practice guidelines must be available upon request.

Oversight Activities

At least once every three years, MDH audits MCO compliance with state and federal requirements. The results of the MDH audit are reviewed by the EQRO. A follow-up examination is conducted if deficiencies are identified.

The MCO must annually audit provider compliance with the practice guidelines and report to the State the findings of their audits. Each year, DHS submits the MCO's practice guideline audits to the EQRO for review.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information gathered and assess each MCO's compliance with this standard. The EQRO also makes recommendations for improving the quality of health care services furnished by each MCO.

42 C.F.R. §438.240 Quality assessment and performance improvement program

MCO Duties

Conducting quality improvement projects provides a mechanism for the MCO to target high risk, high volume or problem prone care or service areas that can be improved with a focused strategic

² Refer to Appendix C DHS Supplemental Triennial Compliance Assessment item 5.

intervention(s).³ These projects are designed to identify and subsequently introduce evidence-based interventions to improve the quality of care and services for the at-risk enrollees. Quality improvement projects reflect continuous quality improvement concepts including identifying areas of care and service that need improvement, conducting follow-up, reviewing effectiveness of interventions, making additional changes, and repeating the quality improvement cycle as needed.

Each year the MCO must select a topic for a performance improvement project on which to conduct a quality improvement project. Projects must be designed to achieve, through ongoing measurements and interventions, significant improvements in clinical and non-clinical areas sustained over time, as required by CMS protocol.

Proposed projects are submitted to DHS for review and validation assuring the project meets the following criteria:

- Have a favorable effect on health outcomes,
- Use measurements of performance that are objective quality indicators,
- Implement system interventions to achieve improvement in quality,
- Evaluate the effectiveness of the interventions, and
- Plan and initiate activities that will increase or sustain the improvements obtained.

When a project is completed the MCO writes a final report and submit to DHS for review. The final report describes the impact and effectiveness of the project.

Oversight Activities

Each year the MCO selects a project topic and submits to DHS a project proposal describing the project to be undertaken beginning in the next calendar year. The project usually spans a three to four year period with an annual interim report, due upon request, leading to a final project report. DHS reviews and recommends changes as appropriate and submits the final reports to the EQRO for evaluation to determine if significant improvement has been achieved and if it will be sustained over time.

The MCO is expected to include all quality program requirements in the project, where appropriate; such as mechanisms to detect both under and over utilization of services, and assess the quality and appropriateness of care provided to enrollees with special health care needs if they are included in the project population.

Reporting and Evaluation

Annually, the EQRO summarizes and evaluates all information gathered and assess each MCO's compliance with this standard. The EQRO also makes recommendations for improving the quality of health care services furnished by each MCO.

³ Refer to Appendix C DHS supplemental Triennial Compliance Assessment item 6.

42 C.F.R. §438.242 Health information systems

MCO Duties

A health information system must have the capabilities to produce valid encounter data, performance measures and other data necessary to support quality assessment and improvement, as well as managing the care delivered to enrollees.

The MCO must maintain a health information system that collects, analyzes, integrates and reports data that demonstrates the MCO quality improvement efforts. The system must also provide information that supports the MCO's compliance with state and federal standards.

The model contract sets standards for encounter data reporting and submission that meet the requirements of Section 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. Section 1396b(m)(2)(A)(xi). This includes formats for reporting, requirements for patient and encounter specific information, information regarding treating provider and timeframes for data submission.

The Health Information System is required to possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, incorporate safeguards against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status.

Oversight Activities

Annually, DHS contracts with an NCQA Certified HEDIS Auditor to assess its information system's capabilities. The auditor's report is reviewed by the EQRO and a determination made on DHS and MCO's compliance.

When MCOs submit encounter data to DHS, automated systems data audits are conducted to ensure data integrity for accuracy and administrative feasibility. In 2008, DHS established a unit dedicated to the improvement of encounter data quality. The Encounter Data Quality Unit (EDQU) monitors encounter data submission and works with MCOs on corrections.

Reporting and Evaluation

MMIS contains more than 100 automated edits that are applied to MCO submissions. MCO submissions are manually reviewed in two separate processes for format, accuracy, and possible duplication. MCOs receive reports on data quality and completeness. DHS monitors service utilization using encounter data that has been uploaded to the data warehouse. Potential problems and issues are identified and the MCOs are notified. DHS uses encounter data to develop Risk Adjustment Calculation and Reporting.

Annually, the EQRO summarizes and evaluates all information gathered and assess each MCO's compliance with this standard. The EQRO also makes recommendations for improving the quality of health care services furnished by each MCO.

SANCTIONS

42 C.F.R. §438.700 Basis for imposition of sanctions

The contract between the State and the MCO contain provisions for intermediate sanctions. These sanctions are referred to as “remedies” for partial breach of the contract. A sanction may be applied for any breach of the contract, including quality of care. The State may impose a sanction if it determines that the MCO has failed substantially to provide medically necessary services, has inappropriately required or allowed its providers to require enrollees to pay cost-sharing, has discriminated among enrollees based on health status or need for care, has falsified or misrepresented information provided to the State or CMS, or has failed to comply with the physician incentive plan requirements.

If a quality of care issue were subject to sanction, the MCO would be notified of the breach and would be given an opportunity to cure the breach. The amount of time allowed for the MCO to cure the breach depends on the seriousness of the issue, and whether there is risk to enrollees in allowing time for the MCO to cure. Failure to cure within the designated time frame would result in the imposition of a remedy or sanction.

In determining a remedy or sanction, the State is obligated to consider the number of enrollees or recipients, if any, affected by the breach, the effect of the breach on enrollees’ health and enrollees’ and recipients’ access to health services or, in the case that only one enrollee or recipient is affected, the effect of the breach on that enrollee’s or recipient’s health, whether the breach is an isolated incident or part of a pattern of breaches, and the economic benefits, if any, derived by the MCO as a result of the breach.

The type of sanctions included in the contract satisfies most of the requirements of 42 C.F.R. §438.702 and §438.704. The State may impose temporary management of the MCO. The contract has provisions for due process for the MCOs, including the opportunity to cure a breach and access to a mediation panel. The State’s rights to terminate a contract are defined in the contract.

Appendix C

DHS Supplemental Triennial Compliance Assessment Elements (Information gathered during the MDH QA Examination) August 2013

During the QA Examination, MDH will collect and validate MCO compliance information for DHS publicly funded managed care programs.¹ The compliance information will be gathered and reported for each publicly funded program (Family & Children MA, MinnesotaCare, MSHO, MSC+ and SNBC) as appropriate. MDH will produce a written summary of the information gathered during the MCO's QA Examination. Listed below are the areas that MDH will gather compliance information for DHS Supplemental Triennial Compliance Assessment (TCA).

SFY 2013 TCA Elements

1. QI Program Structure 2013 Contract Section 7.1.1

- A. The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 C.F.R. § 438, Subpart D, (Access, Structure and Operations, and Measurement and Improvement). At least annually, the MCO must assess program standards to determine the quality and appropriateness of care and services furnished to all Enrollees. This assessment must include monitoring and evaluation of compliance with STATE and CMS standards and performance measurement.

2. Accessibility of Providers. 2013 MSHO/MS C+ Contract Section 6.1.4(C)(2) and 6.1.5(E)

In accordance with the DHS/MCO managed care contracts for MSHO, and MSC+, the MCO must demonstrate that it offers a range of choice among Waiver providers such that there is evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services so that appropriate choices among nursing facilities and/or waiver services may be offered to meet the individual need as of Enrollees who are found to require a Nursing Facility Level of Care. These procedures must also include strategies for identifying Institutionalized Enrollees whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility²

3. Utilization Management. 2013 Contract Section 7.1.3

¹ DHS/MCO Contracts and current NCQA Standards and Guidelines for the Accreditation of Health Plans.

² Evidence that choice is offered to Enrollees qualifying for a Nursing Home Level of Care is reviewed #10

- A. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA “Standards and Guidelines for the Accreditation of Health Plans.” The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall:
- (1) Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.
 - (2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.
 - (3) Conduct qualitative analysis to determine the cause and effect of all data not within thresholds.
 - (4) Analyze data not within threshold by medical group or practice.
 - (5) Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions.³
- B. The following are the 2013 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1-4 and 10-14.
- (1) ***NCQA Standard UM 1: Utilization Management Structure***
The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.
 - (a) Element A: Written Program Description
 - (b) Element B: Physician Involvement
 - (c) Element C: Behavioral Healthcare Practitioner Involvement
 - (d) Element D: Annual Evaluation
 - (2) ***NCQA Standard UM 2: Clinical Criteria for UM Decision***
To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.
 - (a) Element A: UM Criteria
 - (b) Element B: Availability of Criteria
 - (c) Element C: Consistency in Applying Criteria
 - (3) ***NCQA Standard UM 3: Communication Services***
The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

³ 42 C.F.R §438. 240(b)(3)

- (a) Element A: Access to Staff
- (4) ***NCQA Standard UM 4: Appropriate Professionals***
Qualified licensed health professionals assess the clinical information used to support UM decisions.
 - (a) Element D: Practitioner Review of BH Denials
 - (b) Element F: Affirmative Statement About Incentives
- (5) ***NCQA Standard UM 10: Evaluation of New Technology***
The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals, and devices.
 - (a) Element A: Written Process
 - (b) Element B: Description of the Evaluation Process
- (6) ***NCQA Standard UM 11: Satisfaction with the UM Process***
The organization evaluates member and practitioner satisfaction with the UM process.
 - (a) Element A: Assessing Satisfaction with UM Process.
- (7) ***NCQA Standard UM 12: Emergency Services***
The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.
 - (a) Element A: Policies and Procedures
- (8) ***NCQA Standard UM 13: Procedures for Pharmaceutical Management***
The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals
 - (a) Element A: Policies and Procedures
 - (b) Element B: Pharmaceutical Restrictions/Preferences
 - (c) Element C: Pharmaceutical Patient Safety Issues
 - (d) Element D: Reviewing and Updating Procedures
 - (e) Element E: Considering Exceptions
- (9) ***NCQA Standard UM 14: Triage and Referral for Behavior Health Care***
The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. *This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated.*
 - (a) Element A: Triage and Referral Protocols

4. Special Health Care Needs 2013 Contract Section 7.1.4 A-C.^{4, 5}

- A. The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.
- (1) Mechanisms to identify persons with special health care needs,
 - (2) Assessment of enrollees identified (Senior and SNBC contract - care plan), and
 - (3) Access to specialists

5. Practice Guidelines. 2013 Contract Section 7.1.5⁶

- A. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for children, adolescents, prenatal care, young adults, adults, and seniors age 65 and older, and as appropriate for people with disabilities populations.
- (1) Adoption of practice guidelines. The MCO shall: adopt guidelines based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; consider the needs of the MCO enrollees; adopt in consultation with contracting Health Care Professionals; review and update them periodically as appropriate.
 - (2) Dissemination of guidelines. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to enrollees and potential enrollees.
 - (3) Application of guidelines. The MCO shall ensure that these guidelines are applied to decisions for utilization management, enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

6. Annual Evaluation. 2013 Contract Section 7.1.8^{7, 8,}

- A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA “Standards for Accreditation of Managed Care Organization”.

⁴ 42 C.F.R §438.208 (c)(1-4)

⁵ MSHO/MS C+ Contract Section 7.1.4 A-C

⁶ 42 C.F.R §438.236

⁷ 42 C.F.R §438.240(e)

⁸ MSHO/MS C+ Contract Section 7.1.8 also includes the requirement that the MCO must include the “Quality Framework for the Elderly” in its Annual Evaluation

This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standardized measures (example: HEDIS®) and MCO's performance improvement projects.

B. NCQA QI 1, element B: There is an annual written evaluation of the QI program that includes:

- (1) A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service
- (2) Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- (3) Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network wide safe clinical practices.
- (4) Evaluation of the overall effectiveness of the QI program, including progress toward influencing network wide safe clinical practices.

7. Interim and Completed Performance Improvement Projects: 2013 Contract Section 7.2.^{9, 10}

- A. Interim Project Reports. By December 1st of each calendar year, the MCO must produce an interim performance improvement project report for each current project. The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight and ten as appropriate.
- B. Completed PIP Project Improvements Sustained Over Time. Real changes in fundamental system processes result in sustained improvements:
- (1) Were PIP intervention strategies sustained following project completion?
 - (2) Has the MCO monitored post PIP improvements?

8. Disease Management: 2013 Contract Section 7.3¹¹

- A. The MCO shall make available a Disease Management Program for its Enrollees with diabetes, asthma and heart disease.

⁹ 42 C.F.R §438.240 (d)(2)

¹⁰ CMS Protocols, Conducting Performance Improvement Projects, Activity 10

¹¹ MSHO/MS+ Contract Section 7.3, require only diabetes and heart DM programs. SNBC Contract Section 7.2.9

- B. The MCO's Disease Management Program shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" - QI Standard Disease Management.
- C. If the MCO's diabetes, asthma and heart disease management programs have achieved 100 percent compliance during the most recent NCQA Accreditation Audit of QI Standard- Disease Management, the MCO will not need to further demonstrate compliance.

9. Advance Directives Compliance: 2013 Contract Section 16 Advance Directives Compliance^{12 13}

- A. The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on advance directives and the following:
 - (1) Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive.
 - (2) Written policies of the MCO respecting the implementation of the right; and
 - (3) Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change.
 - (4) Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 C.F.R. §422.128 as required in 42 C.F.R. §438.6(i).
- B. To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an individual has executed an advance directive.
- C. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.
- D. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38.

¹² MSHO/MSc+ and SNBC Contract Article 16.

¹³ Pursuant to 42 U.S.C. 1396a(a)(57) and (58), 42 C.F.R. §489.100-104 and 42 C.F.R. §422.128

- E. To provide, individually or with others, education for MCO staff, providers and the community on advance directives.

10. Validation of MCO Care Plan Audits for MSHO and MSC+ 2013 Contract Sections 6.1.4(A)(2), 6.1.4(A)(3), 6.1.4(A)(4), 6.1.5(B)(5)

- A. DHS will provide MDH with a Data Collection Guide for the random sample of 30 MCO enrollees (plus an over sample of 10 MCO enrollees for missing or unavailable enrollee records) for MSHO and MSC+ program. Of the 40 records sampled, 20 records will be for members new to the MCO within the past 12 months and other 20 records will be for members who have been with the MCO for more than 12 months. Instructions on selecting the sample are included in the Data Collection Guide.
- B. MDH will request the MCO make available during the MDH QA Examination on-site audit the identified enrollee records. A copy of the Data Collection Guide and data collection tool will be included with MDH'S record request.
- C. An eight-thirty audit methodology will be used to complete a data collection tool for each file in each sample consistent with the Data Collection Guide.
- D. Within 60 days of completing the on-site MDH QA Examination, MDH will provide DHS with a brief report summarizing the data collection results, any other appropriate information and the completed data collection tools.

11. Information System^{14, 15} The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. During each of the past three years, all MCO MDH annual HEDIS performance measures have been certified reportable by an NCQA HEDIS audit.

12. Other areas by mutual agreement.

¹⁴ Families and Children, Seniors and SNBC Contract Section 7.1.2

¹⁵ 42 C.F.R. §438.242

Appendix D

Proposed Evaluation for Section 1115 Demonstration Waiver Extension

The state of Minnesota has provided care to eligible individuals under a Section 1115 Demonstration Waiver for many years. One of the primary components of the waiver has been approval of the MinnesotaCare program for people above Medicaid income levels with components that differ from state plan eligibility and coverage.

This proposed evaluation plan relates to the demonstration period January 1, 2014 through December 31, 2014. The proposed hypotheses were first submitted to CMS on August 9, 2013 as part of the waiver renewal request. Minnesota has received no comments from CMS on the proposed hypotheses.

During this demonstration period, the primary purpose of the demonstration was to continue to provide cost-effective and comprehensive health insurance coverage to people with family incomes above Medicaid state plan income levels.

1. Background on the PMAP+ Section 1115 Waiver

Minnesota has long been known for its low rates of uninsurance, high quality of care, mature managed care environment, and generous publicly funded health care programs.

Minnesota began using demonstration authority to purchase coverage for people served in the Medicaid program (Medical Assistance or MA) from health plans on a prepaid capitated basis long before managed care became an option under the state plan. Enrollees began receiving services from health plans under the first Prepaid Medical Assistance Project (PMAP) Section 1115 Demonstration in July of 1985, almost thirty years ago. The project required that nondisabled MA recipients be enrolled with a health plan, and remain enrolled with that plan for a 12-month period. PMAP was originally limited to a few Minnesota counties.

In April 1995, HCFA approved a statewide health care reform amendment to the PMAP waiver. Generally, this amendment, known as Phase I, allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 FPG into the Medicaid Program. An amendment approved in February 1999 expanded the program to include parents enrolled in MinnesotaCare.

In March 1997, the state proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that HCFA authorize a second phase of provisions that had been enacted by the Minnesota Legislature. On August 22, 2000, HCFA approved most aspects of Minnesota's Phase 2 amendment request, known as the PMAP+

waiver. Some important components of this waiver amendment allowed for administrative simplification and mandatory enrollment of certain MA populations in managed care.

With promulgation of the BBA managed care regulations in 2002, states were able to implement through their state plans many provisions that were previously only permitted under a section 1115 waiver. Minnesota has taken advantage of this option, and now provides prepaid managed care coverage to infants, children, pregnant women and parents via the state plan.

In March of 2011, Minnesota included nondisabled adults without dependent children with family incomes at or below 75 percent FPG in its state plan for the first time under new authority granted by the Affordable Care Act. Effective August 1, 2011, Minnesota was also granted authority to cover MinnesotaCare adults without dependent children with family incomes above 75 and at or below 250 percent of the FPG as an expansion population under the PMAP+ waiver.

In January of 2014, many provisions of the Affordable Care Act were implemented, and the waiver was changed significantly to reflect the expansion of eligibility in Minnesota's Medicaid program and to reflect legislative intent that the 2014 MinnesotaCare program act as a bridge to 2015, when the federal Centers for Medicare & Medicaid Services (CMS) will implement the basic health plan (BHP) option. During 2014, the waiver continued to support Minnesota's longstanding policy of providing affordable and comprehensive health insurance for working families.

2. The PMAP+ § 1115 waiver for the period January 1, 2014 through December 31, 2014

In 2014, the Affordable Care Act made federal tax credits and cost sharing subsidies available to families to help purchase private insurance through MNsure, Minnesota's health insurance exchange. For lower-income families, however, that financial assistance may not be enough to purchase coverage comparable to what is available today through MinnesotaCare. Therefore, Minnesota continued MinnesotaCare under the PMAP+ demonstration to ensure the stability of health coverage for low-income working families and adults. The coverage offered minimizes out-of-pocket expenses for health care for people with incomes just above Medicaid levels, and provides comprehensive benefits to meet people's needs.

The 2014 waiver makes coverage available to 19- and 20-year olds and adults with incomes between 133% and 200% of the federal poverty level, providing a more generous benefit set and lower cost sharing than people at these income levels are likely to be able to purchase with federal tax credits through MNsure. The 2014 demonstration also reflects the new "bright line" policy separating MinnesotaCare from Medical Assistance. In addition, the demonstration allows Minnesota to provide coverage to additional groups during the interim year that Congress included in the BHP: children who are barred from Medicaid due to Medicaid income methodologies; and adults and children who would not otherwise qualify for MinnesotaCare

using Medicaid income methodologies but would be eligible under Marketplace income methodologies. Finally, the 2014 demonstration also continues to provide important authorities for Minnesota's Medicaid program such as streamlining benefit sets for pregnant women, authorization of medical education funding, preserving eligibility methods currently in use for children ages 12 to 23 months, simplifying the definition of a parent or caretaker to include people living with child(ren) under age 19, and allowing mandatory enrollment of certain populations in managed care.

Summary of changes occurring between 2013 and 2014:

- Beginning January 1, 2014, a “bright line” is established between MinnesotaCare and Medical Assistance or MA. People who are eligible for MA must enroll in MA rather than MinnesotaCare. This ensures that people who are eligible for MA receive the most generous coverage they are entitled to receive.
- With more generous eligibility standards for Medical Assistance in 2014, MinnesotaCare coverage is no longer needed for certain groups. For example:
 - MinnesotaCare no longer covers adults, parents and 19-20 year olds with incomes below 133% of the FPL because these groups are enrolled in MA. In 2013, adults, parents and 19-20 year olds may be eligible for MA if they have family incomes at or below 100% of the Federal Poverty Level or FPL. In 2014, this was expanded to 133% of the FPL.
 - Pregnant women and children under age 19 with family incomes at or below 275% of the FPL were enrolled in MinnesotaCare in 2013, but were transitioned to MA in 2014. Certain children under age 19 may enroll in MinnesotaCare if they are ineligible for MA but they have family incomes at or below 200% FPL using Marketplace household composition rules.
 - In 2014, MinnesotaCare covers parents, adults and 19-20 year olds with family incomes up to 200% FPL instead of 250% or 275% FPL to align eligibility standards with requirements in the Affordable Care Act for Basic Health Plans. This change is designed to minimize disruption with the transition to a Basic Health Plan in 2015.
- In 2014, MinnesotaCare benefits for certain adults were increased to conform to benefits requirements in the Affordable Care Act and to minimize disruption with the transition to a Basic Health Plan in 2015. As before, MinnesotaCare enrollees under age 21 receive the full MA benefit set and pay MA copays.
 - Benefits: For adults without children, the \$10,000 cap on inpatient hospital services is eliminated.

- Cost-sharing: For adults without children, the 10% co-pay on inpatient hospital services is eliminated.
- Reduced premiums. Premiums are reduced for adult in MinnesotaCare. Enrollees under age 21 pay no premium.
- Certain MinnesotaCare eligibility rules have changed in 2014 to align with requirements in the Affordable Care Act.
 - MinnesotaCare no longer has an asset test.
 - Affordable Care Act income calculation methods are used to determine eligibility.
 - The 4-month and 18-month eligibility waiting periods are eliminated.
 - MinnesotaCare coverage may begin while an individual is hospitalized.
 - Individuals who are eligible for minimum essential coverage are not eligible for MinnesotaCare.
 - Eligibility for certain special populations (volunteer firefighters, former foster care children) is eliminated. (Former foster care children are covered under MA).
- In 2014, MinnesotaCare eligibility was expanded to include groups that are expected to be covered by the Basic Health Plan in 2015 so that these groups would experience fewer coverage transitions.
 - MinnesotaCare provides coverage for children under [age 19](#) who are not eligible for MA under MA household composition rules but who have family incomes at or below 200% FPL using different household composition rules.
 - MinnesotaCare provides coverage for adults who would not have family incomes at or below 200% FPL using Medicaid income calculation rules, but would have incomes at or below 200% FPL using income calculation rules that will apply under the Basic Health Plan

3. Evaluation Strategy

A. Demonstration Goals, Hypotheses and Objectives

Under the demonstration Minnesota seeks to reduce the proportion of uninsured and provide better coverage and better value for those who are participating in the program as compared to people who are not covered under Medicaid expansion. The evaluation will compare coverage levels under Medicaid expansion (MinnesotaCare) and Affordable Care Act Marketplace (MNSure). The demonstration also seeks to provide comparable access and quality of prevention and chronic disease care to the waiver populations as

compared to Minnesota's non-waiver Medicaid populations. The objective is to demonstrate that access, quality of care and enrollee satisfaction is maintained under the demonstration and is comparable to care provided to non-waiver Medicaid enrollees.

The goals and hypotheses that will be tested during the evaluation period are summarized below:

Goal 1: Provide Better Coverage for Insured. Provide better health insurance coverage to Minnesotans at MinnesotaCare income levels than they might otherwise select through MNSure.

- **Objective:** Increase the proportion of Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance as compared with the Minnesotans at 200-250% FPL on MNSure.
- **Measurement:**
 - Categorize MinnesotaCare waiver benefits, cost-sharing and premiums, and that of plans available through MNSure, to determine comparative levels of coverage comprehensiveness.
 - Determine the proportions of people receiving coverage through MNSure with incomes 200-250% FPL who are enrolled in bronze, silver, gold and platinum level plans.
 - Determine the proportion of people at incomes of 200-250% FPL enrolled through MNSure who have benefit sets just as or more comprehensive than the benefit set of the waiver group.
- **Hypothesis:** Minnesotans in the waiver group will have more comprehensive coverage and lower cost-sharing than they would likely have otherwise chosen through Minnesota's health insurance exchange, MNSure, assuming their choices would be similar to those Minnesotans purchasing coverage through MNSure with incomes between 200 and 250% FPL.
- **Data Source:** MNSure eligibility data.

Goal 2: Value. Provide more comprehensive health insurance coverage for Minnesotans at MinnesotaCare income levels at competitive rates, taking into consideration enrollee cost sharing, federal and state expenditures.

- **Objective:** Provide Minnesotans over 18 at 133-200% FPL with comprehensive health insurance in a cost effective manner.
- **Measurement:**
 - Compare MinnesotaCare benefits, cost-sharing and premiums to plans available through MNSure.

- Calculate premiums, cost-sharing and tax credit expenditures for purchase of MinnesotaCare-level coverage via MNsure for people at incomes of 200-250% FPL, by level of coverage (bronze, silver, gold and platinum).
- **Hypothesis:** Combined federal and state per capita spending on the waiver group and average enrollee cost sharing will be equal to or less than spending and cost sharing for Minnesotans at the 200-250 % FPL income level enrolled through MNsure if they to choose benefit coverage similar to what the waiver group will receive.
- **Data Source:** MNsure eligibility data; state and federal expenditure data on waiver group; CMS data on cost-sharing settle-ups.

Goal 3: Improve the Quality of Care. Provide quality health care that has comparable access, prevention and chronic disease care for all public program child and adult populations.

- **Objectives:** Improve:
 - Utilization of preventative services for children (childhood immunizations, child access to PCP, annual dental visits, and well-child visits)
 - Utilization of preventative and chronic disease care services for adults (diabetes care, depression management, adult preventive visits, cervical cancer screening and dental visits)
 - Enrollee satisfaction with the delivery and quality of services (satisfaction survey results)
- **Measurement:** Compare waiver and non-waiver Medicaid enrollees using selected HEDIS 2015 and other performance measures of utilization, preventive and chronic disease care, physical and mental health services, and satisfaction with managed care services to compare, contrast and draw out differences between the populations.
- **Hypothesis:** Providing health care coverage to child and adult populations who would otherwise be uninsured will result in improved outcomes:
- **Data Source:** MCO submitted encounter data.

B. Evaluation Populations

Waiver Evaluation populations will consist of the following subgroups:

1. Medical Assistance One Year Olds. Children enrolled in F&C MA with no spend down, 12-23 months and family incomes 133-275 FPG.
2. MinnesotaCare Children age 19 and 20 years old. 133-200% FPL.
3. MinnesotaCare Parents and Caretakers. Adults caring for children. 133-200% FPL
4. MinnesotaCare Adults without Children. Adults over 21 years without dependent children. 133-200% FPL.

Comparison Groups:

1. People enrolled via MNsure, 200-250% FPL
2. MA Children. Age 2-18 years children in MA with family incomes at or below 150% FPG.
3. MA Caretaker Adults. Adults caring for children with family incomes at or below 133% FPG.
4. Adults over 21 years without dependent children, and incomes at or below 75% FPG.

The benefit set offered to MinnesotaCare Children and MA One Year Olds is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid state plan, including all services that meet the definition of early and periodic screening, diagnostic, and treatment (EPSDT) found in section 1905(r) of the Act. The benefit offered to MinnesotaCare Caretaker Adults and MinnesotaCare Adults without Children is identical to the benefits offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (a) through (h) below are excluded.

- a) Services included in an individual's education plan;
- b) Private duty nursing;
- c) Orthodontic services;
- d) Non-emergency medical transportation services;
- e) Personal Care Services;
- f) Targeted case management services (except mental health targeted case management);
- g) Nursing facility services; and
- h) ICF/MR services.

The 2011-2013 PMAP+ demonstration included MinnesotaCare Pregnant Women with incomes at or below 275% FPL. After January 1, 2014, this eligibility group is not included in MinnesotaCare. Pregnant women with incomes at or below 275% FPL were converted to Medical Assistance for coverage effective January 1, 2014.

- The 2011-2013 PMAP+ demonstration included MinnesotaCare Adults with incomes at or below 2500% FPL and MinnesotaCare Adult Caretakers with incomes at or below 275% FPL. After January 1, 2014, the MinnesotaCare demonstration included adult caretakers and adults with incomes above 133% and equal to or less than 200% FPL. Adults and Adult Caretakers with incomes at or below 133% FPL were converted to Medical Assistance for coverage effective January 1, 2014. Adult Caretakers with incomes above 200% FPL were notified of the opportunity to seek coverage via MNsure. MinnesotaCare Adults and Adults with Children with incomes above 133% and equal to or less than 200% FPL remained on MinnesotaCare. The increased benefits took effect on January 1, 2014 as outlined in the transition plan currently under discussion with CMS.

- The 2011-2013 PMAP+ demonstration included MinnesotaCare Children with incomes at or below 275% FPL. After January 1, 2014, the MinnesotaCare demonstration included MinnesotaCare Children ages 19-20 with incomes above 133% and equal to or less than 200%

FPL. Children ages 18 and under with incomes at or below 275% FPL were converted to Medical Assistance for coverage effective January 1, 2014, as were children ages 19 and 20 with incomes at or below 133% FPL. Children ages 19 and 20 with incomes over 200% FPL will be notified of the opportunity to seek coverage via MNsure. MinnesotaCare Children ages 19 and 20 with incomes above 133% and equal to or less than 200% FPL remained on MinnesotaCare, with state plan benefits and cost-sharing.

C. Evaluation Plan

Goals one and two will require examination and contrast MinnesotaCare and MNsure populations program attributes, MinnesotaCare and MNsure coverage plans and coverage patterns.

For goal three, a comparison and stratification of the selected HEDIS 2015 and other performance measures will be made between the waiver (MA and MinnesotaCare) populations and other public program managed care enrollees to show the ongoing improvement in care for all publicly funded program enrollees. Performance measurement rates for the baseline period (CYs 2011, 2012 and 2013) will be calculated for the targeted populations and compared to CY 2014. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass to compare performance of Minnesota's populations with national and other state's performance.

To demonstrate continued satisfaction with program level care and services, a review of historical and evaluation period adult CAHPS satisfaction information will be done to assess the domains of enrollee experiences.

E. Evaluation Metrics

1. Measures:

Calendar year 2014 will be graphically displayed to show rates and program attributes to assist in making comparisons between MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

The selected HEDIS 2015 performance measures will be used to evaluate the childhood prevention and adult chronic disease care management for the waiver population compared to Medicaid managed care enrollees. Performance measure data will be extracted from DHS' managed care encounter database in June the following year to allow for a sufficient encounter run-out period.

The table below provides a list of the annual HEDIS 2015 performance measures that will be analyzed in the evaluation.

Childhood Prevention (0-19 yrs.)
Childhood immunizations (2 yrs)
Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs)
Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs)
Well –child visits first 15 months
Well-child visits 3 to 6 yrs.
Adolescent well-care visits (12-19 yrs)
Adult Access
Adult access preventive/ambulatory health services
Annual Dental Visit
Adult Chronic Care Management
Comprehensive Diabetes Care
Cervical CA screening
Antidepressant Medication Management

The quality of managed care organization (MCO) encounters is essential to the validity of the evaluation. DHS contracts with a NCQA certified HEDIS auditor. The HEDIS auditor annually validates DHS produced performance measures are accurate and consistent with HEDIS Technical Specifications and 42 CFR 438.358(b)(2). An annual audit is consistent with federal protocol to ensure MCO-submitted encounter data are accurate and DHS produced performance measures follow HEDIS specifications.

The performance measures will be evaluated for period-to-period changes:

- Utilization of preventative and chronic disease care services for children. Analysis of trends/comparisons over the baseline/measurement period performance of the child waiver population and non-waiver child populations based on the following measures childhood immunizations, child access to PCP, annual dental visits, and well-child visits.
- Improved health and utilization of preventative and chronic disease care services for adults. Analysis of trends/comparisons over the baseline measurement period performance of the adult caretaker waiver population and non-waiver adult caretaker population by the diabetes screening, adult preventive visits, and cervical cancer screening measures.
- Enrollee satisfaction analysis and comparison of satisfaction survey results reflecting the enrollee's perspective on agreement with the delivery and quality of health care services. The DHS conducted annual CAHPS satisfaction survey access and quality care provided by MCOs of adults will be the information used.

2. Comparison Metrics between CYs 2011-2013 and CY 2014. The key factor that would limit the comparison metric is subpopulation size. Modification of the planned metrics may be needed based upon the initial data analytical step to determine subpopulation enrollment characteristics. Public program eligibility changes will also influence metric comparisons and would need to be assessed during the initial data analytical step.

3. Other Quality Performance Measures. As part of the performance measure and stratification evaluation step (June 2015), annual AHRQ ambulatory care sensitive conditions (ACSC) program level measures will be calculated to provide additional insight into the quality of care provided over the calendar years 2011 through 2014.

D. Design Approaches

4. Evaluation Implementation Strategy and Timeline

a. Summary of Evaluation Requirements in the Demonstration Special Terms and Conditions

Paragraph 65 of the Special Terms and Conditions includes the following requirements regarding the evaluation design for the demonstration:

1. A discussion of the demonstration goals and objectives, as well as the specific hypotheses that are being tested.
2. A discussion of the outcome measures that will be used to evaluate the impact of the demonstration during this extension period.
3. A discussion of the data sources and sampling methodology for assessing the outcomes.
4. A detailed analysis plan that describes how the effects of the demonstration will be isolated from other initiatives occurring in the State.

D. Evaluation Design

a. Management and Coordination of the Evaluation

The Minnesota Department of Human Services (DHS), Health Care Research and Quality Division will conduct the waiver evaluation and review results over the second half of calendar year 2015, with the final report submitted to CMS by the end of 2015. Below is an overview of evaluation activities and timeline:

- May 2015 DHS will calculate measurement rates for goals one and two.
- June 2015 DHS staff will review and evaluate goal rates and drawn conclusions.
- July 2015 DHS will calculate and stratify HEDIS 2015 performance measures. As CMS is aware, HEDIS based measures are annually calculated each June and more frequent reporting is inefficient utilization of State resources.

- July –August 2015 HEDIS and CAHPS results will be reviewed and results evaluated.
- September-October 2015 Draft and final waiver report is written, reviewed and approved.
- December 2015 Final report is submitted to CMS.

**Waiver Evaluation Process Steps Timeline
CY 2015**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CAHPS Data Collection		X	X	X	X	X						
CAHPS Data Analysis							X	X				
Goal 1 and 2 Data collection					X							
Goal 1 and 2 Results Analysis						X	X					
Performance Measures Validation			X	X	X	X						
Performance Measures Calculation & Stratification							X					
Performance Measure Analysis							X	X				
Draft Report									X	X		
Final Report & Approval											X	X

- June through August 2013 - Calendar years 2009 through 2012 HEDIS rates are calculated and performance measure validation process completed. The calculation of annual HEDIS based performance measurement process starts each June for the current measurement year and the previous three years. The previous three year of rates provide comparisons calculated using the same set of technical specifications. More frequent calculation of annual HEDIS measures is inappropriate and an inefficient utilization of State resources.
- September through December 2013- an analysis of the rates is conducted
- January through March 2014 - The draft and final waiver report is written, reviewed and approved
- May 1, 2014- Final report is submitted to CMS.

b. Integration of the Quality Improvement Strategy

Compliance, oversight and improvement activities for all Minnesota managed health care programs are conducted in a comprehensive manner across all managed care programs. These activities are not segregated according to the waiver. Annually, DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCOs' compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, imposes

corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the Annual Technical Report (ATR). Since 2004, the ATR is the most comprehensive evaluation of quality, access and timeliness of Minnesota's health care programs.

The DHS Quality Strategy provides a high level plan for monitoring, overseeing and assessment of the quality and appropriateness of care and service provided by MCOs for all managed care contracts, programs and enrollees including those covered under the PMAP + 1115 Waiver. The Quality Strategy incorporates elements of current managed care organization contract requirements, state licensing requirements, and federal Medicaid managed care regulations. The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) is the core of DHS' responsibility to ensure the delivery of quality care and services in publicly funded managed health care programs. Annually, DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The Quality Strategy and related documents are posted on the Minnesota DHS web site at: www.dhs.state.mn.us/managedcarereporting.

Because of the comprehensive nature of the state's Quality Strategy and its applicability across all of Minnesota's publicly funded managed health care programs, elements of this strategy are continuously applied to monitor and improve quality, access and timeliness of services for demonstration enrollees. Therefore, while not formally incorporated in the evaluation, these activities further the goals of the demonstration. These activities also simplify some PMAP+ waiver-related reporting, such as monitoring of grievances and appeals for the quarterly reports. Where possible, DHS will seek opportunities to design and implement these activities in coordination with PMAP+ waiver-related reporting and evaluation.

c. Limitations and Opportunities

The following limitations may impact the results of this evaluation:

- Unexpected consequences due to changes in state law regarding public programs.
- Future changes to HEDIS Technical Specifications influence future coding or data reporting that would bias this type of longitudinal analysis. If these types of changes occur the biases and potential consequences will be reported in the final report limitation section. Changes that will result from transiting from ICD-9 to ICD-10 codes are not expected to have an impact.
- Measures with high rates may show only small changes or remain stable over time.
- The HEDIS Technical Specification criteria of continuous enrollment, while reducing the population included in the measure offers a simple methodological adjustment that allows a straightforward comparison. The HEDIS methodology is critical for the evaluation's longitudinal design, providing the opportunity to retrospectively identify factors that may seem insignificant, but became important with the passage of time. These types of relationships will be considered during the analysis to provide a deeper understanding of the

motivational forces behind the complex relationships of how enrollees utilize and value prevention and chronic health care services.

d. Conclusion, Best Practices, and Recommendations

The final evaluation report will discuss the principle conclusions and lessons learned based upon the findings of the evaluation and current program and policy issues. The discussion will also include a review of any changes in enrollee satisfaction as measured by the annual CAHPS and disenrollment surveys conducted before and during the waiver period. A discussion of recommendations for potential action to be taken by DHS to improve health care services in terms of quality, access and timeliness will be provided for CMS and other states with similar demonstration waivers.

Appendix E

Proposed Evaluation for Reform 2020

Section 1115 Demonstration Waiver

This is a proposed evaluation plan for the Minnesota's demonstration waiver entitled Reform 2020: Pathways to Independence. It was approved in October of 2013.

The state's Medicaid program, known as Medical Assistance (MA), offers an array of home and community-based waiver services for low-income seniors and people with disabilities.

Minnesota has been reducing use of institutions through development of home and community-based long-term supports and services for over thirty years. Minnesota has rebalanced its system so that a large majority of the seniors (61% in 2010) and people with disabilities (94% in 2010) enrolled in MA who need long term care services are living in the community rather than in an institutional setting.

Minnesota covers the following long-term services and supports through the state plan: home health agency services, private duty nursing services, rehabilitative services (several individualized community mental health services that support recovery) and personal care assistant (PCA) services.

The PCA program has played a critical role in supporting people in their homes and avoiding institutional care, and has been important to rebalancing the system. The service was designed in the late 1970's to support adults with physical disabilities to live independently in the community. Over time, the Legislature expanded PCA as a cost-effective option to support people of all ages with physical, cognitive and behavioral needs. PCA services are available to people based on functional need, without enrollment limits or waiting lists. PCA services help people who need assistance with activities of daily living (bathing, dressing, eating, transferring, toileting, mobility, grooming, positioning) or independent activities of daily living (e.g. cooking, cleaning, laundry, shopping). The PCA program grew from 200 participants in 1986 to over 30,000 currently. In 2009, the Legislature authorized changes to the PCA program to manage costs, which resulted in changes in authorized levels of services for many people, both increases and reductions, and loss of access to one hundred and seventy people. At times, in an effort to get a specific service (such as special equipment or modifications to their home) or additional supports beyond traditional PCA services, those using PCA services have accessed one of the HCBS waivers (e.g. Developmental Disabilities or Elderly Waiver).

Minnesota has five home and community-based services waivers: Developmental Disability (DD)¹, Community Alternatives for Disabled Individuals (CADI)², Community Alternative Care (CAC)³, Brain Injury (BI)⁴ and Elderly Waiver (EW)⁵. Similar services to support individuals living in the community are offered under each waiver, but since each was developed over time,

¹ 2011 unduplicated enrollment: 15,761

² 2011 unduplicated enrollment: 18,927 (reflects high turnover rate)

³ 2011 unduplicated enrollment: 390

⁴ 2011 unduplicated enrollment: 1,513

⁵ 2011 unduplicated enrollment: 29,291 (managed care and FFS)

under different constraints and opportunities and for different populations, they differ from one another in areas such as eligibility criteria and annual spending.

There are other Medicaid and state programs that support community living such as day treatment and habilitation, semi-independent living services, the Family Support Grant Program, mental health services, AIDS assistance programs, group residential housing, independent living services, vocational rehabilitation services, extended employment, special education and early intervention.

Minnesota's Reform 2020 demonstration enables the state to continue its history of on-going improvement to enhance its home and community-based service system in two ways. First, the demonstration allows the state to provide preventive services to seniors who are likely to become eligible for Medicaid and who need an institutional level of care. Second, the demonstration supports the state's efforts to reform the personal care benefit.

1. Background on the Reform 2020 Section 1115 Waiver

The Reform 2020 demonstration waiver is approved for the period October 18, 2013 through June 30, 2018. The demonstration is made up of two programs known as Alternative Care and Community First Services and Supports.

The Alternative Care or AC program was implemented under Reform 2020 beginning November 1, 2013. Formerly a state-funded program, Alternative Care provides home and community-based services to people ages 65 and older who need a nursing facility level of care, who have combined adjusted income and assets exceeding Medical Assistance (MA) standards for aged, blind and disabled categorical eligibility, but whose income and assets would be insufficient to pay for 135 days of nursing facility care. Acute care benefits are not covered under the program. Connecting seniors with community services earlier will divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established. Minnesota has a home and community-based waiver for people over age 65 that need nursing facility care called the Elderly Waiver. Although Alternative Care covers fewer benefits, service definitions and provider standards for the Alternative Care program are the same as the service definitions and provider standards specified in Minnesota's federally approved Elderly Waiver. Services are provided by qualified enrolled Medicaid providers.

The Reform 2020 demonstration also supports Minnesota's efforts to redesign the state plan PCA benefit and expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after Community First Choice. It will reduce pressure on the system as people use the flexibility within CFSS instead of accessing the more expanded service menu of one of the state's five home and community-based waivers to meet their needs.

The new CFSS benefit will replace the existing PCA benefit. To ensure continuity of care and safety of enrollees, Minnesota must ensure that implementation of the consumer-directed option does not restrict eligibility for these services. Minnesota is currently negotiating with CMS to obtain authority for the CFSS benefit under state plan amendments utilizing sections 1915(i) and 1915(k) of the Social Security Act. Once these state plan amendments are approved, Reform

2020 will provide authority to provide CFSS to two groups of people who would otherwise be ineligible to receive CFSS.

Minnesota is committed to implementing CFSS because all services should be designed in a way that is person-centered, and involves the person throughout planning and service delivery. The term self-direction in this context refers to a service model with increased flexibility and responsibility for directing and managing services and supports, including hiring and managing direct care staff to meet needs and achieve outcomes. Currently each of Minnesota's home and community-based waivers offers Consumer Directed Community Services and Supports (CDCS)⁶. This service option gives individuals receiving waiver services an option to develop a plan for the delivery of their waiver services within an individual budget, and purchase them through a fiscal support entity that manages payroll, taxes, insurance, and other employer-related tasks as assigned by the individual. CDCS allows individuals to substitute individualized services for what is otherwise available in the traditional menu of services in the waiver programs. Purchases fall into three categories: personal assistance, environmental modifications, and treatment and training.

In addition to CDCS, other existing self-directed options include PCA Choice option within the state plan PCA program, the Consumer Support Grant and the Family Support Grant. In PCA Choice the participant works with an agency, but can select, train and terminate the person delivering the service. Direct staff wages are typically higher under PCA Choice. The Consumer Support Grant is a state-funded program that provides individuals otherwise eligible for home care services to receive and control a budget for buying the supports they need to remain in the community. The family Support Grant program provides state-funded grants to families caring for a child with a disability.

2. Alternative Care

The Reform 2020 waiver allows Minnesota to receive federal financial participation to provide Alternative Care services to people over age 65 whose functional needs indicate eligibility for nursing facility care but have combined adjusted income and assets exceeding state plan standards for aged, blind and disabled categorical eligibility. To be eligible, combined income and assets must be insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate. The applicant must not be within an uncompensated transfer penalty period, and home equity must be within the home equity limit applicable under the state plan. Functional eligibility for nursing home care and identification of needed services for Alternative Care is performed using the Long-term Care Consultation process, which is the same assessment tool and process that is used for the Elderly Waiver. Applicants for Alternative Care also discuss the option of qualifying for Medical Assistance under a medically needy basis.

The Alternative Care program provides an array of home and community-based services based on assessed need and as authorized in the community support plan or care plan developed for each beneficiary. The monthly cost of the Alternative Care services must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs

⁶ As of March 31, 2011 recipients using CDCS by waiver: BI – 53; CAC – 139; CADI – 1167; DD – 1689

participating in the Elderly Waiver program. The benefits available under Alternative Care are the same as the benefits covered under the federally approved Elderly Waiver, except that Alternative Care covers nutrition services and discretionary benefits, and Alternative Care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits that meet primary and acute health care needs. Alternative Care benefits include:

- Adult day service/adult day service bath;
- Family caregiver training and education and family caregiver coaching and counseling/assessment;
- Case management and conversion case management;
- Chore services;
- Companion services;
- Consumer-directed community supports;
- Home health services;
- Home-delivered meals;
- Homemaker services;
- Environmental accessibility adaptations;
- Nutrition services;
- Personal care;
- Respite care;
- Skilled nursing and private duty nursing;
- Specialized equipment and supplies including Personal Emergency Response System (PERS); and,
- Non-medical transportation.
- Tele-home care

3. Community First Services and Supports

Community First Services and Supports or CFSS is designed to replace the existing personal care assistance benefit with a consumer-driven and flexible benefit that will allow consumers to better direct their own care and access the services they need when they need them. This service, designed to maintain and increase independence, will be modeled after the Community First Choice option.

While PCA services work well for many people, they are limited for others by only providing services that are doing “for” people in situations when individuals could learn to do more for themselves. In those cases PCA provides some support but less optimally than possible. The same is true in situations where technology or a home modification would enable a person to do more for her or himself, and may be able to substitute for a level of human assistance, but these services are only available today through the waivers.

Some people in these situations will apply for home and community-based waiver services in order to access technology, modifications or more flexible services, triggering an administrative

process to enroll. Some people need these services, but cannot access the waiver when they need it, either because they do not meet the institutional level of care (LOC) requirements, or because there are delays in accessing waiver services due to limits set to manage growth.

In some cases, PCA services alone do not adequately address individual needs because the service is not delivered by the provider with the appropriate skills, or the service isn't the right service to address core needs. For example, while PCA services can provide redirection and assistance when a person has significant behaviors, such as physical aggression to self or others or destruction of property, they do not deal with the underlying issues nor are they intended to substitute for appropriate services to address the cause of the behavior. To be most effective in these instances, the PCA services need to be provided in coordination with mental and behavioral health, and/or educational plans.

A limitation of the current system is that home and community-based services waivers are organized as alternatives to institutional care and are tied to an assessed need for an institutional level of care. We know, however, that there are services which, if provided before a person reaches a certain level of care threshold, could increase that person's ability to be independent, stay in the community and avoid or delay reliance on more intensive services.

There are people who are eligible but do not get connected with the appropriate service and others who are accessing many services across multiple systems that are not well coordinated. Both of these situations can result in poor outcomes such as unstable housing, high medical costs, frequent crises, provider time spent in planning, re-planning and crisis management, and institutionalization.

Data analysis shows that approximately ten percent of people currently using PCA services utilize a variety of other systems and services that, when not well coordinated, result in fragmented, duplicative and/or inappropriate services, including use of more expensive services such as emergency departments and hospitalizations, and lead to poorer outcomes. Similarly, data shows that people who have high costs for avoidable services are often people who touch the system at many points or have multiple needs. CFSS would allow people to access more useful services tailored to their needs.

Implementation of the new CFSS benefit is an important next step in Minnesota's efforts to enhance Minnesota's home and community-based service system to support inclusive community living. In order to meet rapidly growing demands, the system must be efficient and effective in supporting people's independence, recovery and community participation. CFSS is a flexible service designed to meet more needs, more appropriately, for more people. This more flexible service may reduce pressure on the system as people use CFSS instead of accessing the more expanded service menu of one of the State's five existing HCBS waivers.

3.1 Eligibility for CFSS

The Reform 2020 waiver allows Minnesota to receive federal financial participation to provide CFSS services to the following eligibility groups:

- 1) 1915(i)-like CFSS recipients: People eligible for MA with incomes above 150% of the federal poverty level and at or below the relevant state plan limit for categorical eligibility. These individuals meet the personal care assistance criteria. This means they have an assessed need for assistance with at least one activity of daily living or demonstrate physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person. Demonstration waiver authority is necessary for this group because they do not meet the Medicaid financial eligibility criteria to be eligible for the Section 1915(i) state plan benefit. They do not meet an institutional level of care for a NF, ICF-ID or hospital; and are categorically eligible for Medical Assistance;
- 2) 1915(k)-like CFSS recipients: In order to encourage utilization of CFSS instead of home and community-based services where appropriate, Minnesota has been granted authority to extend Medicaid eligibility to this group. This group is made up of people who have chosen CFSS services in lieu of home and community-based waiver services but who are financially eligible for Medical Assistance only if they utilize the eligibility rules of one of Minnesota's home and community-based waivers. This group must have incomes above a Medicaid state plan standard, meet all non-financial eligibility factors for eligibility for a home and community-based waiver, and qualify for Medicaid using the rules of the special home and community-based waiver group under 42 CFR §435.217. These individuals must need an institutional level of care and meet the personal care criteria, which means they have an assessed need for assistance with at least one activity of daily living or demonstrate physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person. This group includes people who are
 - a. Age 65 or over and eligible without a spend-down with income at or below 300% of SSI and spousal impoverishment rules;
 - b. Disabled, under age 65 and above age 20, and eligible without a spend-down with income at or below the relevant state plan standard with special institutional rules including an exemption from spousal deeming; or
 - c. Children under age 21 using eligible using special institutional rules including exemption from parental deeming.

3.2 The CFSS Benefit

Community First Services and Supports provides assistance with maintenance, enhancement or acquisition of skills to complete ADLs, IADLs, health-related tasks and back -up systems to assure continuity of services and supports. The CFSS benefit is based on assessed functional needs for people who require support to live in the community.

The form that this assistance takes can vary widely and is driven by and tailored to the needs of the individual, based on a person-centered assessment and planning process. The participant receives a budget, based upon the assessed needs, and can use that budget to purchase CFSS.

3.21 How much CFSS a person receives is determined by the person-centered assessment

The amount of CFSS is determined by the person-centered assessment conducted by a certified assessor. This assessment is very similar to the one currently being utilized for the personal care benefit, except that it allows a higher base level of services for the lowest need individuals. Just as is done now with personal care services, the amount of CFSS authorized will be based on the participant's home care rating, which is determined in the course of the assessment.

The home care rating is determined by identifying the total number of dependencies of activities of daily living (ADL's) that require hands-on assistance and/or constant supervision and cueing; the presence of complex health-related needs; and the presence of Level I behaviors, (meaning physical aggression towards self or others and/or destruction of property that requires the immediate response of another person). The number of units available to each person is assigned based on the number and severity of ADLs, complex health-related needs and Level I behaviors identified in the assessment.

3.22 CFSS service delivery models

Two different self-directed service delivery methods are available to people utilizing CFSS. These delivery methods are known as the agency-provider model and the budget model.

The agency-provider model is available to participants who choose to receive their services from support workers who are employed by an agency-provider that is enrolled as a provider with the state. Participants retain the ability to have a significant role in the selection and dismissal of the support workers who deliver the services and supports specified in their person-centered service delivery plan. A participant using goods and supports under the agency-provider model shall use a financial management services contractor for management of spending; recordkeeping; monitoring and billing. The participant will continue to have their support worker services delivered by an agency-provider. The participant and the consultation services provider shall develop a service delivery plan that specifies the services and funds to be authorized to the agency-provider, and the goods, supports and funds to be managed in by the participant with the financial management services contractor.

Under the budget model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers, and obtain other supports and goods as defined in the service package. Participants will use a financial management services contractor for the billing and payment of services; for ensuring

accountability of CFSS funds; for management of spending; and to serve as an agent to maintain compliance with employer-related duties, including federal and state labor and tax regulations. Participants may utilize the consultation service for assistance in developing a person-centered service delivery plan and budget; and for learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers.

Worker training and development services include a variety of services that assist participants under either model with developing support worker skills. These services may be provided or arranged by the employer of the support worker and consist of training, education, direct observation, evaluation, or consultation to direct support workers regarding job skills, tasks, and performance as required for the delivery of quality service to the participant.

3.23 Services that may be accessed under the CFSS benefit

Under the personal care assistance benefit, people receive assistance with ADLs, IADLs, and health-related tasks. CFSS participants have a much wider variety of services to choose from. CFSS participants may utilize any or all of the following services to meet needs and goals identified in the person-centered assessment:

- **Assistance with ADLs, IADLs, and health-related tasks** through hands-on assistance, supervision, and/or cueing.
- **Acquisition, maintenance, or enhancement of skills** necessary for the participant to accomplish ADLs, IADL's, and health-related tasks.
- **Assistance in accomplishing instrumental activities of daily living (IADLs)** related to living independently in the community and an assessed need: meal planning, preparation, and shopping for food; shopping for clothing or other essential items; cooking; laundry; housecleaning; assistance with medications; assistance with managing money; assist with individualized communication needs; arranging supports; assistance with participating in the community; and other appropriate IADL services.
- **Assistance in health-related procedures and tasks** that can be delegated or assigned by licensed health-care professionals under state law.
- **Observation and redirection of Level I behaviors**, defined as physical aggression towards self or others and/or destruction of property that requires the immediate response of another person.
- **Back-up systems** or mechanisms (such as the use of personal response systems or other mobile devices selected by the participant) to ensure continuity of the participant's services and supports. Specific risks and levels of back-up support needed are addressed during the participant's initial and annual person-centered assessments, in the development of the community support plan and the service delivery plan. Each

participant will have an individualized back-up plan that identifies service options and support people, both formal and informal, that can be called on when needed.

- **Consultation services** provide assistance to support the participant in making informed choices regarding CFSS services in general and self-directed tasks in particular; eliminate barriers to services and streamlines access; assist the person in developing a quality person centered service delivery plan, and offer support with compliance and quality outcomes. Consultation services provided to participants may include, but are not limited to: an orientation to CFSS, including assistance selecting a service model; assistance with the development, implementation, management and evaluation of the service delivery plan; assistance with recruiting, selecting, training, managing, directing, evaluating, supervising, and dismissing support workers; and facilitating the use of informal and community supports, goods or resources.
- **Worker training and development services** to enhance the support worker's skills as required by the participant's service delivery plan. Services provided to the direct support worker may include but are not limited to: training, education, direct observation, consultation, and performance evaluation.
- **Expenditures for environmental modifications, or goods**, including assistive technology. Such expenditures must relate to a need identified in a participant's CFSS community support plan; be priced at fair market value; increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed needs; and fit within the annual limit of the participant's approved service allocation or budget.
- **Financial management services** to provide payroll services for participants who choose the budget model.

CFSS does not cover:

- Services that do not meet a need identified in the person-centered assessment;
- Services that are not for the direct benefit of the participant;
- Health services provided and billed by a provider who is not an enrolled CFSS provider;
- CFSS provided by a participant's representative or paid legal guardian;
- Services that are used solely as a child care or babysitting service;
- Services provided by the residential or program license holder in a residence licensed for more than four persons;
- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;
- Sterile procedures;
- Giving of injections into veins, muscles, or skin;
- Homemaker services that are not an integral part of the assessed CFSS service;
- Home maintenance or chore services;
- Services that are not in the participant's service delivery plan;

- Home care services (including hospice if elected by participant) covered by Medicare or any other insurance held by the participant;
- Services to other members of the participant's household;
- Services not specified as covered under Medical Assistance as CFSS;
- Application of restraints or implementation of deprivation procedures;
- Person-centered assessments;
- Services provided in lieu of staffing required by law in a residential or child care setting;
- Services not authorized by the Department or the Department's designee;
- Services that are duplicative of other paid services in the written service delivery plan
- Services available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act;
- Any fees incurred by the participant, such as Minnesota Health Care Program fees and co-pays, legal fees, or costs related to advocate agencies;
- Insurance;
- Special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;
- Assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports;
- Medical supplies and equipment;
- Environmental modifications, except as specified in the State Plan
- Expenses for travel, lodging, or meals related to training the participant, the participant's representative, or legal representative;
- Experimental treatments;
- Any service or good covered by other Medical Assistance state plan services;
- Membership dues or costs, except when the service is necessary and appropriate to treat a health condition or to improve or maintain the participant's health condition. The condition must be identified in the participant's community support plan and monitored by a physician enrolled in a Minnesota health care program;
- Vacation expenses other than the cost of direct services;
- Vehicle maintenance or modifications not related to the disability, health condition, or physical need; and
- Tickets and related costs to attend sporting or other recreational or entertainment events.

4. Evaluation Strategy for Alternative Care

4.1 Demonstration Goals, Hypotheses and Objectives for Alternative Care

The objective of the evaluation is to demonstrate that access, quality of care and program sustainability for Alternative Care recipients is comparable to that of Elderly Waiver recipients.

4.11 Goal One: Access

Objective: Provide access to coverage of home and community-based services for individuals with combined adjusted income and assets that meet program requirements, are higher than Medicaid standards, and who require an institutional level of care.

Measurement: Comparison of assessment data for people enrolled in AC to people enrolled in the Elderly Waiver on Medicaid to measure number and percentage of recipients using Alternative Care by diagnosis groups and by case mix, as compared to Elderly Waiver.

Evaluation Question: How do the trends we see in the population served under the AC waiver compare with similar participants in the EW population, especially in terms of level of need?

Hypothesis: As compared with Elderly Waiver, the Alternative Care program serves individuals with similar levels of need for institutional care and equally complex diagnoses, demonstrating that the program meets a defined need.

Data Sources: MMIS claims, assessment and support planning data.

4.12 Goal Two: Quality

Objective: Provide improved access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets that meet program requirements, are higher than Medicaid standards, and who require an institutional level of care.

Measurement: Comparison over time within Alternative Care program of the number and percent of individuals receiving consumer-directed community supports, the units of consumer-directed community supports, and dollars paid for consumer-directed community supports.

Evaluation Question: Are AC recipients able to access and use consumer-directed services at a higher rate than previously observed?

Hypothesis: Over time, an increasing proportion of AC participants will be using consumer-directed service options.

Data Sources: MMIS claims data.

4.13 Goal Three: Sustainability

Objective: Provide high-quality and cost-effective home and community-based services in Alternative Care that results in improved outcomes for participants measured by nursing home use over time.

Measurement: Comparison over time of the proportion of Alternative Care participants admitted to nursing homes, examining the amount and frequency of use. Examination of the change in average service cost of Alternative Care participants as they move to the Elderly Waiver or into nursing homes.

Evaluation Question: Does the AC program support a continued decrease in the rate of AC eligible clients entering nursing facilities or experiencing other negative health outcomes?

Hypothesis: Over time, a decreasing proportion of Alternative Care participants will exit the program to nursing homes, and the number of people entering Alternative Care from the nursing home will increase.

Data Sources: MMIS claims data.

4.2 Evaluation Populations for Alternative Care

The populations included in the evaluation consist of the Alternative Care program enrollees and Elderly Waiver enrollees. Elderly Waiver enrollees are very similar to Alternative Care program enrollees. Both groups are aged 65 and above, both groups must have an assessed need for an institutional level of care, and both groups are using home and community-based services to meet their needs and remain living in the community instead of in a nursing facility.

4.3 Evaluation Metrics for Alternative Care

Please see the “Measurement” paragraph under each of the goals listed in section 4.1 as well as the chart in section 4.41.

4.4 Plan for Analysis of Alternative Care

4.41 Maintenance of comparable access, quality and satisfaction across waiver and state plan populations

The goals and associated metrics identified in section 4.1 will be evaluated by DHS using MMIS claims and assessment data. It is appropriate for DHS to conduct this component of the evaluation using readily available data sources as part of its ongoing quality monitoring and management activities.

Overview of Populations, Measures and Years

Waiver Populations	Comparison Populations	Measures	Data Source
AC recipients	EW recipients	% of AC applicants who meet LOC criteria over time, compared with EW	Assessments; Screening Documents
AC recipients, post-waiver	AC recipients, pre-waiver and trend over time	Change in the # & % of recipients receiving consumer-directed community supports over time	MMIS Claims
AC recipients, post-waiver	AC recipients, pre-waiver and trend over time	Change in the # & % of units paid for consumer-directed community supports over time	MMIS Claims
AC recipients, post-waiver	AC recipients, pre-waiver and trend over time	Change in the # & % of dollars paid for consumer-directed community supports over time	MMIS Claims
AC recipients, post-waiver	AC recipients, pre-waiver and trend over time	% of AC participants using consumer-directed service models over time	MMIS Claims
AC recipients, post-waiver	AC recipients, pre-waiver and trend over time	% of AC participants admitted to nursing homes during the year by amount and frequency of use over time	Screening documents; MDS
AC recipients, post-waiver	AC recipients, pre-waiver and trend over time	# of AC participants who moved from nursing homes onto the AC program over time	Screening documents; MDS
AC recipients, post-waiver	AC recipients, pre-waiver and trend over time	Change in the overall average service cost of AC recipients as they move to EW or nursing homes by demographic groups	MMIS Claims

4.42 External Evaluation

In addition to the designated activities to be conducted by DHS, DHS will contract with Robert Kane, M.D., Professor and Minnesota Chair in Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management to conduct an evaluation of the impact of the continuation of the Alternative Care program under the waiver on access, quality and cost on the low-income senior population in the state. Greg Arling, PhD, Katherine Birck Professor, School of Nursing, Purdue University, will assist in the analysis. This component of the evaluation will include analysis of service use and payments during the period before the demonstration and during the demonstration. Analysis will also be conducted on the relationship of Alternative Care to prior nursing facility use, Medicaid conversion and subsequent nursing facility use and Elderly Waiver use. Elderly Waiver and Alternative Care will be compared to determine whether different types of clients are being served and different needs are being met. The evaluation will also compare Alternative Care and Elderly Waiver client characteristics and service use. For this evaluation, the following data sources will be utilized:

1. MMIS
2. Medicaid files
3. MDS
4. Medicare claims
5. Board on Aging Title III service use records
6. Client surveys
7. Waiver recipient case studies
8. Program staff interviews
9. Assessment data

In addition to the research questions listed in the paragraph above and in section 4.1, descriptive statistics will be used to analyze characteristics of waiver recipients in the pre-waiver period (where data are available) and during the period that waivers are in place. We will also compare waiver recipients with other Medicaid services users (e.g., Elderly Waiver). Changes in service use and costs will be examined with a time series trend analysis, either multilevel models of change or differencing models. We also will use regression models to test whether amount of services at one point in time (T_0) predict future outcomes for service use (HCBS, Title III), medical use, NH use, and functional status at a subsequent point in time (T_1).

Table 1. Major Variables and Data Sources for External Evaluation of Alternative Care

Variable	Description	Source
AC use	Amount and cost of AC services	MMIS, Medicare claims
Health and functional status		Assessment
Financial characteristics		Assessment
Living arrangement	Home alone, home with family, organized setting	Assessment
Medicaid payments	By type of service	MMIS
Disability level, function	ADLs, IADLs	Assessment
Prior LTC use		MDS and MMIS
NH use	Days, dollars	MDS and MMIS
Title III services	List	Board on Aging
Acute services	Hospital, ER, SNF, DME, outpatient	Managed Care Plans, MMIS, Medicare
Health outcomes	Acute care use, death	Managed Care Plans, MMIS, Medicare
Independence		AC Recipient Survey
Community integration		AC Recipient Survey
Access to LTSS	Utilization	AC Recipient Survey
Simplification of LTSS		AC Recipient Survey

5. Evaluation Strategy for Consumer First Services and Supports

5.1 Demonstration Goals, Hypotheses and Objectives for CFSS

The goals and hypotheses that will be tested during the evaluation period are summarized below:

5.11 Goal 1: Comparable Access for Waiver Groups

Provide a comparable level of access to CFSS to the waiver populations as the other CFSS recipients.

Objective: Despite the need for multiple federal authorities to implement the reformed personal care benefit, access to CFSS services for waiver populations will be as good as access experienced by people receiving CFSS services who are eligible under the state plan (hereinafter “state plan eligibility groups.”)

Measurement: The number and percentage of recipients using each CFSS service will be compared between waiver and state plan eligibility groups. The percentage of CFSS authorized units paid over time will be compared between waiver and state plan eligibility groups.

Evaluation Question: Are the experiences of the 1115 subgroups (“i-like” and “k-like”) comparable to what we see in the rest of the CFSS program?

Hypothesis: The number and percentage of recipients compared by eligibility group will demonstrate that access to CFSS services is equal across waiver populations and state plan populations.

Data Source: MMIS

5.12 Goal 2: Comparable Quality for Waiver Groups

Achieve comparable health outcomes after utilization of CFSS for the waiver populations as is achieved for the comparable state plan eligibility groups using CFSS.

Objective: Despite the need for multiple federal authorities to implement the reformed personal care benefit, health and consumer satisfaction outcomes following use of CFSS services for waiver populations will be as good as outcomes experienced by comparable state plan eligibility groups using CFSS.

Measurement A: The percentage of participants admitted to nursing homes during the year by amount and frequency of use will be compared between waiver and state plan eligibility groups. The number of participants that moved from nursing homes onto the program and the % of participants also using institutional services by amount of use will be compared between waiver and state plan eligibility groups.

Measurement B: The percentage of CFSS participants reporting that they are the primary decision makers regarding their service plans (or their child's plan), the percentage of CFSS participants reporting that support workers arrive when they are supposed to and perform the tasks requested, and the percentage of CFSS participants reporting satisfaction with their service providers will be compared between waiver and state plan eligibility groups.

Evaluation Question: Do individuals covered under the 1115 waiver on the "i-like" and "k-like" plans fare differently from state plan eligibility groups using CFSS in terms of health outcomes and program satisfaction?

Hypothesis A: The data will demonstrate comparable health outcomes due to utilization of CFSS services across waiver and state plan populations.

Hypothesis B: Satisfaction rates compared by eligibility group will demonstrate comparable satisfaction with CFSS services across waiver and state plan populations.

Data Sources: MMIS and Annual CFSS participant survey

5.13 Goal 3: Comparable Program Sustainability for Waiver Groups

Consumers utilizing CFSS services under the waiver are expected to have comparable costs as compared to state plan CFSS participants.

Objective: Despite the need for multiple federal authorities to implement the reformed personal care benefit, the average cost per waiver participant will be comparable to average cost per participant in state plan populations.

Measurement: The average cost per recipient of LTC services by geographic and demographic group will be compared between waiver and state plan eligibility groups. Percentage of CFSS participants also using institutional services by amount of use will be compared between waiver and state plan eligibility groups. Percentage of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time will be compared between waiver and state plan groups.

Evaluation Question: Are the i-like and k-like subgroups taking advantage of the flexible CFSS budget in a way that makes costs comparable to the rest of the CFSS program?

Hypothesis: The average cost per recipient, percentage of participants also utilizing institutional services and percentage of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time compared by eligibility group will demonstrate comparable average cost of CFSS services across waiver populations and state plan populations.

Data Source: MMIS

5.2 Evaluation Populations for CFSS

The waiver evaluation populations will consist of the following subgroups:

- 1) **CFSS 1915(i)-like group.** This group is comprised of people who are eligible for Medicaid with incomes above 150% of the federal poverty level who do not have an assessed need for an institutional level of care. This group will be compared to people receiving CFSS under the 1915(i) state plan option.
- 2) **CFSS 1915(k)-like group.** This group is comprised of people who are financially eligible for Medical Assistance only if they utilize the special eligibility rules of one of Minnesota's home and community-based waiver. This group is comprised of people who have an assessed need for an institutional level of care and are not currently receiving HCBS waiver services. This group will be compared to people receiving CFSS under the 1915(k) state plan option.

The waiver population groups above will be compared to the following groups:

- 1) **People receiving CFSS under 1915(i) state plan option.** This group is comprised of people enrolled in Medicaid with incomes under 150% of the federal poverty level who do not have an assessed need for an institutional level of care. This state plan group will be compared to the waiver population called the "CFSS 1915(i)-like group."
- 2) **People receiving CFSS under 1915(k) state plan option.** This group is comprised of people enrolled in Medicaid who have an assessed need for an institutional level of care. This group will include a subgroup of people who are receiving HCBS waiver services in addition to CFSS and a subgroup of people who are not receiving HCBS waiver services in addition to CFSS. The experience of the subgroup of people who are not receiving HCBS waiver services in addition to CFSS are likely to be more similar to the CFSS 1915(k)-like waiver population. This state plan group will be compared to the waiver population called the "CFSS 1915(k)-like group."

5.3 Evaluation Metrics for CFSS

Please see the "Measurement" paragraph under each of the goals listed in section 5.1 as well as the chart in section 5.41.

5.4 Evaluation Plan for CFSS

5.41 Maintenance of comparable access, quality and satisfaction across waiver and state plan populations

The goals and associated metrics identified in section 5.1 will be evaluated by DHS using MMIS claims and assessment data. It is appropriate for DHS to conduct this component of the evaluation using readily available data sources as part of its ongoing quality monitoring and management activities.

Overview of Populations, Measures and Years

Waiver Populations	Comparison Populations	Measures	Data Source
CFSS i-like & k-like groups	CFSS i and k groups	# and % of recipients using each CFSS service, compared by eligibility group	MMIS Claims
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS authorized units paid over time by eligibility group	MMIS Claims; MMIS Service Agreement; Screening Documents
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	% of participants admitted to nursing homes during the year by amount and frequency of use	Screening documents; MDS
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	# of participants that moved from nursing homes onto the program	Screening documents; MDS
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	% of CFSS participants also using institutional services by amount of use	MMIS Claims
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting they are the primary deciders of what is in their service plan (or their child's plan), compared by eligibility group	Assessment Data
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that those paid to help them come when they are supposed to, compared by eligibility group	Assessment Data
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that those paid to help them do the things you want them to	Assessment DATA
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that they satisfied with their service provider	Assessment Data
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	Overall average cost per recipient of LTC services by eligibility group, lead agency, and demographic group, compared as well by eligibility group	MMIS Claims
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	% of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time	MMIS Claims

5.42 External Evaluation

In addition to the designated activities to be conducted by DHS, DHS will contract with Robert Kane, M.D., Professor and Minnesota Chair in Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management, to conduct an evaluation of the impact of the 1915 i-like and k-like waiver populations on access, quality and cost for eligible children, adults and low-income senior population in the state. Greg Arling, PhD, Katherine Birck Professor, School of Nursing, Purdue University, will assist in the analysis. This component of the evaluation will include analysis of pre-waiver and post-waiver 1915(i)-like and 1915(k)-like program service use and payments, and the relationship to utilization of flexible benefits, medical care, nursing facility use and HCBS Waiver use.

6. Evaluation Implementation Strategy

6.1 Management and Coordination of the Alternative Care and CFSS Evaluations

The goals and associated metrics identified in section 4.1 and 5.1 will be evaluated by DHS using MMIS claims and assessment data. It is appropriate for DHS to conduct this component of the evaluations using readily available data sources as part of its ongoing quality monitoring and management activities.

In addition to the designated activities to be conducted by DHS, DHS will contract with Robert Kane, M.D., Professor and Minnesota Chair in Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management, to conduct an evaluation of the impact of the continuation of the Alternative Care program under the waiver on access, quality and cost on the low-income senior population in the state. Greg Arling, PhD, Katherine Birk Professor, School of Nursing, Purdue University, will assist in the analysis. As discussed in section 4.42, this component of the evaluation will include analysis of service use and payments during the period before the demonstration and after the demonstration. Analysis will also be conducted on the relationship of Alternative Care to prior nursing facility use, Medicaid conversion and subsequent nursing facility use and Elderly Waiver use. Elderly Waiver and Alternative Care will be compared to determine whether different types of clients are being served and different needs are being met. The evaluation will also compare Alternative Care and Elderly Waiver client characteristics and service use. The CFSS external evaluation will include analysis of flexible benefits use before and after implementation of CFSS as well as the relationship between the utilization of flexible benefits, medical needs, nursing facility and HCBS waiver services use.

6.2 Integration of Alternative Care, CFSS and HCBS Waiver Quality Improvement Strategies

Compliance, oversight and improvement activities for all Minnesota home and community-based waiver programs are conducted in a comprehensive manner across all HCBS waiver programs and Alternative Care. Many HCBS waiver recipients will also be CFSS recipients once the state plan amendments are approved, and quality monitoring for CFSS will be folded into the existing comprehensive quality plan.

The Department conducts site reviews of counties and tribes to monitor their compliance with HCBS waiver policies and procedures. At the conclusion of a review the Department issues a summary report that includes recommendations for program improvements (i.e., sharing best practice ideas) and corrective actions. Corrective actions are issued if the county or tribe being reviewed is found to be out of compliance with waiver policies and procedures. The county or tribe is required to submit a corrective action plan and evidence of the correction. The Department evaluates whether the correction and evidence are sufficient to demonstrate that the corrective action was implemented.

The Department also monitors HCBS waiver and case management activities through quality assurance plans and MMIS subsystems. Counties and tribes are required to submit a quality assurance plan to the Department every one to two years. The plan is a self-assessment of compliance with waiver policies and procedures, some of which directly apply to case management activities. Our MMIS design supports HCBS waiver policies and procedures, including those related to case management. DHS uses data from MMIS to monitor case management activities. DHS reports on the quality assurance plans and MMIS subsystems in accordance with the §1915(c) waiver requirements.

In addition, the CFSS state plan amendments, still under negotiation with CMS, provide that individuals receiving CFSS are active participants in quality assessment and management through support planning and design of the service delivery plan to meet identified needs and mitigate risks. Counties, tribes and managed care organizations under contract with the Department to manage home and community-based services and supports (lead agencies) perform person-centered assessments and develop community support plans that reflect consumer preferences in services and support for self-direction and include risk management, back-up and emergency planning. Consultation service providers assist the participant with planning developing, and implementing the service delivery model by providing information about service options, choices in providers, and rights and responsibilities, including appeal rights. The FMS (financial management service), agency provider, consultation service provider and CFSS workers are mandated reporters for adult and child maltreatment. The Department establishes and manages the budget methodology for the CFSS authorization, ensures lead agencies perform their roles, ensures provider qualifications and other enrollment requirements are met, authorizes services, develops and implements quality measures and remediation strategies, and periodically analyzes aggregated measurement data for system improvement opportunities. The Department develops and delivers training to lead agencies and providers, manages provider enrollment, pays claims, and oversees county financial eligibility determination for Medical Assistance programs.

At least annually, DHS will monitor timeliness of CFSS beneficiary access to consultation services by reviewing data from consultation service providers, service authorization and claims data. Lead agency reviews will be expanded to include the review of the assessments and community support plans for people receiving CFSS.

Because of the comprehensive nature of the state's HCBS waiver quality improvement strategies, elements of this strategy are continuously applied to monitor and improve quality, access and timeliness of services for Reform 2020 demonstration enrollees. Therefore, while not formally incorporated in the evaluation, these activities further the goals of the demonstration. Where possible, DHS will seek opportunities to design and implement these activities in coordination with Reform 2020 waiver-related reporting and evaluation.

6.3 Conclusion, Best Practices, and Recommendations

The final evaluation report will discuss the principal conclusions and lessons learned based upon the findings of the evaluation and current program and policy issues. A discussion of recommendations for potential action to be taken by DHS to improve health care services in terms of quality, access and timeliness will be provided.

Appendix F

Evaluation Plan Objectives and Indicators for Minnesota Family Planning Program §1115 Waiver

Short Term Objectives

The waiver is expected to increase access to and use of family planning services by low-income women in Minnesota.

- **Objective 1:** Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs (MHCP).
- **Objective 2:** Increase the proportion of men and women enrolled in MHCP who utilize family planning services.

Long Term Objectives

With the improvement of the short-term indicators there should also be improvement in long-term indicators including reductions in teen births and unintended pregnancy, and increases in birth intervals and average age of mother at first birth. There is a lag expected between the inception of the program and any effect of the program on long term objectives.

- **Objective 3:** Increase the average age of mother at first birth among MHCP enrollees.
- **Objective 4:** Reduce the teen birth rate among MHCP enrollees.

Objective 1

Increase the number of Minnesotans who have access to family planning services through MHCP.

Measurement

Access the number of Minnesotans that have access to Family Planning services through MHCP.

Hypothesis

Enrollment in the family planning program and/or MHCP programs offering family planning services will increase during the demonstration.

Indicators

Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of Waiver), stratified by sex, age, race/ethnicity, and major program.

- a. Annual unduplicated count of individuals aged 15 to 49 ever enrolled in *MHCP programs that offer family planning services* (including MFPP) will be determined from enrollment data (MMIS).

Measured for each state fiscal year (SFY) since the start of the waiver (July 2006-present), stratified by sex, age, race/ethnicity, and major program.

- b. Annual unduplicated count of individuals ever enrolled in MFPP from program implementation to present.
- c. Percentage of MFPP enrollees who enroll in the program after the presumptive eligibility period.

Appendix F

Evaluation Plan Objectives and Indicators for Minnesota Family Planning Program §1115 Waiver

Data Sources

MMIS eligibility data

Definitions:

MHCP programs that offer family planning services include all programs except Emergency MA.

Objective 2

Increase the proportion of men and women enrolled in MHCP who utilize family planning services.

Measurement

Access the percentage of MHCP enrollees who utilize family planning services.

Hypothesis

The proportion of MHCP enrollees utilizing family planning services will increase during the demonstration.

Indicators

Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of Waiver), stratified by sex, age, race/ethnicity, and major program.

- a. Annual proportion of MHCP enrollees with a family planning service or pharmacy claim.
- b. Annual proportion of MHCP enrollees receiving contraceptive services and supplies.
- c. Annual proportion of MHCP enrollees receiving testing for a sexually transmitted disease (STD).

Data Sources

Numerator - MMIS paid claims data; *Denominator* - eligibility data

Definitions

Family planning related claim includes services that are offered in the MFPP benefit set including family planning supplies or health services, and screening, testing, and counseling for STDs and HIV (per Minnesota Rules, part 9505.0280).

Objective 3

Increase the average age of mother at first birth among MHCP enrollees.

Measurement

Access the average age of mother at first birth among MHCP enrollees.

Hypothesis

Appendix F

Evaluation Plan Objectives and Indicators for Minnesota Family Planning Program §1115 Waiver

The mother's age at first birth among MHCP-financed births will increase following implementation of the demonstration.

Indicators

Measured for each calendar year (CY) from 2003 to present (3 CY before inception of Waiver).

- a. Maternal age distribution for MHCP-financed births.
- b. Annual average maternal age among MHCP-financed births.

Data Sources

Linked State of Minnesota resident birth certificate data and MMIS enrollment/claim data

Definitions

MHCP-financed births are defined as those birth records that match with MMIS data.

Objective 4

Reduce the teen birth rate among MHCP enrollees.

Measurement

Access the teen birth rate among MHCP enrollees.

Hypothesis

The proportion of adolescent MHCP enrollees with a MHCP-financed birth will decrease following implementation of the demonstration.

Indicators

Measured for each calendar year (CY) from 2003 to present (3 CY before inception of Waiver).

- a. Annual proportion of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP.

Data Sources

Linked State of Minnesota resident birth certificate data and MMIS enrollment/claim data

Definitions

MHCP-financed births are defined as those birth records that match with MMIS data.

Appendix F
Evaluation Plan Objectives and Indicators for
Minnesota Family Planning Program §1115 Waiver

Table 1. MFPP Short-Term Objectives and Associated Indicators				
Objectives	Hypotheses	Indicators	Data Sources	Notes
1) Increase the number of Minnesotans who have access to family planning services through MHCP.	Enrollment in the family planning program and/or MHCP programs offering family planning services will increase during the demonstration.	1a) Annual unduplicated count of individuals aged 15 to 49 enrolled in MHCP offering family planning services (includes Medical Assistance, MinnesotaCare, General Assistance Medical Care, and MFPP; excludes programs that do not offer family planning services)	MMIS eligibility data	Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of MFPP) Stratify by sex, age group, race/ethnicity and program
		1b) Annual unduplicated count of individuals enrolled in MFPP	MMIS eligibility data	Measured for each SFY since the start of the waiver (July 2006 to present) Stratify by sex, age group, and race/ethnicity
		1c) Percentage of MFPP enrollees who enroll in the program after the presumptive eligibility period	MMIS eligibility data	
2) Increase the proportion of men and women enrolled in MHCP who utilize family planning services.	The proportion of MHCP enrollees utilizing family planning services will increase during the demonstration.	2a) Annual proportion of MHCP enrollees with a family planning service or pharmacy claim	Numerator: MMIS paid claims data Denominator: MMIS eligibility data (annual unduplicated counts from first objective)	Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of MFPP) Stratify by sex, age group, race/ethnicity and program
		2b) Annual proportion of MHCP enrollees receiving contraceptive services and supplies		
		2c) Annual proportion of MHCP enrollees receiving testing for a sexually transmitted disease (STD)		

Appendix F
Evaluation Plan Objectives and Indicators for
Minnesota Family Planning Program §1115 Waiver

Table 2. MFPP Long-Term Objectives and Associated Indicators				
Objectives	Hypotheses	Indicators	Data Sources	Notes
3) Increase the average age of mother at first birth among MHCP enrollees.	The mother's age at first birth among MHCP-financed births will increase following implementation of the demonstration.	3a) Maternal age distribution for MHCP-financed births	Linked MN resident birth certificates and MMIS enrollment and claims data	Measured each calendar year, starting with 2003 MHCP-financed births are defined as those birth records that match with MMIS data
		3b) Annual average maternal age among MHCP-financed births		
4) Reduce the teen birth rate among MHCP enrollees.	The proportion of adolescent MHCP enrollees with a MHCP-financed birth will decrease following implementation of the demonstration.	4a) Annual proportion of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP	Linked MN resident birth certificates and MMIS enrollment and claims data	Measured each calendar year, starting with 2003 MHCP-financed births are defined as those birth records that match with MMIS data

JUNE 2014



Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota

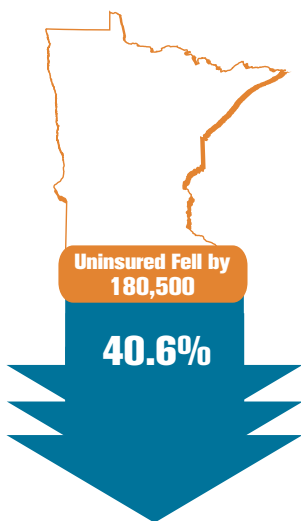
Executive Summary

With full implementation of the Affordable Care Act's (ACA's) health insurance coverage provisions on January 1, 2014, there has been great interest in assessing the law's early impact on health insurance coverage in Minnesota. At the request of Minnesota's State-Based Health Insurance Marketplace, MNsure, researchers from the University of Minnesota's State Health Access Data Assistance Center (SHADAC) compiled data from a variety of sources to analyze, at an aggregate level, the shifts in health insurance coverage that have taken place in Minnesota since the fall of 2013. Support for this work was provided through the Robert Wood Johnson Foundation's State Health Reform Assistance Network.

To our knowledge, this report is the first assessment of early state-level impacts of the ACA on health insurance coverage. The major findings of this report include the following:

- Between September 30, 2013 and May 1, 2014, the number of uninsured Minnesotans fell by 180,500, a reduction of 40.6 percent. The number of uninsured in Minnesota fell from 445,000 (8.2 percent of the population) to about 264,500 (4.9 percent of the population).
- This increase in health insurance coverage was primarily driven by an increase in the number of Minnesotans enrolled in state health insurance programs, Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare. Enrollment increased by over 155,000 for these two programs combined.
- Coverage in the private health insurance market also increased. The total number of Minnesotans with private group coverage (primarily employer-sponsored coverage) was relatively stable with a decline of about 6,000 (a 0.2 percent change); growth in self-insured plans was balanced by a decline in fully-insured coverage. The nongroup market grew by almost 36,000 and included gains both inside and outside of MNsure.

Our findings on the change in the number of uninsured are consistent with national reports of early ACA impact, and with research on the impacts of Massachusetts reforms implemented in 2007 which are quite similar to the access expansion provisions included in the ACA. Further research and analysis are needed to answer questions such as what are the characteristics of Minnesotans who gained or lost coverage from different sources, how many Minnesotans who purchased coverage through MNsure were previously uninsured, and what are the characteristics of the remaining uninsured population in Minnesota.



Introduction

On January 1 2014, Minnesotans gained access to new health insurance coverage options through the Affordable Care Act (ACA). These options included an expansion of Medicaid coverage for adults with annual incomes of up to 138 percent of the federal poverty level and new premium tax credits and cost-sharing subsidies for the purchase of private coverage through MNsure.¹ MNsure is a new state-based health insurance marketplace with the goal of helping people shop and sign up for health insurance coverage. These new options, along with an individual mandate to have health insurance coverage or pay a tax penalty, have undoubtedly led to shifts in Minnesota's coverage landscape.

By the end of May, MNsure reported that more than 227,500 individuals had enrolled in health insurance coverage through MNsure.² This total included enrollment in both private and public health insurance plans. While this figure signals growth in some types of coverage, it doesn't provide an accurate picture of how many *uninsured* have gained coverage since open enrollment began and whether there have been significant shifts in where people are getting coverage. To understand the shifts in health insurance coverage and to more fully understand the impact of recent changes on rates of uninsurance, additional information is required to account for the potential shifts among all sources of coverage (for example, between employer-sponsored group coverage and MNsure or between nongroup coverage and public insurance).

The best way to assess coverage shifts would be through a population survey. Minnesota conducts a bi-annual household survey, the Minnesota Health Access Survey (MNHA), to understand state coverage rates and trends in health insurance coverage over time. However, the next MNHA is not scheduled to take place until the latter half of 2015, with results available in early 2016; similarly, 2014 estimates from national surveys that provide state-level health insurance estimates will not be available until the fall of 2015.

At the request of MNsure, we developed an alternative and more timely approach to assess the

early impact of the ACA on health insurance coverage in the state. We rely on the most current information on Minnesota's uninsured population along with administrative data from public and private health plans to estimate changes in health insurance coverage. We use this data to analyze shifts in the aggregate distribution of health insurance coverage in Minnesota across all segments of the health insurance market before and after MNsure's open enrollment period. The purpose of the report is to estimate the early impact of the ACA on the number of uninsured in the state, and to show how the distribution of health insurance coverage has changed.

Methods

SHADAC collected information from private and public payers on the number of Minnesota residents enrolled in their health plans at two points in time: September 30, 2013 and May 1, 2014.³ These data provide a snapshot of coverage in Minnesota just before the MNsure open enrollment period began, and one month after it closed, allowing for processing of enrollments that had been started but not completed prior to the end of open enrollment.

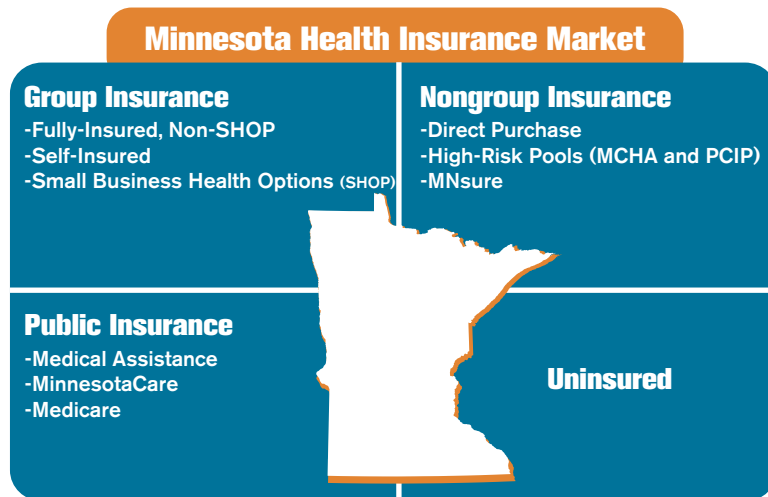
Figure 1 illustrates the categories of health insurance coverage in Minnesota. Within each major coverage type (group, nongroup, and public) there are several subtypes, as shown in the figure.

The methodology used in this analysis is similar to one that has been used by the State of Minnesota to estimate the distribution of health insurance coverage in Minnesota since the early 1990s.⁴ The data come from a variety of sources, including private health plans, MNsure, the Minnesota Department of Human Services (DHS), the U.S. Census Bureau, the Minnesota Health Access Survey, and other sources as detailed below. The analysis begins with the total population of the state, and then accounts for the number of people with each type of health insurance coverage, for which data are available. Since enrollment in self-insured plans is not subject to state regulation and is not reported publicly, this coverage type is calculated as a residual for September 2013.⁵ In other words, the estimated number of people

The purpose of the report is to estimate the early impact of the ACA on the number of uninsured in the state, and to show how the distribution of health insurance coverage has changed.

covered by self-insured plans is the number that are “left over” after accounting for all other categories (including the uninsured); as a result, any errors or imprecision in the other coverage types are captured in this coverage category.

FIGURE 1. MINNESOTA HEALTH INSURANCE MARKET



Total population

According to the most recent estimates from the U.S. Census Bureau, Minnesota’s population was 5,420,380 as of July 1, 2013.⁶ SHADAC calculated an average monthly growth rate for the period from July 1, 2010 to July 1, 2013 and applied this growth rate to estimate Minnesota’s population on October 1, 2013 and on May 1, 2014.

Private group coverage

Enrollment counts as of September 30, 2013 and May 1, 2014 for Minnesota residents in fully-insured group coverage, outside of MNsure’s SHOP exchange, were provided to SHADAC by the Minnesota Council of Health Plans (MCHP) for its members.⁷ SHADAC adjusted this number upward to account for the market share held by plans that are not members of MCHP. Market share was calculated by using information on premiums and market shares in the fully-insured market as a whole⁸ and subtracting premiums for nongroup coverage.⁹ SHADAC estimated that the MCHP member plans account for 88.9 percent of the fully-insured group market, and adjusted the MCHP enrollment counts

accordingly to represent the total market.

Estimated enrollment in self-insured plans as of September 30, 2013 was calculated as a residual after accounting for all other coverage sources and subtracting it from the total population. To account for growth in this market over the time period in question, SHADAC used information provided by MCHP that indicates that enrollment in self-insured plans administered by MCHP members grew by 1.6 percent between September 30, 2013 and May 1, 2014. May 1 enrollment in self-insured plans was calculated by applying this growth rate to the September 30 estimated enrollment in self-insured plans.

Enrollment in SHOP plans as of May 1 was provided by MNsure, using data from monthly reports related to advance payments of tax credits and cost sharing reductions that participating carriers submit to the federal government.¹⁰

Private nongroup coverage

Estimates for private nongroup coverage were calculated in a manner similar to the calculations for group coverage. MCHP provided counts of Minnesota residents enrolled in its members’ plans as of September 30, 2013 and May 1, 2014, and SHADAC adjusted the estimates to represent the entire private nongroup market. SHADAC estimated that the MCHP member plans accounted for 91.5 percent of covered lives in the private nongroup market,¹⁰ and this assumption was used to adjust the enrollment counts from MCHP to represent the complete private nongroup market outside of MNsure. SHADAC also obtained enrollment counts as of September 30, 2013 and April 30, 2014 from the Minnesota Comprehensive Health Association (MCHA), Minnesota’s state high-risk health insurance pool; to avoid double counting, these enrollment counts exclude Medicare Supplemental policies. In addition, SHADAC used enrollment data published by the Centers for Medicare and Medicaid Services (CMS) to account for enrollment in the temporary federal high-risk pool established by the ACA (Pre-Existing Condition Insurance Program, or PCIP).¹² Finally, MNsure provided counts of enrollment in nongroup Qualified Health Plans (QHPs) as of May 1, 2014, using data from the

monthly reports that participating carriers submit to the federal government.

Medical Assistance and MinnesotaCare

SHADAC obtained counts of enrollment in Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare (a separate state program with sliding-scale premiums based on income) as of September 30, 2013 and April 30, 2014 from DHS. To avoid double counting, the counts used in this analysis for Medical Assistance and MinnesotaCare excluded individuals who were dually eligible for Medicare and Medical Assistance or MinnesotaCare. Because the April 30 enrollment counts are still preliminary and final enrollment counts are typically higher, SHADAC's analysis used an adjustment factor recommended by DHS, based on historical experience, to estimate the complete enrollment counts for April 30.

Notably, the figures for Medical Assistance and MinnesotaCare reflect substantial shifts between these two programs. This is due in part to new requirements effective January 2014 that all income-eligible MinnesotaCare populations be shifted into Medical Assistance.¹³

Medicare

The most recent publicly available enrollment counts for Minnesota residents in Medicare are for July 1, 2012.¹⁴ SHADAC calculated average monthly enrollment growth rates in Medicare for Minnesota residents for July 2009 to July 2012, and applied this average monthly growth rate to the 2012 enrollment count to estimate enrollment of Minnesota residents in Medicare as of October 1, 2013 and May 1, 2014.

Uninsured

The estimated number of uninsured in September 2013 comes from the Minnesota Health Access Survey (MNHA), a bi-annual survey of Minnesota households that is conducted jointly by the Minnesota Department of Health and SHADAC. Approximately 445,000 Minnesotans were uninsured in the fall of 2013. This estimate reflects the most recent survey of nearly 12,000 Minnesota households conducted between mid-August and mid-November 2013.¹⁵

The estimated number of uninsured in Minnesota as of May 1, 2014 was calculated by starting with the total state population and subtracting all other coverage sources described above.

Results

Figures 2 and 3 present our results. We estimate that there were approximately 180,500 fewer Minnesotans who were uninsured on May 1, 2014 compared to the number of uninsured on October 1, 2013. In other words, the size of the uninsured population in Minnesota declined by 40.6 percent. While the private group market remained relatively stable (a decline of about 0.2 percent), the distribution of enrollment shifted slightly from fully-insured to self-insured plans. The nongroup market grew by 12.5 percent and was driven by enrollment in MNsure, but included enrollment growth in the nongroup market outside of MNsure (direct purchase). Not surprisingly, there were enrollment declines in two market segments: (1) the high-risk pools, MCHA and PCIP, where enrollees were widely expected to take advantage of lower premium rates available elsewhere through guaranteed issue of coverage with no premium rating based on health status (and the programs are slated to close), and (2) MinnesotaCare, which experienced a shift of enrollment to Medical Assistance as described above.¹⁶

Previous MNsure releases of enrollment counts have included the number of people who selected a plan and payment method,¹⁷ while the counts used in this analysis include only those with coverage in effect on May 1. The difference between these figures reflects the fact that some people may have never paid their first month's premium or may have dropped coverage between January and May (for example, if they obtained a job with health benefits or stopped paying premiums due to affordability issues or other reasons). These types of changes are common for people with nongroup insurance coverage – for example, one recent study found that over one-third of people with nongroup coverage in May 2008 no longer had nongroup coverage four months later.¹⁸

The fastest enrollment growth occurred in public health insurance coverage through Medical Assistance and MinnesotaCare. Combined, these programs

We estimate that there were approximately 180,500 fewer Minnesotans who were uninsured on May 1, 2014 compared to the number of uninsured on October 1, 2013. In other words, the size of the uninsured population in Minnesota declined by 40.6%.

exhibited an enrollment growth rate of 20.6 percent from the end of September 2013 to the beginning of May 2014. Given that two-thirds of Minnesotans who were uninsured in 2013 were estimated to be eligible for public health insurance coverage, this rapid growth in state public program coverage is not surprising.¹⁹

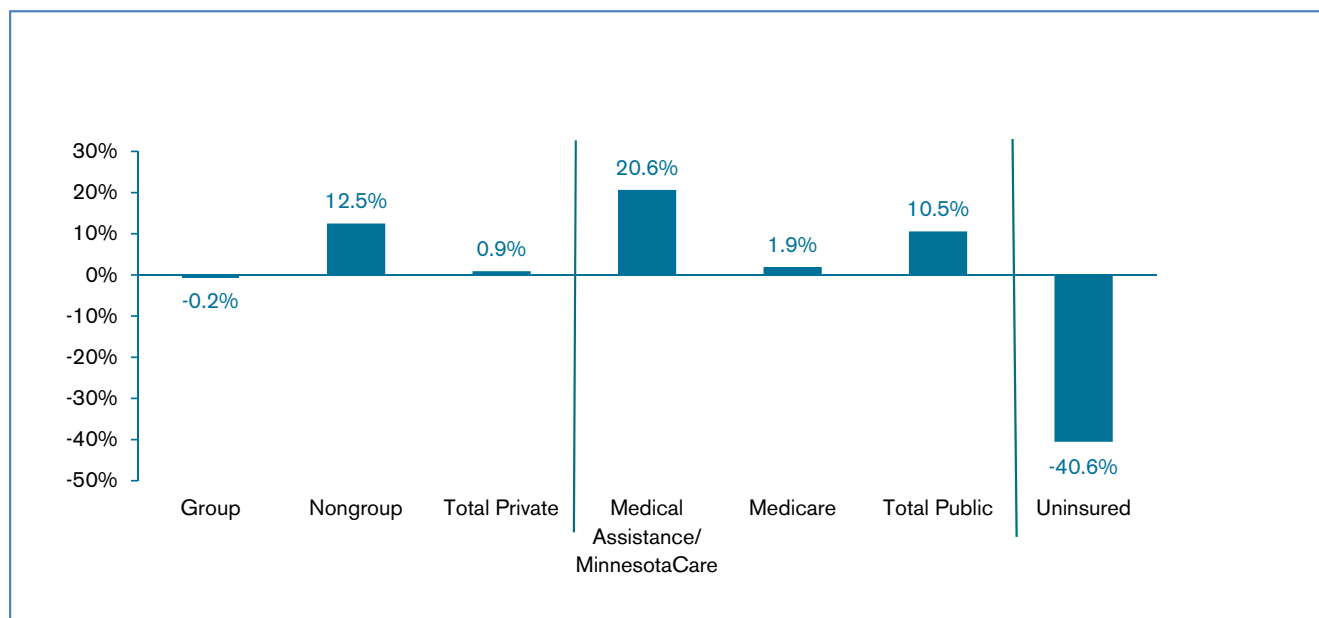
Although nearly all of the information that we relied on for this study was reported to us directly from the entities that provide health insurance coverage in the state of Minnesota, we did make some assumptions about portions of the market for which we couldn't collect data. For example, we assumed that

enrollment in MCHP members' plans represented 88.9 percent and 91.5 percent of the group and nongroup markets, respectively, at both the start and the conclusion of the open enrollment period. We performed a sensitivity analysis to determine how much our results would change under different assumptions for changes in enrollment in portions of the market for which we did not collect enrollment data directly from payers. This assumption had little impact on our conclusion about the size of the reduction in Minnesota's uninsured population.²⁰ In addition, we assumed that total enrollment in self-insured plans grew at the same rate reported to us by members of MCHP for their self-insured enrollment.

FIGURE 2. SHIFTS IN MINNESOTA HEALTH INSURANCE COVERAGE
SEPTEMBER 30, 2013 - MAY 1, 2014

Type of insurance	Number of people			Percent of population		
	September 30, 2013	May 1, 2014	Difference	September 30, 2013	May 1, 2014	Difference
Private insurance						
Group insurance						
Fully-insured (non-SHOP)	948,925	908,984	(39,941)	17.5%	16.7%	-0.8%
Self-insured	2,113,828	2,146,982	33,154	38.9%	39.4%	0.5%
SHOP	-	761	761	0.0%	0.0%	0.0%
Total, group insurance	3,062,753	3,056,726	(6,027)	56.4%	56.1%	-0.3%
Nongroup insurance						
Direct purchase	262,301	273,555	11,254	4.8%	5.0%	0.2%
MCHA	25,506	8,690	(16,816)	0.5%	0.2%	-0.3%
Federal high-risk pool (PCIP)	733	-	(733)	0.0%	0.0%	0.0%
MNsured	-	42,265	42,265	0.0%	0.8%	0.8%
Total, nongroup insurance	288,540	324,510	35,970	5.3%	6.0%	0.6%
Total, private insurance	3,351,293	3,381,236	29,943	61.7%	62.0%	0.3%
Public insurance						
Medical Assistance	622,044	834,140	212,096	11.5%	15.3%	3.8%
MinnesotaCare	131,926	75,345	(56,581)	2.4%	1.4%	-1.0%
Medicare	879,389	896,150	16,760	16.2%	16.4%	0.2%
Total, state programs	753,970	909,485	155,515	13.9%	16.7%	2.8%
Total, public insurance	1,633,359	1,805,634	172,275	30.1%	33.1%	3.0%
Uninsured						
Uninsured	445,000	264,480	(180,520)	8.2%	4.9%	-3.3%
Total population	5,429,653	5,451,350	21,698	100.0%	100.0%	

FIGURE 3. PERCENT CHANGE BY TYPE OF INSURANCE
SEPTEMBER 30, 2013 - MAY 1, 2014



Discussion

Aggregating enrollment in public and private health plans in Minnesota over the initial months of implementation of the ACA (October 1 – May 1) we found substantial gains in health insurance coverage leading to a significant drop in rates of uninsurance. Enrollment in the total private market grew slightly, and was driven by gains in the nongroup market which were slightly offset by a modest decline in the group market. We found the largest enrollment growth in Medical Assistance due in part to the Medicaid expansion provisions of the ACA but also due to the fact that more than two-thirds of uninsured Minnesotans were already eligible for public coverage.

To our knowledge, this analysis provides the first state-level estimate of the ACA's early impacts on the number of people without health insurance coverage. This analysis was possible due to Minnesota's strong data infrastructure and voluntary participation in this study by the Minnesota Council of Health Plans (MCHP) and its members, MNsure, Minnesota's Department of Human Services (DHS) and the Minnesota Comprehensive Health Association

(MCHA). Their willingness to provide enrollment data to support this effort was critical to our ability to estimate total enrollment in a timely manner. In addition, the availability and timing of the 2013 Minnesota Health Access Survey provided a high quality, well-established baseline for the number of uninsured in Minnesota. The methods that we used are fairly straightforward, and could be readily replicated in other states if the appropriate data are available and if both public and private payers are willing to provide enrollment counts.

Our findings are consistent with early national analysis of the ACA's impacts on the share of the population without health insurance coverage. For example, the Urban Institute's Health Reform Monitoring Survey (HRMS) showed a drop of 2.7 percentage points in the share of nonelderly adults without health insurance between September 2013 and March 2014; states that implemented the law's expansion of Medicaid coverage saw a decline of 4 percentage points, compared to 1.5 percentage points in states that did not expand Medicaid.²¹ Similarly, results from the RAND Corporation's Health Reform Opinion Study indicate a 4.7 percentage point drop in the share of nonelderly adults without

We found increases in private coverage as well as public program enrollment.

Our results for Minnesota are consistent with early national analysis, and also consistent with early results from implementation of a comprehensive set of health reforms in Massachusetts in 2007.

insurance between September 2013 and March 2014.²² The Gallup Corporation has also published survey findings showing a drop in the share of U.S. adults who lack health insurance, from 17.1 percent in the fourth quarter of 2013 to 13.4 percent in April 2014,²³ with larger declines in states that have implemented the ACA's Medicaid expansion than in those that have not.²⁴

Our results for Minnesota are also consistent with early results from implementation of a comprehensive set of health reforms in Massachusetts in 2007; the Massachusetts coverage reforms were very similar to those in the ACA. Between the fall of 2006 and fall of 2007, the share of working-age adults who were uninsured in Massachusetts fell from 13.0 percent to 7.1 percent, a 45 percent decline.²⁵ Further research comparing changes in Massachusetts to other states during the same period found that the uninsurance rate in Massachusetts fell by over half.²⁶

This report provides a snapshot of insurance coverage in Minnesota at two distinct points in time. However, it is important to recognize that insurance coverage is dynamic and many people experience changes in their coverage over time – through the gain or loss of a job, changes in family income or the cost of health insurance, and decisions about whether to apply for coverage through public programs. As a result, the picture of insurance coverage and the composition of the population without health insurance also will shift over time. Additional monitoring and research will be needed to understand the ACA's medium-and longer-term impacts on coverage in Minnesota.

Because the analysis in this report relies on aggregated data gathered from payers, there are many important questions that we cannot yet answer. For example, what are the characteristics of people who gained and lost coverage? How many people who purchased coverage through MNsure were previously uninsured? What are the characteristics of the remaining uninsured in Minnesota?

To provide additional information on the impact of the ACA on Minnesota, SHADAC is collaborating with the Minnesota Department of Health's Health Economics Program to conduct a survey of individuals who responded to the 2013

Minnesota Health Access Survey. This study will survey individuals who were most likely directly affected by the insurance coverage provisions of the ACA: respondents who in the fall of 2013 reported being uninsured, purchased nongroup coverage or received insurance through the state's high-risk pool (MCHA). The goal of the survey is to find out if previously uninsured Minnesotans gained coverage; whether people with individual or MCHA coverage experienced changes in coverage; and to what extent survey respondents had remaining barriers to obtaining care. The survey will also determine whether individuals used MNsure to access coverage. Results from this survey are expected to be available in the fall/winter of 2014.

Acknowledgements

Support for this report was provided through the Robert Wood Johnson Foundation's State Health Reform Assistance Network.

We are grateful for the assistance of several people who helped us obtain access to the information that we used in this analysis: Eileen Smith and Julie Brunner at the Minnesota Council of Health Plans and staff at private insurers who helped to assemble the information; Katie Burns at MNsure; Shawn Welch at the Minnesota Department of Human Services, and Peggy Zimmerman-Belbeck at the Minnesota Comprehensive Health Association.

ENDNOTES

¹The federal poverty guideline for a family of four in 2014 is \$23,850. <http://aspe.hhs.gov/poverty/14poverty.cfm>, accessed May 30, 2014.

²MNSure, “MNSure Continues Outreach Push With Statewide Enrollment Opportunities,” Press Release, May 30, 2014. Accessed May 30, 2014 at <https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-131235>

³Some estimates vary from these dates by one day – for example, the estimate that we used for total population is as of October 1, 2013, and estimates for some types of insurance coverage represent enrollment counts as of April 30, 2014. This one-day variation is unlikely to have much impact on the results of our analysis.

⁴See, for example, Minnesota Department of Health, Health Economics Program Chartbook, “Trends and Variation in Health Insurance Coverage.” Accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section2.pdf>

⁵There are two types of private coverage: fully-insured and self-insured. In a fully-insured plan, the purchaser pays a premium to an insurance carrier, which is then financially responsible for all claims costs. In a self-insured (or self-funded) plan, the purchaser retains the financial risk associated with claims costs but often contracts with a third party administrator to administer the plan. Many large employers self-insure their employee health benefit plans.

⁶U.S. Census Bureau, Population Division. “Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013 (NST-EST2013-01). December 2013. Accessed May 21, 2014 at <http://www.census.gov/popest/data/state/totals/2013/index.html>

⁷Excluding dental-only plans.

⁸Minnesota Department of Health, Health Economics Program Chartbook, “Health Plans.” Accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section7.pdf>

⁹Minnesota Department of Commerce, “Report of 2012 Loss Ratio Experience in the Individual and Small Employer Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations, and Health Maintenance Organizations.” May 2013. Accessed May 21, 2014 at <http://mn.gov/commerce/insurance/images/LossRatioReport.pdf>

¹⁰These reports include all enrollees, not just those receiving financial assistance.

¹¹Ibid.

¹²Centers for Medicare and Medicaid Services. “State by State Enrollment in the Pre-Existing Condition Insurance Plan.” Accessed June 5, 2014 at: <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/pcip-enrollment.html>

¹³Minnesota Department of Human Services. February 2014 Forecast. Accessed May 21, 2014 at http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs16_181293.pdf

¹⁴Centers for Medicare & Medicaid Services. “Medicare Enrollment Reports, Medicare Enrollment as of July 1, 2012.” Accessed May 12, 2014 at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/index.html?redirect=/medicareenrpts/>

¹⁵Minnesota Department of Health, Health Economics Program. “Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey.” Fact Sheet Update May 2014, accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2013primary.pdf>

¹⁶PCIP was scheduled to end on December 31, 2013, but benefits for existing members were extended for up to four months. Benefits were not extended to May, so we assumed zero enrollment on May 1, 2014.

ENDNOTES (CONTINUED)

¹⁷See, for example, MNsure Dashboard, <https://www.mnsure.org/images/bd-2014-05-14-dashboard.pdf>, accessed May 21, 2014.

¹⁸Benjamin D. Sommers. Insurance Cancellations in Context: Stability of Coverage In The Nongroup Market Prior to Health Reform. *Health Affairs* 33, no. 5 (2014): 887-894.

¹⁹Minnesota Department of Health, Health Economics Program. "Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey." Fact Sheet Update May 2014, accessed May 21, 2014 at <http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2013primary.pdf>

²⁰Under an alternative assumption of no change in enrollment in the portion of the market for which we do not have data, our estimated enrollment in private group coverage on May 1, 2014 would be higher by about 4,400 people. Similarly, estimated nongroup market enrollment on May 1, 2014 would be lower by about 960 people.

²¹Long SK, Kenney GM, Zuckerman S, Wissoker D, Goin D, Hempstead K, Karpman M, Anderson N. Early Estimates Indicate Rapid Increase in Health Insurance Coverage Under the ACA: A Promising Start. April 15, 2014. Accessed May 27, 2014 at <http://hrms.urban.org/briefs/early-estimates-indicate-rapid-increase.html>

²²Carman KG, Eibner C. Changes in Health Insurance Enrollment Since 2013: Evidence from the RAND Health Reform Opinion Study. 2014. Accessed May 27, 2014 at http://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR656/RAND_RR656.pdf

²³Levy J. U.S. Uninsured Rate Drops to 13.4%. May 5, 2014. Accessed May 27, 2014 at <http://www.gallup.com/poll/168821/uninsured-rate-drops.aspx>

²⁴Witters D. Uninsured Rate Drops More in States Embracing Health Law. April 16, 2014. Accessed May 27, 2014 at <http://www.gallup.com/poll/168539/uninsured-rates-drop-states-embracing-health-law.aspx>

²⁵Long SK. On the Road to Universal Coverage: Impacts of Reform in Massachusetts At One Year. 2008. *Health Affairs* 27(4):w270-w284.

²⁶Long SK, Stockley K, Yemane A. Another Look at the Impacts of Health Reform in Massachusetts: Evidence Using New Data and a Stronger Model. 2009. *American Economic Review: Papers & Proceedings* 99(2), 508-511.



State Health Access Data Assistance Center (SHADAC)

SHADAC is a health policy research center within the University of Minnesota School of Public Health whose faculty and staff are recognized as national experts on the collection and use of health policy data. SHADAC health economists and policy analysts cover the full range of technical, research and policy expertise involved in using federal and state data to inform health policy, while leveraging hands-on experience working in state government. SHADAC specializes in issues related to health insurance access, use, cost and quality with a particular focus on state implementation of health reform. Work includes providing technical assistance to many agencies and individuals across the country, at both the federal and state government levels. In addition, SHADAC contributes to general health policy literature and debate by conducting timely health policy research, which is translated into issue briefs, reports and peer-reviewed journal articles.

For more information, visit www.shadac.org. SHADAC is funded by the Robert Wood Johnson Foundation.

For more information, please contact us at shadac@umn.edu, or call 612-624-4802.

The State Health Reform Assistance Network

The State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.statenetwork.org. For more information, visit www.rwjf.org.

Report Authors



Julie Sonier, MPA

Julie Sonier is a Senior Research Fellow and Deputy Director at SHADAC. She has 17 years of experience in the analysis, development, and implementation of state health reforms, and previously served as Minnesota's State Health Economist. Ms. Sonier holds a master's degree in public affairs with a concentration in economics from Princeton University and a bachelor of arts degree in economics from Amherst College.



Elizabeth Lukanen, MPH

Elizabeth Lukanen is a Senior Research Fellow at the State Health Access Data Assistance Center (SHADAC) where she manages SHADAC's technical assistance to states in the areas of data use, analysis and evaluation. Ms. Lukanen has over 10 years of experience in the health policy arena where she has analyzed issues related to cost, access and quality. Prior to joining SHADAC, Ms. Lukanen worked as a Senior Research Economist in the Health Economics Program (HEP) at the Minnesota Department of Health. Ms. Lukanen holds a master's degree in public health from Columbia University and a bachelor's degree in economics from McGill University.



Lynn Blewett, PhD

Dr. Blewett is a Professor of Health Policy in the School of Public Health at the University of Minnesota. She is the Founding Director of the State Health Access Data Assistance Center (SHADAC), a research and health policy center focused on issues related to health insurance coverage, barriers to access to needed care and use of the federal and state population-level data to inform health policy. She also directs the State Health Reform Access Network (State Network) providing data analysis and support to 11 states committed to the implementation of the Affordable Care Act (ACA). Dr. Blewett has a Master's Degree of Public Affairs from the Hubert Humphrey Institute of Public Affairs and her PhD in health services research and policy from the University of Minnesota School of Public Health.

Other Contributors:

Andrea Stronghart and Carrie Au-Yeung provided assistance with document layout and graphics.

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