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DEPARTMENT OF HUMAN SERVICES

Minnesota Medicaid Managed Care Comprehensive Quality Strategy

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Executive summary

The Minnesota Medicaid Managed Care Comprehensive Quality Strategy provides an overview of the different methods the Department of Human Services uses to assess the performance of Minnesota's Medicaid managed care program, including program improvement activities, results, achievements and opportunities. The Department of Human Services (DHS) has continuously engaged in various quality improvement initiatives for different components of the Medicaid managed care program. This document ties these various components together into one comprehensive strategy. Creating one overarching quality improvement strategy provides an opportunity to gather and enumerate the numerous quality improvement efforts occurring throughout the department and move toward coordination of all the initiatives.

DHS aims to ensure access to quality health care for all Medicaid managed care enrollees and to work with enrollees, the state's External Quality Review Organization, managed care organizations, providers and other state agencies, such as the Minnesota Department of Health, to improve access, quality and continuity of care. DHS strives to achieve results in seven essential outcomes through its Minnesota Medicaid Managed Care Comprehensive Quality Strategy:

- Purchasing quality health care services
- Protecting the health care interests 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 though process standardization, improvement and innovation
- Strengthening the relationship between patients and health care providers.

DHS uses standing advisory and stakeholder groups, including the MCO Quality Workgroup, to review the strategy and its components. Comments from the general public will also be solicited.

DHS will review and update this comprehensive quality strategy at the end of each calendar year for submission by the end of the first quarter of the following year. DHS will solicit input from multiple internal and external stakeholders through workgroups and posting a draft of the comprehensive quality strategy document on its website for public review and comment.

Introduction

The Minnesota Medicaid Managed Care Comprehensive Quality Strategy provides an overview of the different methods the Department of Human Services uses to assess the performance of Minnesota's Medicaid managed care program, including program improvement activities, results, achievements and opportunities. The Department of Human Services (DHS) has continuously engaged in various quality improvement initiatives for different components of the Medicaid managed care program through:

- The Managed Care Quality Strategy
- The quality framework for Minnesota's five home- and community-based services waivers:
    - Developmental Disability waiver
    - Community Alternatives for Disabled Individuals waiver
    - Community Alternative Care waiver
    - Brain Injury waiver
    - Elderly waiver.
- The evaluation of two of Minnesota's section 1115 demonstration waivers:
    - Reform 2020
    - Prepaid Medical Assistance Project Plus.

This document ties these various components together into one comprehensive strategy. Creating one overarching quality improvement strategy provides an opportunity to gather and enumerate the numerous quality improvement efforts occurring throughout the department and move toward coordination of all the initiatives.

History of managed care in Minnesota Health Care Programs

Most Minnesotans enrolled in Medicaid receive services through the state's contracted managed care organizations (MCOs), which include both health maintenance organizations and county-based purchasing plans. The remaining enrollees receive services through the traditional fee-for-service system, where providers receive a payment from the Department of Human Services (DHS) directly for each service provided to an enrollee. In 2016, about 280,000 people were enrolled in the state's fee-for-service system in any given month with just over 807,000 people enrolled in managed care.

View a timeline and read a report that details the history of managed care in Minnesota at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7659-ENG. The timeline begins on Page 50.

Minnesota Medicaid and MinnesotaCare MCO contracts

Program	Federal authority	Name of contract	Type of enrollment	Number of contracts
Medical Assistance	State plan and 1115 PMAP+ waiver; mandatory enrollment with exclusions	Families and children contract	Mandatory enrollment with exclusions	7
MinnesotaCare	Basic Health Plan under the Affordable Care Act	Families and children contract	Mandatory enrollment with exclusions	7
Minnesota Senior Health Options (MSHO)	State plan	Seniors contract	Voluntary enrollment	7
Minnesota Senior Care Plus (MSC+)	1915(b) MSC+ waiver and 1915(c) home- and community-based services waivers	Seniors contract	Mandatory enrollment with exclusions	7
Special Needs Basic Care (SNBC)	State plan	SNBC contract	Voluntary enrollment	6

Objectives of the comprehensive quality strategy

DHS aims to ensure access to affordable, high quality health care for all Medicaid managed care enrollees and to work with enrollees, the state's External Quality Review Organization, managed care organizations, providers and other state agencies, such as the Minnesota Department of Health, to improve access, quality and continuity of care. To achieve quality health care services, there must be measurable improvement in enrollee health outcomes to affect cost.[1]

DHS based its comprehensive quality strategy on these continuous quality improvement principles:

Accountability and transparency: As stewards of public funds, DHS must hold the managed care organizations (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 DHS, enrollees and the public. The 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.

[1] In special needs populations, improvement measurement may focus on maintenance or efforts to slow the decline in status which is a commonly expected outcome of a chronic condition.

Value: The worth of services provided will be determined in relation to long-term health care outcomes and satisfaction of principal consumers, the managed care enrollees. 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 patient in the health care decision process. In order for patients to participate, they must be provided with the prerequisite health care information. Patients must also assume responsibility as informed consumers to make responsible choices and reduce high-risk behaviors in order to realize optimum outcomes. A measured, thoughtful, strategic and systematic patient-centered approach must be employed to achieve sustained improvement.

DHS strives to achieve results in seven essential outcomes through its Medicaid Managed Care Comprehensive Quality Strategy:

- Purchase high quality health care services
- Protect the health care interests of managed care enrollees through monitoring of care and services
- Assist in the development of affordable health care
- Review and realign any DHS policies and procedures that act as unintended barriers to the effective and efficient delivery of health care services
- Focus health care improvements on enrollee demographics and cultural needs
- Improve the health care delivery system's capacity to deliver desired medical care outcomes though process standardization, improvement and innovation
- Strengthen the relationship between patients and health care providers.

Reform 2020 waiver-specific outcomes

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
- Create a program that is more fiscally sustainable.

Minnesota Family Planning Program-specific outcomes

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

Components of the Minnesota Medicaid Managed Care Comprehensive Quality Strategy

Technical and regulatory monitoring

The DHS Managed Care Quality Strategy was developed in accordance with federal Medicaid managed care regulations (42 CFR §438.340), which require state agencies to have a written strategy for assessing and improving the quality of health care services offered by MCOs. The quality strategy encompasses the following managed care health care programs and contracts:

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

Each year, the External Quality Review Organization (IPRO of New York State in 2018) performs an overall external quality review of Minnesota's managed care system. The review includes current contract requirements, federal Medicaid managed care regulations and state law, including health maintenance organization (HMO) licensing requirements.

The Minnesota Department of Health (MDH) licenses HMOs and regulates county-based purchasing entities doing business in Minnesota. MDH conducts a triennial quality assurance examination of all MCOs to monitor and assess compliance with state HMO licensing regulations. While the primary purpose of the exam is to monitor compliance with Minnesota's HMO licensing regulations, some of the information collected and assessed is used by the External Quality Review Organization to assess DHS and CMS requirements.[2] DHS and MDH work collaboratively to assure that, when possible, information collected for the MDH Quality Assurance Examination includes information consistent with federal external quality review 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.

If MDH discovers an MCO deficiency, a corrective action and mid-cycle follow-up review is required to ensure all deficiencies are resolved. The External Quality Review Organization uses information from the Quality Assurance Exam, Triennial Compliance Assessment report and

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

follow-up deficiency audits to determine MCO compliance with DHS and CMS requirements. DHS also collects other contractually required reports directly from the MCO for its external quality review, including the annual MCO Quality Work Plan and Evaluation.

The External Quality Review Organization is charged with assessing the strengths and weaknesses of MCOs and reporting on their:

Quality, access and timeliness of health care services they provided under managed care.
Conformity with contract requirements.
Compliance with state and federal Medicaid and Medicare managed care requirements.
Validation of performance measures and performance improvement projects.
Enrollee satisfaction.

The External Quality Review Organization provides the MCOs with recommendations for improvement for areas of weakness and assesses the degree to which each MCO addressed problems previously identified. When necessary, DHS imposes corrective actions and appropriate sanctions if MCOs are out of compliance with requirements and standards.

The External Quality Review Organization also provides comparative information about all MCOs, offers technical support to the MCOs which deliver services through DHS contracts, and advises DHS on opportunities for improvement.

The External Quality Review Organization details its findings, outcomes and recommendations for improvement in the Annual Technical Report available online at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp. See Appendix B for further detail on the managed care quality strategy.

DHS reviews and reports on the effectiveness of the Managed Care Quality Strategy at least annually. Significant modifications will be published in the State Register to obtain public comment, presented to key Medicaid advisory groups, and reported to CMS.

As is the current practice, performance improvement project activities are included in the annual External Quality Review Organization report. In future years, as new healthcare issues emerge, additional clinical or nonclinical focused quality improvement studies may be undertaken.

Performance Improvement Projects

Managed care plans must conduct three year performance improvement projects designed to improve care and services provided to enrollees. The 2018-2020 PIPs focus on Reducing New Chronic Opioid Users. DHS publishes the summary reports online at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp.

Opioid Prescribing Improvement Program

The Opioid Prescribing Improvement Program is a statewide initiative proposed in the 2015 legislative session. The program's goal is to reduce the opioid dependency and substance use of Minnesotans due to or related to the prescribing of opioid analgesics by health care providers. This program is a collaborative effort between the Department of Human Services (DHS) and Minnesota Department of Health (MDH), building upon recommendations made by DHS' Health Services Advisory Council (HSAC), DHS' Emergency Department Utilization Work Group, and other community initiatives.

As part of this legislation, an Opioid Prescribing Work Group (OPWG) will be established to recommend development of prescribing protocols, sentinel measures, and patient educational resources to help reduce overprescribing of opioids. Non-voting members of OPWG include: a representative of MDH, DHS' Minnesota Health Care Programs (MHCP) medical director, a representative of DHS pharmacy program, and the medical director for the Minnesota Department of Labor and Industry. OPWG's voting members include:

- At least two consumer members who individually or in their families have been impacted by opioid abuse disorder or opioid dependence disorder;
- a licensed and actively practicing physician;
- a licensed and actively practicing pharmacist;
- a licensed and actively practicing nurse practitioner;
- a licensed and actively practicing dentist;
- a licensed and actively practicing non-physician health care professional whose practice includes treating pain;
- a licensed and actively practicing health or mental health professional whose practice includes treating patients with chemical dependence or substance abuse;
- a medical examiner for Minnesota county;
- a voting member of DHS' HSAC;
- at least one medical director of a health plan doing business in Minnesota;
- at least one pharmacy director of a health plan doing business in Minnesota; and
- a representative of law enforcement in Minnesota.

The Statewide Opioid Prescribing Improvement Program focuses on improving the health and quality of care of MHCP recipients by implementing the following activities:

- OPWG will recommend opioid quality improvement standard thresholds and MHCP opioid disenrollment standards pertaining to opioid prescribers and provider groups.
- DHS, on annual basis, will collect and report to MHCP prescribers the data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers.
- DHS will notify MHCP opioid prescribers and the MHCP opioid prescribers' provider groups when their prescribing patterns exceed MHCP opioid quality improvement standard thresholds. Each MHCP opioid prescriber and provider group will submit a quality improvement plan for DHS' review and approval. The goal of which shall be to bring MHCP opioid prescribers' practices into alignment with community standards. The quality improvement plans should include, but not be limited to: components of the

Statewide Opioid Prescribing Improvement Program such as appropriate opioid prescribing protocols and use of educational messages with patients; internal practice-based measures to review the prescribing practice of the MHCP opioid prescriber, and where appropriate, any or all other MHCP opioid prescribers who are employed by or affiliated with the provider group(s); and appropriate use of the Minnesota Prescription Monitoring Program.

- If, after a year from DHS' initial notice, the MHCP opioid prescriber's practice does not improve to the degree necessary to consider it consistent with community standards, DHS will take any or all of the following steps: monitor performance more frequently than annually; monitor more aspects of prescribing practices than the sentinel measures; and/or require additional quality improvement efforts including, but not limited to, mandatory use of the Minnesota Prescription Monitoring Program.
- DHS will dis-enroll from Minnesota Health Care Programs all MHCP prescribers and provider groups that meet applicable MHCP opioid disenrollment standards.

This program (upon legislative approval and implementation) will allow DHS, MDH, and the larger provider community the opportunity to build on and synergize existing quality improvement efforts among health systems, other provider groups, and professional associations. The most immediate hurdle is receiving support and passing this proposed legislation.

Integrated Care for High Risk Pregnant Women

Adverse birth outcomes result in high care costs due to intensive treatment requirements for newborns, related to prematurity, low birthweight, and maternal substance abuse, especially opiates. The proposed program will target resources for prenatal prevention and treatment to improve birth outcomes.

Minnesota has excellent birth outcomes overall, with among the lowest rates nationally for prematurity, low birth weight, and infant mortality. However, the state has some of the nation’s highest disparities for these outcomes for African Americans and American Indians, in comparison to Whites. Also, Neonatal Abstinence Syndrome (NAS), which occurs when newborns withdraw from opiates due to maternal opiate use during pregnancy, is rapidly growing in Minnesota. There is an 8-fold higher rate of NAS in Minnesota among infants born to American Indians. Prematurity, low birth weight and NAS are the leading causes of costly neonatal intensive care unit (NICU) admissions, and these adverse birth outcomes are known to be strongly associated with behavioral risks and disadvantaged social conditions. Integrated prenatal care that links risk assessment with community-supported interventions has been shown to result in lower rates of these adverse outcomes.

Integrated Care for High Risk Pregnant Women is a grant program designed to provide targeted, integrated services for pregnant mothers who are at high risk of poor birth outcomes due to drug use or low birth weight in areas of high need. A state funded grant program allows us to target resources for Medicaid recipients. These services are expected to improve birth outcomes, reducing the number of low birth weight infants and the use of costly neonatal intensive care (NICU) services in the Medical Assistance program within the target population.

Based on experience from similar interventions across the country, this proposal is expected to reduce the number of days infants stay in the NICU by nearly 600 in the affected areas.

Participating mothers will be connected to existing maternal health and substance abuse services through community and public health programs. The program will work with community organizations, lay and professional providers to develop local systems of care that are community held, community monitored and maintained with appropriate state oversight. Participating clinics will include tribal health providers and community clinics; local public health and social service agencies; and substance abuse treatment providers.

Project goals include:

- Early identification of opiate dependency and abuse during pregnancy, effectively coordinated referral and follow-up of identified patients to evidence-based treatment, and integrated perinatal care services with behavioral health and substance abuse services;
- Access to, and effective use of, needed services by bridging cultural gaps within systems of care, through integration of community-based paraprofessionals such as doulas and community health workers, as a component of perinatal care;
- Patient education including prenatal care, birthing, and postpartum care, nutrition, reproductive life planning, breastfeeding, parenting, and documentation of the processes used to educate patients;
- Systematized screening, care coordination, referral, and follow up for behavioral and social risks known to be associated with poor birth outcomes and prevalent within the targeted populations, such as substance abuse, homelessness, domestic violence and abuse, chronic mental illness, and poorly developed self-care knowledge and skills;
- Facilitated ongoing continuity of care, including postpartum coordination and referral for interconception care, provision for ongoing substance abuse treatment, identification and referral for maternal depression, continued medical management of chronic diseases, and appropriate referral to tribal or county-based social and public health nursing services.

Within four years of implementing the recommendations, DHS anticipates:

- Lower rates of untreated maternal opiate and other substance use disorders at birth.
- A decline in rates of prematurity and LBW within targeted areas, resulting in lowered statewide disparities for these outcomes.
- A decline in child protection findings driven by untreated substance abuse in mothers of newborns.
- A reduction in the incidence of newborns exposed to illicit or abused substances.
- Better integration of existing resources for high risk maternity populations.
- Development of a mechanism to sustain this work via a Medicaid payment model.

The project is expected to serve nearly 1,200 pregnant mothers at risk of poor birth outcomes through the end of State Fiscal Year 2019. Legislation was recently approved in 2015.[3]

[3] Minn. Statutes § 256B.79 can be viewed at: https://www.revisor.mn.gov/statutes/?id=256B.79&year=2015.

Delivery System and Payment Reform: Value-Based Payment Program

The MN DHS value-based purchasing initiative is called the Integrated Health Partnership (IHP) program. The IHP program uses direct contracts with providers to enhance accountability through shared savings and shared risk, creating incentives for quality improvement. The program operates across both fee-for-service and managed care (under 65 non-duals).

The IHP model (IHP Legacy) has been in operation since 2013. Beginning in 2018, DHS launched IHP 2.0 which includes a population-based payment which all IHP 2.0 participants (both Tracks 1 and 2) receive and a total cost of care risk-based payment that only Track 2 IHP 2.0 participants may receive.

IHP Legacy

In the IHP legacy contracts, a portion of an IHP's potential shared savings is contingent on their overall quality score. An IHP's overall quality score is calculated based on their compliance with the reporting requirements, and, from year 2 onward, their performance rates. In years 1 and 2, the overall quality score impacts 25% of an IHP's shared savings; this portion increases to 50% beginning in year 3. Measures are organized into the following categories: clinical quality at a clinic and at a hospital; and patients' experience of care at a clinic and at a hospital. Points are awarded for improvement and achievement.

IHP 2.0 Track 1 – Population Based Payment

For the purpose of the population-based payment in tracks 1 and 2, IHPs are evaluated on health equity, quality, and utilization measures to determine eligibility to continue participation after the conclusion of each three-year cycle. Each IHP is required to design interventions to address social risk factors and health disparities. The health equity measures gauge the effectiveness of each intervention and IHP's cooperation with community partners. These equity measures are agreed to upon review of DHS-produced data. These data demonstrate the prevalence of social risk factors and the prevalence of correlated negative health outcomes among IHP-attributed population of patients. Some examples of current IHP health equity interventions include: community collaborative to fight food insecurity, integration of behavioral and physical health to support adolescents who screen positive for depression, and an opioid management program.

IHP 2.0 Track 2 – Total Costs of Care

For the purpose of the total costs of care model in track 2, IHPs are evaluated on a core set of measures to determine how much shared savings an IHP receives. In each demonstration year fifty percent of IHP's portion of shared savings is contingent on its overall quality score. The overall quality score is calculated based on IHP performance on measures organized into the following categories: Care Quality (Prevention & Screening; Effectiveness of Care for at Risk Populations, Behavioral Health; Access to Care; Patient-centered Care; Patient Safety), Health

Information Technology (Meaningful Use of EHR: Care Coordination objective and Health Information Exchange objective), and Pilot Measures (e.g. patient engagement, care coordination, opioid use or specialty measures).

Home- and community-based services

A. Waiver review initiative

Since 2006, DHS has conducted a thorough review of the home- and community-based services programs that help Minnesotans stay in their homes as they age and regardless of ability. Home- and community-based services 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 are conducted in a comprehensive manner across all of the waiver programs and alternative care. These activities are not segregated by waiver.

DHS conducts triennial onsite reviews of counties and tribes to monitor their compliance with home- and community-based services waiver policies and procedures. At the conclusion of the triennial site reviews, DHS issues a summary report that includes recommendations for program improvements (i.e., sharing best practice ideas) and corrective actions if the county or tribe is 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. DHS evaluates whether the correction and evidence are sufficient to demonstrate that the corrective action was implemented.

Find more details on the waiver review initiative at www.minnesotahcbs.info/.

B. Quality assurance plans and MMIS systems

DHS also monitors home- and community-based services waiver and case management activities through quality assurance plans and the Medicaid Management Information System (MMIS). Counties and tribes are required to submit a quality assurance plan to DHS every one to two years. The plan provides a self-assessment of compliance with waiver policies and procedures, some of which directly apply to case management activities. DHS reports on the quality assurance measures in accordance with the §1915(c) waiver requirements.

The MMIS design supports home- and community-based services waiver policies and procedures, including those related to case management. DHS uses data from MMIS to monitor case management activities.

C. Home- and community-based services report card

The 2013 Minnesota Legislature directed the creation of a home- and community-based services report card to give enrollees, their families, case managers and other care coordinators and providers the ability to compare Minnesota providers. This work will include developing a new version of the website MinnesotaHelp.info that:

Provides a new interface for people who use home- and community-based services to find services based on their needs and preferences (services are ranked).
Provides a way for people, professionals and families or caregivers to review services.
Provides new opportunities for providers to reveal more about their services and upload information about their customer satisfaction and quality strategies.
Offers interactive service reviews that allow providers to respond to feedback and make their quality improvements transparent based on user feedback.

The new website will offer a dramatic and real-time method to capture community satisfaction and engagement while encouraging the provider to improve the quality of health care services. The project will also help people who use long-term care services and supports compare providers when making decisions about their care.

The report card is under development and goals will be further defined as this process continues.

D. Quality improvement projects

2014 legislation increased home- and community-based services provider rates by 5 percent. For most providers, 1 percent of that increase was tied to submitting a required plan for a self-designed quality improvement project. Providers were required to submit their project to DHS through a web-based tool by Dec. 31, 2014. DHS supported providers in this process by offering information and tools for implementing quality improvement projects on a quality improvement website at http://www.hcbsimprovement.info/content/improving-quality-hcbs-provider%E2%80%99s-toolkit.

Projects needed to address one of the following goals:

- Improve the quality of life of home- and community-based service enrollees in a meaningful way.
- Improve the quality of services in a measurable way.
- Deliver good quality services more efficiently while using the savings to enhance services for the participants served.

Behavioral Health Homes Model

The Patient Protection and Affordable Care Act of 2010 (ACA) created an optional “health home” benefit so that states could better coordinate care for Medicaid enrollees with chronic conditions. Behavioral Health Homes (BHH) Initiative is Minnesota’s version of the federal “health home” benefit for Medical Assistance (MA) enrollees. BHH is a DHS project, jointly managed by the Health Care Administration and the Community Supports Administration (Adult and Children’s Mental Health). The goals of the health home framework are to:

Improve health outcomes (preventative, routine, treatment of health conditions) of individuals enrolled.

- Improve experience of care for the individual.
- Improve the quality of life and wellness of the individual.
- Reduce health care costs.

Behavioral Health Home services will be made available to the following MA enrollees:

- Adults with serious mental illness;
- Adults with a serious and persistent mental illness; and
- Children and youth experience a severe emotional disturbance.

In Minnesota, DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS will build on this framework to serve other complex populations in the future.

In Minnesota, within the MA population, individuals with serious mental illness, and children and youth with severe emotional disturbance are two to three times the medical cost risk and use more impatient services. In 2012, of the adults with serious mental illness, 25 percent had at least one chronic health condition and 13 percent had at least two. BHH offers an opportunity to provide more person-centered care in order to deliver better health outcomes for adults and children with serious mental illness.

- "Health Home Services" as articulated by the Affordable Care Act, Section 2703 and in Minnesota State law (256B.0757)4 requires:
- Comprehensive care management, using team-based strategies,
- Care coordination and health promotion,
- Comprehensive transitional care between health care and community settings,
- Individual and family support, including authorized representatives,
- Referral to community and social support services, and
- The use of health information technology to link services, as feasible and appropriate.

Evidence suggests that better coordination and integration of primary and behavioral health care will result in: improved access to primary care services; improved prevention, early identification and intervention to reduce the incidence of serious physical illnesses including chronic disease; and increased availability of integrated holistic are for physical and behavioral disorders as well as better overall health status for individuals. Behavioral health homes services will begin in July, 2016 contingent upon federal approval.

Providers will address MA enrollees' comprehensive physical and behavioral health needs in a coordinate manner. Behavioral health home services will:

[4] To view Minn. Statutes § 256B.0757: https://www.revisor.mn.gov/statutes/?id=256B.0757.

- Use a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care;[5]
- Better meet the needs of individuals experiencing serious mental illness and their families by addressing the individual's physical, mental, substance use and wellness goals;
- Take a person-centered approach, and engage and respect individuals and families in their health care, recovery and resiliency; and
- Respect, assess and use the cultural values, strengths, languages, and practices of individuals and families in supporting an individual's health goals.

DHS will certify Behavioral Health Homes. A provider must be enrolled as an MA provider and meet federal and state standards to become certified as a Behavioral health home. Behavioral health homes must serve as the central point of contact for MA enrollees and ensure consumer-centered development of a health action plan.

Minnesota established a group of providers from across the state to be the first implementers of Behavioral Health Home services. This group of first implementers, interested in becoming certified behavioral health homes, will share best practices about how to best meet a person's individual needs under the behavioral health home model. Best practices include person-centered planning and supporting integrated service delivery. BHH likely candidates include community mental health centers, pediatric clinics, and fully integrated primary care clinics. First implementers will also receive support from DHS as they prepare for certification. The current list of first implementers includes:

- Amherst H. Wilder Foundation
- Avera Marshall
- CentraCare Health Plaza/ Behavioral Health Clinic St Cloud Hospital
- Canvas Health, Inc.
- Central Minnesota Mental Health Center
- Fairview Clinics- Integrated Primary Care
- Fraser
- Greater Minnesota Family Services
- Guild Incorporated
- Headway Emotional Health Services
- HCMC/Aqui Para Ti
- Human Development Center
- Indian Health Board of Minneapolis
- Lakeland Mental Health Center, Inc.
- Mental Health Resources, Inc.
- Mental Health Systems, PC.
- Natalis Counseling and Psychology Solutions
- North Homes, Inc. DBA: Children and Family Services

- Northern Pines Mental Health Center
- Northland Counseling Center Inc.
- Northwestern Mental Health Center
- Range Mental Health Center
- Range Regional Health Services
- RESOURCE
- Sanford Medical Center, Thief River Falls
- South Central Human Relations Center
- South Lake Pediatrics
- South Metro Human Services
- Southwestern Mental Health Center, Inc.
- Stellher Human Services, Inc.
- Touchstone Mental Health
- University of Minnesota/ Community University Health Care Center (CUHCC)
- Vail Place, Inc.
- Valhalla Place, Inc.
- Washburn Center for Children
- Western Mental Health Center
- Woodland Centers
- Woodland Hills
- Zumbro Valley Health Center

DHS has engaged stakeholders and community members to ensure that the behavioral health home model addresses the needs of MA enrollees with serious mental illness. DHS held a short-term advisory workgroup for initial input on planning in 2013. DHS also convened a long-term advisory group in August 2013. This long-term group meets quarterly to provide input into the model planning and design, and the group represents over 26 different stakeholder groups.6

Additionally, to develop the BHH model, DHS entered into an agreement with the National Alliance on Mental Illness Minnesota to gather feedback from MA enrollees living with mental illness across the state. Focus group participants concentrated on several topics. DHS is using the feedback from these focus groups to shape behavioral health home policy.

- Access to physical and mental health care;
- Transition of care experiences;
- Methods of obtaining health information;
- Opinions about the facets of integrated care; and
- Inclusion of individual, cultural, spiritual and gender values into the care process

[6] To learn more about stakeholder and community engagement, visit: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_178045#.

BHH will monitor avoidable hospital admissions, cost savings from improved care management, and the use of health information technology. Quality measures for this initiative include CMS core set of measures and additional Minnesota state measures.

Integrated Care System Partnerships

Special Needs Plans (SNPs) build on current state initiatives to improve performance of primary care, behavioral health and care coordination models by shifting some of their delivery systems to be more in line with a value based purchasing (VBP) model through the Integrated Care System Partnerships (ICSP). Since 2013, State Medicaid contracts for managed care services with Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs BasicCare (SNBC) managed care organizations (MCOs) have required the development and implementation of ICSPs. ICSP's align with Integrated Health Partnerships (IHPs) and other statewide reform efforts in Medicaid. An additional bonus with ISCPs contracted with MSHO plans and the two integrated SNBC plans is that Medicare dollars may also be leveraged.

The State contract with MCOs has given MCOs flexibility over ICSP models, implementation and payment design. The State requires MCOs to build and expand on previous successes of MCO provider contracting arrangements to improve health care access, coordination and health outcomes through payment reform by establishing partnerships between primary, acute, long-term care and mental health providers serving seniors and people with disabilities enrolled in MSHO, MSC+ and SNBC.

MCOs submitted ICSP proposals for review. DHS has approved over fifty ICSPs and continue to grow serving thousands of enrollees. The goal of ICSPs is to pay for outcomes, quality care and to reward strongly performing providers. ICSPs differ based on population served, geographic area, care coordination models, performance measures and financial incentives. The MCO provider contract with the ICSP may use a range of combined payment mechanisms such as per member per month (PMPM), virtual sub-capitations for total cost of care, pay for performance (P4P), incentive pools, or risk and gain sharing options.

Examples of the assortment of ICSPs implemented with various providers, target populations and payment models under different MCOs:

- Traditional Accountable Care Organizations (ACOs)
- Sub-capitation for all services with risk and gain sharing
- Fairview Partners, Accountable Rural Community Health (ARCH)
- Health Care Homes (HCH)
- Primary care and care coordination PMPM with risk/gain sharing , may include gain sharing against virtual cap for key services
- Essentia or Bluestone
- Community Behavioral Health Providers
- PMPM for integrated Care Coordination with P4P
- Mental Health Resources (MHR), Guild, Touchstone Mental Health
- HCH/Rehabilitation Facility Combo

- PMPM with P4P for primary Care and related support services:
- Courage Center
- Long Term Care Organizations
- P4P on gain sharing
- Care Choice, Presbyterian Homes

All ICSPs are subject to state contract requirements for care coordination, quality metrics, and reporting. Provider told DHS they wanted some alignment of measures with the advice of a clinical workgroup, DHS developed a set of performance measures from which ICSPs may choose.

Examples of outcome measures ICSPs may choose:

- Improve member experience, health outcomes and quality of care
- Reduction in hospital admits and readmissions
- Medication reconciliation and follow-up with member after discharge
- Evidence of integration of behavioral, mental and physical health
- Advance Directives
- Flu shots
- Reduce falls with fracture, falls prevention
- Patient Activation Measurement implementation (PAM)
- Care coordination to avoid fragmentation of service delivery
- Reduce per capita costs of health care
- Reduce all cause hospital readmissions
- Reduce use of high risk medications
- Anti-depression medication management

MCOs must report annually on a standardized template each ICSP including the payment model, performance measures, outcomes and next steps planned to increase effectiveness of each ICSP. It is too early in the implementation of ICSPs to have meaningful data. Some key takeaways are:

- State sets the larger vision and the MCO in cooperation with the providers move forward together through the ICSPs to foster a culture of learning to 1) support improved provider performance, 2) incentivize provider efficiency, 3) reduce unnecessary spending, and 4) improve health outcomes.
- Flexibility is important as MCOS move providers of various sizes, serving diverse populations to a higher degree of integration, accountability and increased risk. The goal is to pay for good outcomes, high quality care and to reward strongly performing providers.
- ICSPs are an opportunity to provide quality health care for Minnesotans while transforming the relationship among health care users, providers and payers.

Reports show some arrangements are seeing some success and are saving dollars, but comprehensive information as to which arrangements yield the most promising results is not yet available.

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 survey is conducted using a four-wave mail plus telephone data collection method. The CAHPS vendor works toward the goal of collecting 300 completed surveys from enrollees in each MCO health plan product and fee-for-service enrollees for a total of at least 6,600 completed surveys. DHS also sponsors an annual satisfaction survey for senior enrollees in the Medicare-integrated MSHO program. DHS and CMS collaborate to send MSHO enrollees a single, annual CAHPS survey, to which DHS adds questions on topics of special interest to the state. CMS then sends the CAHPS survey to MSHO enrollees. Find survey results at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp.

Managed care grievances summary

DHS compiles an annual report summarizing data on enrollee grievances and appeals filed with MCOs; notices of MCO denials, terminations or reductions; and managed care state fair hearings filed with DHS. See the report at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp.

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 HMO licensure requirements.

The Minnesota Department of Health conducts triennial audits of the HMO licensing requirements. See the most recent results from examinations of each health plan at http://www.health.state.mn.us/divs/hpsc/mcs/quality.htm.

HEDIS report

The Minnesota Department of Health 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. The MDH methodology includes hybrid data, which includes medical records reviews. Read the reports online at www.health.state.mn.us/divs/hpsc/mcs/hedishome.htm.

DHS conducts an annual technical validation of its ability to use MCO claims data to monitor HEDIS measures used in the Annual Technical Report (ATR) and to support various policy development and quality improvement initiatives across the department. The latest ATR can be found on the DHS website here:

https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp

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 for Minnesota Health Care Program enrollees. Each summary highlights what each MCO considers significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement. The reports are posted on the DHS public website at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp.

As of calendar year 2016, MCOs established website pages describing quality improvement activities that have resulted in measurable, meaningful, and sustained improved health care outcomes for the contracted populations. The website links:

Blue Plus: www.bluecrossmn.com/qualityimprovement
HealthPartners: www.healthpartners.com/hp/about/understanding-cost-and-quality/quality-improvement/index.html
Itasca Medical Care: www.co.itasca.mn.us/657/Community
Medica: www.medica.com/providers/quality-and-cost-programs/quality-improvement-program
Hennepin Health: www.hennepinhealth.org/quality
PrimeWest Health: https://primewest.org/annual-report
South Country Health Alliance: http://mnscha.org/?page_id=5924
UCare: https://www.ucare.org/About/Pages/QualityHighlights.aspx

Annual report of managed care in Minnesota Health Care Programs

This comprehensive report provides a summary of oversight activities in Minnesota's state managed care programs. Find the report at www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_160044.

Managed care regulations

Federal regulation 42 CFR § 438

DHS' quality strategy has been developed to incorporate federal regulation governing managed care at 42 CFR §438.340. 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 the quality strategy
Ensures MCO compliance with state and federal law.
Requires periodic reviews to evaluate strategy effectiveness and make revisions.

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 2003. The quality strategy is regularly reviewed and revised.

State managed care regulations

The Managed Care Quality Strategy is organized to reflect the standards outlined in Subparts A, D, and E of the Medicaid Managed Care Regulation, which includes rules around:

- Availability of services
- Assurances of adequate capacity and services
- Coordination and continuity of care
- Coverage and authorization of services
- Provider selection
- Enrollee information
- Confidentiality
- Grievance systems
- Subcontractual relationships and delegation
- Practice guidelines
- Quality assessment and performance improvement program
- 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 other state and federal requirements.

National Committee for Quality Assurance standards

To avoid duplication, the Managed Care Quality Strategy's assessment of mandatory activities includes information obtained from the National Committee for Quality Assurance (NCQA) in addition to the Minnesota Department of Health's triennial Quality Assurance Examination. DHS, the Minnesota Department of Health, 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 External Quality Review Organization information to complete its assessment consistent with 42 CFR §438.364.

Currently, five 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 onsite review. If the MCO is in 100 percent compliance with NCQA standards considered by DHS as equal or greater than state and federal requirements, then MDH will not audit the applicable section. Likewise, equivalent CMS Medicare Audit Standards will be used to reduce the triennial audit data collection burden. Data collection burden is reduced since:

- MDH and DHS agree on joint aspects of the review, for example Credentialing, delegation oversight. MDH does the review for both entities.
- MDH and TCA review is done at the same time
- Same Quality documents, annual work plan and annual evaluation – submitted to DHS only. MDH gets these document from DHS at time of audit. DHS accepts MDH review of written Quality plan.
- Overlapping requirement for UM, for example
    - DTR requirements in §438.404 regarding timing of notice and written and oral notifications as well as 438.210 (coverage and authorization of services) as interpreted by DHS are consistent with MS §62M requirements as reflected in the contract
    - Appeal requirements in §438.406 and 438.408 are reviewed in concert with MS §62M.06 requirements since requirements overlap
- Same timelines for submission of audit materials and CAPs with submission to one agency

Appendix A provides a current listing of comparable NCQA and CMS standards.

Review of Minnesota Medicaid Managed Care Comprehensive Quality Strategy

DHS uses standing advisory and stakeholder groups, including the MCO Quality Workgroup, to review the strategy and its components. Comments from the general public will also be solicited.

DHS will review and update this comprehensive quality strategy at the end of each calendar year for submission by the end of the first quarter of the following year. DHS will solicit input from multiple internal and external stakeholders through workgroups and posting a draft of the comprehensive quality strategy document on its website for public review and comment. The feedback provided by stakeholders, including Medicaid enrollees and their representatives, will be taken into consideration and incorporated into the comprehensive quality strategy updates.

Other factors requiring a review of the comprehensive quality strategy

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.

Next steps

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. Future submissions of Minnesota's Medicaid Managed Care Comprehensive Quality Strategy will include descriptions of and reports of progress on the coordination of health quality improvement efforts throughout the department. Appendix G includes descriptions and reports of progress on many of these health quality improvement efforts throughout the department.

With the larger view of Medical Assistance program improvement efforts, the department will be in a position to assess the alignment and intersection of all the initiatives. Continued dialogue amongst the departments and stakeholders around updating the quality strategy towards aligning the various components where applicable will strengthen and make the strategy more consistent and cohesive. The progress of the updated strategy and continued updates of program improvement efforts will be included in the next annual report.

List of appendices

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

- Appendix A: Data Collection Burden Reduction
- Appendix B: Managed Care Core Quality Strategy Components
- Appendix C: DHS Supplemental Triennial Compliance Assessment Elements
- Appendix D: Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver
- Appendix E: Proposed Evaluation for Reform 2020
- Appendix F: Evaluation Plan Objectives and Indicators for Minnesota Family Planning Program §1115 Waiver
- Appendix G: Medicaid Tribal Consultation Policy
- Appendix H: State Public Notice Process
- Appendix I: Ongoing DHS Performance Measurement
- Appendix J: Directed Payment Arrangements
- Appendix K: IHP Specific Measures
- Appendix L: Initiatives Under Development
- Appendix M: Catalog of Past Quality Improvement Efforts

Appendix A: Data Collection Burden Reduction

The following table provides private accreditation (NCQA) and Medicare standards that are comparable to Managed Care standards to satisfy the non-duplication requirements of 42 CFR §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	100% Compliance with the NCQA Standard
Utilization Review and Over/Under Utilization of Services 42 CFR §438.240 (b)(3)	UM 1-4, UM 10-13, QI 4 (Plans must show compliance with MS §62M for UM)
Health Information Systems 42 CFR §438.242	Annual NCQA Certified HEDIS Compliance Audit 1
Clinical Practice Guidelines 42 CFR §438.236 (b-d)	QI 7 - Elements A, B, C, D (2017 NCQA)
Case Management and Care Coordination 42 CFR §438.208 (b)(1-3)	QI 4 Element B, QI 5, QI 7
Confidentiality 42 CFR §438.208 (b)(4), §438.224, and 45 C.F.R. Parts 160 and 164, Part 431, Subpart F	RR5, Elements A-G
Credentialing and Re-credentialing 42 CFR §438.214	CR 1 - 8

An MCO will be considered to have met the requirements in 42 CFR §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.

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.

Appendix B: Managed Care Core Quality Strategy Components

Under 42 CFR 438.340, the state agency must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by its contracted MCOs. The elements of this strategy for Minnesota are described below.

42 CFR 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 Member Handbook. 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 may exceed the State limits provided through the FFS delivery system. The MCO may also provide additional or substitute services. The contracts specify availability of services including, but not limited to 24-hour, 7-days per week access to Medical Emergency, Post-Stabilization Care, and Urgent Care services. These services must be available during hours of operation at least equivalent to the level available to commercial or FFS enrollees.

Enrollees receive information in the Member Handbook 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 information issued by DHS. MCOs are required to make enrollee materials available in predominant languages and to translate any MCO specific information vital to an enrollees understanding of how to access necessary services. These requirements ensure that information regarding MCO services and enrollee rights are available to enrollees with limited English proficiency (LEP). These documents are updated on a monthly, quarterly or annual basis. In addition to being sent to potential enrollees, the information is available on the individual MCO and DHS public websites.

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 CFR §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 agency offers special needs programs that either integrate 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. Through 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 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. 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 agency strives to provide the MCO with demographic 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 METS eligibility system (or the county or MinnesotaCare financial worker for those who are aged, blind, or have disabilities) 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 in the MCO's enrollment file. 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 CFR §438.68 Network adequacy standards and 42 CFR §438.207 Assurance of adequate capacity and services

State and MCO Duties

The state agency requires its contracted MCOs to comply with the standards for all HMOs in the state, which are in state law.[7] The state law and MCO contract requirements include distance and travel time standards for primary care, specialty care (including behavioral health and OB/GYN), hospitals, dental, optometry, laboratory, and pharmacy services. All other services must be as available to Medicaid enrollees as they are to the general population.

MCO Duties

In a managed care delivery system, the MCO, through its contract with DHS, assures the state agency 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.

On a monthly basis the MCO is required by the contract to provide a complete list to DHS of participating providers. The MCO must furnish on its web site a complete provider directory including the names and locations of primary care providers, hospital affiliations, whether providers are accepting new patients, languages spoken in the clinics, how to access behavioral health services, and other important information. As of 2018, the provider directories must also include cultural competency training and handicap accessibility indicators.

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

[7] Minnesota Statutes, § 62D.124; § 62Q.19.

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 agency 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 agency 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 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.

In addition to the network adequacy reviews performed by MDH, DHS reviews provider directories monthly for accuracy. 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. As of contract year 2019, an EQRO will conduct an annual retrospective review of network adequacy consistent with 42 CFR 438.358((b)(1)(iv).

The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

42 CFR §438.208 Coordination and continuity of care

State and MCO Duties

In the event of a contract termination, the MCO contracts require the state agency and MCO to cooperate in transitioning enrollees to a new MCO (Minnesota has mandatory managed care enrollment, and the state agency not the MCO completes all enrollments). The contract requires a transition period of 150 days which has been sufficient to re-enroll large numbers of enrollees into new MCOs. Communication with the affected enrollees is through the state agency to ensure informed choice. Where the enrollee has an established relationship with a particular provider or in certain other situations, continuity of care is required of the enrollee's new MCO by payment for out-of-network services or by a planned transition to network providers.

MCO Duties

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.

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. Coordination of care between acute care settings such as discharge planning for an inpatient stay is required by state law for providers, and the MCO is required to include such compliance in its provider contracts.

The MCO is responsible for the overall 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 initial screening, followed by a diagnostic assessment, as needed; development of an individual treatment plan based on the needs assessment; establishment of treatment goals and objectives; monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. For enrollees with identified special needs, 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. 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.

Most dual-eligible enrollees get their Medical Assistance and Medicare services from the same MCO under a demonstration model that integrates care. MSC+ and some SNBC enrollees may receive their Medicare services from Original Medicare or by enrolling in a Medicare Advantage managed care plan different from their MSC+ MCO. The MCO must coordinate Medicare and Medicaid services.

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. 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.
DHS follows up on a case-by-case basis on specific grievance and appeals regarding coordination and continuity of care.
The state agency contracts with the Minnesota Department of Health as the regulator for HMOs for 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.

MCO Duties

According to their contract MCOs must identify enrollees 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. The initial screening required under 42 CFR 438.208(b)(3) is another resource for identifying 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 agency 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 also coordinates Community Alternatives for Disabled Individuals (CADI) and Brain Injury (BI) waiver services with counties for eligible individuals. Contracts with MCOs also require them to have mechanisms to pay for additional or substitute services. Contracts also ensure enrollee privacy in care coordination for Special Health Care Needs 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 agency 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 CFR §438.210 Coverage and authorization of services

MCO Duties

Article 6 of the MCO contracts specifies which services must be provided and which services are not covered. Medical necessity is defined. The contract requires that all medically necessary services[8] 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 notify the requesting provider and give the enrollee a notice of action including a description of the enrollees' rights with respect to MCO appeals and State Fair Hearing process. Decisions to deny or reduce services must be made by an appropriate healthcare professional.

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 at each MCO. 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

[8] 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)).

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 agency works with a collaborative created by MCOs participating in MSHO to track a core set of "Value Added" utilization measures. 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.

42 CFR §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 a uniform 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. For organizational Providers, including hospitals, and Medicare certified home health care agencies, MCOs must adopt a uniform credentialing and re-credentialing process and comply with that process consistent with state law.

As of 2018, the MCO must ensure that its network providers are enrolled with the state as MHCP providers.[9] Network Providers must comply with the provider disclosure, screening, and enrollment requirements in 42 CFR § 455.

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 CFR §438.10 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 agency or the local agency provides most information to potential enrollees. Most, but not all, information for existing enrollees 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 agency 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 agency must identify the prevalent non-English languages spoken throughout the state and make written information available in those languages. The state agency must make oral interpretation services available in any

[9] 42 CFR § 438.602(b),

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 agency provides model enrollment materials, which meet the requirements above, to the local agency for distribution to all enrollees or potential enrollees. By contract, the state agency 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.

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

42 CFR §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 CFR §431.

Oversight Activities

The state agency has incorporated the requirements of 45 C.F.R. parts 160 and 164, subparts A and E into its contracts with MCOs. The state agency 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 CFR §438.228 Grievance and appeal 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 and appeal 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 resolve each grievance and 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. Minnesota uses a model notice format with required language, from which the MCOs may not deviate. 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/Integrated 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 agency 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 and appeal 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 and appeal 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 CFR §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 agency 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:

The 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.

42 CFR §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.[10] 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 agency the findings of their audits. Each year, DHS submits the MCO's practice guideline audits to the EQRO for review.

[10] Refer to Appendix C DHS Supplemental Triennial Compliance Assessment item 5.

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 CFR §438.330 Quality assessment and performance improvement program

MCO Duties

The MCO contracts require each MCO to provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. The MCO must then implement the quality improvement plan, and conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations. This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standard measures and MCO's performance improvement projects. The MCO must submit the written evaluation to the state agency.

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 intervention(s).[11] 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

[11] Refer to Appendix C DHS supplemental Triennial Compliance Assessment item 6.

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 2018 – 2020 PIP focuses on Reducing New Chronic Opioid Users.

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.

42 CFR §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. The Auditor also validates DHS calculated HEDIS rates.

When MCOs submit encounter data to DHS, automated systems data audits are conducted to ensure data integrity for accuracy and administrative feasibility. DHS has established a unit dedicated to the improvement of encounter data quality, and imposed contractual penalties for uncorrected errors in encounter data. 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. This includes evaluation of the HEDIS rates calculated by DHS and validated by the agency's NCQA Certified HEDIS Auditor.

§438.340(b)(6) Health Disparities Reduction

The state agency works to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The state agency strives to identify this demographic information for each enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. Age and sex indicators are included in all enrollment files, along with the basis for eligibility which includes disability status. Identification of race, ethnicity, and primary language are requested as part of the enrollment process and provided to the MCOs; improving the quality of these data is an ongoing process of training enrollment workers.

The Health Care Disparities Report provided by Minnesota Community Measurement (MNCM), provides performance rates on clients enrolled in Minnesota Health Care Programs (MHCP). The purpose of this report is to provide transparency on data, specifically on performance and health outcomes, to optimize system-wide changes. The Health Care Disparities Report is inclusive of 11 medical group and clinic level measures, which also presents analysis based on

race, ethnicity, and region. The report also aligns with the Minnesota Statutes, section 256B.072(d), "Performance Reporting and Quality Improvement System". The Health Care Disparities Report includes analysis on comparison between MHCPs and Other Purchasers, in order to ensure equity of care, access, and utilization of services. It is published and posted on the Minnesota Community Measurement and the MN Department of Human Services websites. By making this document available, it provides an insight on current challenges and identifies opportunities to reduce health disparities in the state.

42 CFR §438.700 Basis for imposition of sanctions

The contract between the state agency 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 agency 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 agency 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 agency 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. §438.700.

§ 438.702 and § 438.704

The state agency 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

July 2018

During the QA Examination, MDH will collect and validate MCO compliance information for DHS publicly funded managed care programs.[12] The compliance information will be gathered and reported for each publicly funded program (Families & 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 2018 TCA Elements

1. Quality Assessment and Performance Improvement Program – 2017 Contract Section 7.1 and 7.1.1.[13]
   A. The MCO shall provide an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees, ensuring the delivery of quality health care. The Quality Assessment and Performance Improvement Program must be consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR § 438, subpart E, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, 62Q and 256B and related rules, including Minnesota Rules, parts 4685.1105 through 4685.1130, and applicable NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" as specified in this Contract.
   B. Scope and Standards: The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR § 438, Subpart E, (Quality Measurement and Improvement; External Quality Review). 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

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

[13] Families and Children, Seniors (MSHO/MSC+), and Special Needs Basic Care (SNBC) Contract Section 7.1; MSHO/MSC+ Contract Section 7.1 also includes the requirement that the MCO must comply with requirements of "*Quality Framework*," for EW services, including those found in the CMS "*Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers*" published in March 2014
3 §438.242 Health information systems, Contract Section 7.1.2

must include monitoring and evaluation of compliance with STATE and CMS standards and performance measurement.

2. Information System - 2017 Contract Section 7.1.2.3

   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.

3. Utilization Management -2017 Contract Section 7.1.3.
   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*." Pursuant to 42 CFR § 438.330(b)(3), this structure must include an effective mechanism and written description to detect both under- and over-utilization of services. 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 submit to the STATE upon request a written report that includes performance measurement data summarizing identified under-utilization and over-utilization of services. The MCO shall:
      i. Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.
      ii. Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.
      iii. Examine possible explanations for all data not within thresholds.
      iv. Analyze data not within threshold by medical group or practice.
      v. Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions[14].

The following are the 2017 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1-4, 10-13 and QI 4, effective July 1, 2017.

NCQA Standard UM 1: Utilization Program Structure

The organization's UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.

- Element A: Written Program Description
- Element B: Physician Involvement

[14] 42 CFR §438.330(b)(3)

- Element C: Behavioral Healthcare Practitioner Involvement
- Element D: Annual Evaluation

NCQA Standard UM 2: Clinical Criteria for UM Decision

The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.

- Element A: UM Criteria
- Element B: Availability of Criteria
- Element C: Consistency in Applying Criteria

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.

- Element A: Access to Staff

NCQA Standard UM 4: Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

- Element D: Practitioner Review of BH Denials
- Element G: Affirmative Statement about Incentives

NCQA Standard UM 10: Evaluation of New Technology

The organization evaluates the inclusion of new technologies and the new application of existing technology in its benefits plan, including medical and behavioral healthcare procedures, pharmaceuticals and devices.

- Element A: Written Process
- Element B: Description of the Evaluation Process

NCQA Standard UM 11: Procedures for Pharmaceutical Management

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

- Element A: Pharmaceutical Management Procedures
- Element B: Pharmaceutical Restrictions/Preferences
- Element C: Pharmaceutical Patient Safety Issues
- Element D: Reviewing and Updating Procedures
- Element E: Considering Exceptions

NCQA Standard UM 12: Triage and Referral for Behavior Health Care

The organization has written standards to ensure that its centralized triage and referral functions for behavioral healthcare services are appropriately implemented, monitored, and managed. This standard applies only to organizations with a centralized triage and referral *process for behavioral health, both delegated and non-delegated.*

- Element A: Triage and Referral Protocols
- Element B: Supervision and Oversight

NCQA Standard UM 13: Delegation of UM

If the organization delegates UM activities, there is evidence of oversight of the delegated activities.

- Element A: Delegation Agreement
- Element B: Provision of Member Data to the Delegate
- Element C: Provisions for PHI
- Element D: Pre-delegation Evaluation
- Element E: Review of the UM Program
- Element F: Opportunities for Improvement

NCQA Standard QI 4: Member Experience

The organization monitors member experience with its services and identifies areas of potential improvement.

- Element G: Assessing experience with the UM process

4. Special Health Care Needs - 2017 Contract Section 7.1.4 A-D.[15][16]

   The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.[17] If the MCO has in place an alternative mechanism(s), or is proposing a new mechanism(s) that meets or exceeds the requirements of section 7.1.4(A), the MCO must submit a written description to the STATE for approval. If the MCO's mechanism(s) have been approved by the STATE and

[15] 42 CFR §438.330(b)(4)

[16] Families and Children, Seniors (MSHO/MSC+), and SNBC Contract Section 7.1.4 A-D

[17] The definition of special health care needs is different among the three contracts. For MSHO/MSC+ and SNBC, all enrollees are considered to have special health care needs

there has been a material change, the MCO must timely submit a revised description to the STATE for approval.

A. Mechanism to Identify Persons with Special Health Care Needs. The MCO must identify Enrollees that may need additional services through method(s) approved by the STATE.
   i. The MCO must analyze claim data for diagnoses and utilization patterns (both under- and over-utilization) to identify Enrollees who may have special health care needs. At a minimum the MCO must quarterly analyze claim data to identify Enrollees eighteen (18) years and older for the following:
      a. Prevention Quality Indicators as described in the "*Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*" by AHRQ for bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease;
      b. Hospital emergency department utilization as determined by the MCO;
      c. Inpatient utilization stays for the MCO's identified key Minnesota Health Care Program diagnoses or diagnoses clusters;
      d. Hospital readmission for the same or similar diagnoses as defined by the MCO within a timeframe specified by the MCO;
      e. Individual Enrollee claims totaling more than one hundred thousand dollars ($100,000) per year; and
      f. Home Care Services utilization as determined by the MCO.
   ii. In addition to claims data, the MCO may use other methods, such as: 1) health risk assessment surveys; 2) performance measures; 3) medical record reviews; 4) Enrollees receiving PCA services; 5) requests for Service Authorizations; and/or 6) other methods developed by the MCO or its Network Providers.
B. Assessment of Enrollees Identified. The MCO must implement mechanisms to assess Enrollees identified and monitor the treatment plan set forth by the MCO's treatment team, as applicable. The assessment must utilize appropriate Health Care Professionals to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.
C. Access to Specialists. If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs.
D. Annual Reporting to the STATE. The MCO shall incorporate into, or include as an addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in section 7.1.8) a Special Health Care Needs summary describing efforts to identify Enrollees that may need additional services and the following items:
   i. The number of Adults identified in section 7.1.4(A) with special health care needs;

ii. The annual number of assessments completed by the MCO or referrals for assessments completed; and

iii. If the MCO adds the information in this section as an addendum, the addendum must include an evaluation of items 7.1.4(A) through 7.1.4(C).

5. Practice Guidelines - 2017 Contract Section 7.1.5.[18]
   A. The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" QI 7 Clinical Practice Guidelines.
      i. Element A: Adoption of Guidelines. The MCO shall adopt clinical practice guidelines based on scientific evidence or professional standards for at least two medical and two behavioral conditions; update the guidelines at least every two years; distribute the guidelines to the appropriate practitioners.
      ii. Element B: Adoption of Preventive Health Guidelines. The MCO shall adopt preventive health guidelines based on scientific evidence or professional standards for members of all ages; update the guidelines at least every two years; distribute the guidelines to the appropriate practitioners.
      iii. Element C: Relation to DM Programs. The MCO shall base its disease management programs on two of the organization's clinical practice guidelines.
      iv. Element D: Performance Measurement. The MCO shall annually measure performance against at least two key aspects of two of the following:
         a. Clinical practice guidelines for chronic or acute conditions
         b. Clinical practice guidelines for behavioral health conditions
         c. Preventive health guidelines
6. Annual Quality Assurance Work Plan – 2017 Contract Section 7.1.7
   A. On or before May 1st of the Contract Year, the MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner.
   B. B. NCQA QI, Element A: An annual work plan that reflects ongoing progress on QI activities throughout the year and addresses:
      i. Yearly planned QI activities and objectives for improving:
         - Quality of clinical care
         - Safety of clinical care
         - Quality of service

[18] 42 CFR §438.340(b)(1)

- Members' experience

ii. Time frame for each activity's completion
iii. Staff members responsible for each activity
iv. Monitoring of previously identified issues
v. Evaluation of the QI program

Annual Quality Assessment and Performance Improvement Program Evaluation - 2017 Contract Section 7.1.8[19][20]

A. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "*Standards and Guidelines for Accreditation of Health Plans.*" This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standard 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 the following information:

(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 and of its progress toward influencing network-wide safe clinical practices.

Performance Improvement Projects (PIPs), Final PIP Report and New Performance Improvement Project Proposal - 2017 Contract Sections 7.2, 7.2.1 and 7.2.2.[21] [22]– 2017 Contract Sections 7.2, 7.2.1, and 7.2.2

The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction.

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[19] Families and Children, Seniors (MSHO/MSC+) and SNBC Contract Section 7.1.8

[20] MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "*Quality Framework for the Elderly*" in its Annual Evaluation

[21] §438.330(b)(1), §438.330(d); Contract Section 7.2

[22] CMS Protocols, EQR Protocol 3: Validating Performance Improvement Projects (PIPs)

Projects must comply with 42 CFR § 438.330(b)(1) and (d) and CMS protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

A. Final PIP Report. Upon completion of the 2015 PIP the MCO shall submit to the STATE for review and approval a final written report by September 1st, 2018, in a format defined by the STATE.
B. New Performance Improvement Project Proposal. In 2017, the STATE shall select the topic for the new PIP to be conducted over a three year period (Calendar years 2018, 2019, and 2020). The PIP must be consistent with CMS' published protocol entitled *"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects"*, STATE requirements, and include steps one through seven of the CMS protocol.

C. PIP Proposal and PIP Interim Report Validation Sheets. DHS uses these tools to review and validate MCOs' PIP proposals and annual status reports.

Disease Management Program - 2017 Contract Section 7.3[23]

The MCO shall make available a Disease Management Program for its Enrollees with diabetes, asthma and heart disease. The MCO may request the STATE to approve an alternative Disease Management Program topic other than diabetes, asthma or heart disease. The MCO must submit to the STATE appropriate justification for the MCO's request.

A. Disease Management Program Standards. The MCO's Disease Management Program shall be consistent with specified NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" pursuant to the QI Standard for Disease Management.

B. Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program is: 1) not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) would have a negative financial return on investment, then the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.

Advance Directives Compliance - 2017 Contract Section Article 16 Advance Directives Compliance[24][25]

[23] MSHO/MSC+ Contract Section 7.3, require requires prior approval for alternative DM program other than diabetes and heart DM programs. SNBC Contract Section 7.2.6

[24] F&C MA, MSHO/MSC+ and SNBC Contract Article 16.

[25] 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

1. Enrollee Information: 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:

A. 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.

B. Written policies of the MCO respecting the implementation of the right; and

C. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

D. 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 CFR 422.128 as required in 42 CFR 438.(3)(j).

2. Providers Documentation: To require MCO's providers to ensure that it has been documented in the enrollee's medical records whether or not an enrollee has executed an advance directive.

3. Treatment: To not condition treatment or otherwise discriminate on the basis of whether an enrollee has executed an Advance Directive.

4. Compliance with State Law: To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Minnesota Statutes, Chapters 145B and 145C.

5. Education: To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.

<u>Validation of MCO Care Plan Audits for MSHO and MSC+ 2017 - Contract Sections 6.1.4(A)(2), 6.1.4(A)(3), 6.1.4(A)(4), 6.1.5(B)(5).</u>

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.

Subcontractors:

(1) Written Agreement; Disclosures – 2017 Contract Sections 9.3.1[26]

All subcontracts must be current, in writing, fully executed, and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include:

A. Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information:

(1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address;

(2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.3.1(A) is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;

(3) The name of any other disclosing entity in which a Person with an Ownership Control Interest in the disclosing entity also has an ownership or control interest; and

(4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity.

(5) For the purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its Contract with the STATE.

(6) MCO Disclosure Assurance. The MCO must submit to the STATE by September 1st of the Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all subcontractors, and reviewed by the MCO prior to MCO and subcontractor contract renewal. The letter should identify all databases that were included in the review. A data certification pursuant to section 9.10 is required with this assurance.

[26] Families and Children, Seniors and SNBC Contract Sections 9.3.1.A

(7) Upon request, subcontractors must report to the MCO information related to business transactions in accordance with 42 CFR §455.105(b). Subcontractors must be able to submit this information to the MCO within fifteen (15) days of the date of a written request from the STATE or CMS. The MCO must report the information to the STATE within ten (10) days of the MCO's receipt from the subcontractor.

(B) Current and fully executed agreements for all subcontractors, including bargaining groups, must be maintained for all administrative services that are expensed to MHCP. Subcontractor agreements determined to be material, as defined by the STATE, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to MHCP. Upon request, the STATE shall have access to all subcontractor documentation under this section. Nothing in this section shall allow release of information that is nonpublic data pursuant to section Minnesota Statutes, § 13.02.

(2) Exclusions of Individuals and Entities; Confirming Identity – 2017 Contract Section 9.3.16, 9.3.17[27]

(A) Pursuant to 42 CFR § 455.436, the MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or managing employee of the MCO or its subcontractors through routine checks of Federal databases, including the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.

(B) The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest, and Managing Employees to verify that these persons:

(1) Are not excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act; and

(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act.

(C) The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this Contract.

[27] Families and Children 9.3.16 and 9.3.17, Seniors and SNBC Contract Sections 9.3.22 and 9.3.23

(D) The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the Title XX services program, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.

(E) The MCO shall report this information to the STATE within seven (7) days of the date the MCO receives the information.

(F) The MCO must also promptly notify the STATE of any action taken on a subcontract under this section, consistent with 42 CFR § 1002.3 (b)(3).

(G) In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.

(2) Business Continuity Plans: The MCO shall ensure that its subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of Article. 18.

Appendix D: Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver

Evaluation Plan 2015 to 2020

Introduction

The PMAP+ Section 1115 Waiver has been in place for the last 20 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care through Medicaid funding for people with income in excess of the standards in the Medical Assistance Program. The Department of Human Services (DHS) secured approval for BHP funding to run the MinnesotaCare program effective January 1, 2015. Even though the PMAP+ waiver is no longer necessary to continue the MinnesotaCare program, several aspects of the PMAP+ waiver continue to be necessary.

PMAP+ Section 1115 Waiver Extension January 1, 2015 through December 31, 2015

In December 2014, a one-year extension was granted for PMAP+, for the period of January 1, 2015 through December 31, 2015. The 2015 demonstration continues to provide important authorities for Minnesota's Medicaid program such as preserving eligibility methods currently in use for children ages 12 to 23 months, simplifying the definition of a parent or caretaker relative to include people living with children under age 19, providing full Medical Assistance (MA) benefits for pregnant women during the period of presumptive eligibility, allowing mandatory enrollment of certain populations in managed care, and authorization of medical education funding.

PMAP+ Section 1115 Waiver Renewal January 1, 2016 through December 31, 2020

On June 30, 2015 DHS submitted a request to renew the PMAP+ waiver for the time period beginning January 1, 2016, and ending December 31, 2020. The proposed waiver extension seeks to continue federal authority for the following:

Preserving eligibility methods currently in use for children ages 12 through 23 months;

Simplifying the definition of a parent or caretaker relative to include people caring for children under age 19

Providing full MA benefits for pregnant women during the period of presumptive eligibility;

Payments for graduate medical education costs through the MERC fund.

Waiver Populations and Expenditure Authorities for PMAP+ 2015-2020 Evaluation

MA One-Year-Olds

The PMAP+ waiver provides expenditure authority for Medicaid coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medicaid, with incomes above 275% and at or below 283% of the federal poverty level (FPL).

Caretaker Adults with 18-Year-Old

The PMAP+ waiver provides expenditure authority for Medicaid coverage for Caretaker Adults who live with and assume responsibility for a youngest or only child who is age 18 and is not enrolled full time in secondary school. PMAP+ waiver authority allows Minnesota to waive the requirement to track the full-time student status of children age 18 living with a caretaker

Beginning in 2014, Minnesota covers both adults without children and caretaker adults to 133% of the FPL under the state plan. Adults without children and caretaker adults are eligible for the full MA benefit set. Without waiver authority, a caretaker adult with a youngest child or only child turning 18 would need to be re-determined under an "adult without children" basis of eligibility. This exercise is meaningless because Minnesota covers adults and parents to the same income level. Health care coverage and cost sharing are the same.

The household size for the parent is independent of the required tracking of the child's full-time student status. For non-tax filing families, Minnesota has chosen age 19 as the age at which a child is no longer in the household. In a tax filing household, the parent's household size would depend on whether they expect to claim the child as a dependent, regardless of age. By waiving the requirement to track the full-time student status, Minnesota avoids requesting private data that will not be consequential to the consumer's eligibility for health care. In addition to relieving the burden on consumers and not requesting personal information that is not relevant to eligibility, coverage, or cost-sharing, Minnesota expects the waiver to result in administrative efficiency by simplifying the procedures that case workers need to follow.

MERC

Through expenditure authority granted under the PMAP+ waiver, payments made through the Medical Education and Research Costs (MERC) Trust Fund through sponsoring institutions to medical care providers are eligible for federal financial participation.

Pregnant Women

The Patient Protection and Affordable Care Act (ACA) established the hospital presumptive eligibility (PE) program effective January 2014 allowing qualified hospitals to make MA eligibility determinations for people who meet basic criteria. Under hospital PE, covered benefits for pregnant women during a presumptive eligibility period are limited to ambulatory prenatal care. Minnesota has secured PMAP+ waiver authority to allow pregnant women to receive services during a presumptive eligibility period that are in addition to ambulatory prenatal care services. The benefit for pregnant women during a hospital presumptive eligibility period will be the full benefit set that is available to qualified pregnant women in accordance with section 1902(a)(10)(i)(III) of the Act. Implementation of presumptive eligibility began in July 2014.

Hypotheses, Research Questions and Evaluation Metrics

MA One-Year-Olds

Goal/Objective:

The goal of the demonstration is to ensure at least comparable access and quality of preventive care to the MA one-year-old child population as compared to other children enrolled in public health care programs.

Research Question:

Did the MA one-year-old child population experience comparable utilization of services (i.e. childhood immunization status, well-child visits, and access to primary care practitioners) when compared to national Medicaid averages?

Do the rates for each of the measures vary by race within Minnesota's MA one-year-old child population?

Hypothesis:

Providing health care coverage to the MA one-year-old child population, will result in access and quality of care for this population that is comparable to children enrolled in other public programs.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
Did the MA one-year-old child population experience comparable utilization of preventative and chronic disease services, when compared to national Medicaid averages?	Children 12-24 months who are enrolled in Medicaid in the United States.	Childhood immunization status (2 yr) (CIS)* Well-child visits (first 15 months) (W15)* Child access to primary care practitioners (ages 12-24 mo.s) (CAP)*	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data
Do childhood immunization status, well-child visits, or access to primary care practitioners vary by race within the one-year-old child population?	Comparisons by race will be made within the population of MA enrollees who are between 12 and 24 months of age.	Childhood immunization status (2 yr) (CIS)* Well-child visits (first 15 months) (W15)* Child access to primary care practitioners (ages 12-24 mo.s) (CAP)*	MY 2016-2020 RY 2014-2015	MMIS claims data
*NCQA HEDIS Measures				

Statistical Methods:

The evaluation will use selected HEDIS performance measures to evaluate care for the MA one-year-old child population compared to other children enrolled in public health care programs. A

comparison and stratification of the selected HEDIS and other performance measures will be made between the MA one-year-old population and the Medicaid national child (12-24 months) population to show the ongoing improvement in care for children enrolled in Medicaid in Minnesota. The HEDIS performance measures are rates that are generally defined as the sum of eligible individuals who received a service (numerator) divided by the total number of individuals who qualified for the service (denominator).

To address the first research question, each of the state's three overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these three areas relative to the other states in the nation.

For the second analysis, the individual-level state data will be stratified by race (Asian-Pacific Islander, Black, Hispanic, Native American, and White) and three separate tests for equality of proportions (one test per HEDIS rate), will be used to detect whether or not race influences quality and or access to care, as measured by the HEDIS rates.

Medicaid Caretaker Adults with 18 –Year- Old

Goal/Objective

The goal of the demonstration is to ensure at least comparable access and quality of prevention and chronic disease care for MA caretaker adults with an 18-year old child as compared to other adults who are enrolled in public health care programs.

Research Questions:

1. Did the MA caretaker adult waiver population in Minnesota experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?
2. Did the MA caretaker adult waiver population in Minnesota experience comparable utilization of preventative and chronic disease care services for adults when compared to national Medicaid averages (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?

Hypothesis:

Providing health care coverage to this adult caretaker waiver population will result in access and quality of prevention and chronic disease care for this population that is comparable to other adults enrolled in public health care programs.

Research Question(s)	Comparison Population(s)	Measures	Measurement Years (MY)/ Reference Years (RY)	Data Source(s)
Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota?	MA parents in Minnesota MA adults without children in Minnesota	For both comparison populations, the following measures will be used: Annual dental visit Cervical cancer screening Comprehensive diabetes care Follow-up after hospitalization for mental illness Medication management for people with asthma Access preventative/ambulatory health services	MY 2016-2020 RY 2014-2015	MMIS claims data
Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to	Other adults enrolled in MA in the United States	Cervical cancer screening Comprehensive diabetes care	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

Research Question(s)	Comparison Population(s)	Measures	Measurement Years (MY)/ Reference Years (RY)	Data Source(s)
national Medicaid averages (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?		Follow-up after hospitalization for mental illness Medication management for people with asthma Access preventative/ambulatory health services		

Statistical Methods:

The evaluation will use selected HEDIS performance measures to evaluate care for the MA caretaker adult waiver population compared to other adults enrolled in public health care programs. A comparison and race stratification of the selected HEDIS and other performance measures will be made between the waiver population and separate populations (i.e. other adults enrolled in MA in Minnesota to show the ongoing improvement in care for MA caretaker adults in Minnesota.

Since the populations of interest are completely independent, a series of tests for equality of proportions will be used to gauge the quality of care received by caretakers with children in MN and caretakers without children in MN.

To address the second research question, each of the state's five overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these five areas relative to the other states in the nation.

5.3 Medical Education and Research Costs (MERC) Trust Fund

Goal/Objective

There is an on-going need to support training opportunities for medical education in Minnesota. For nearly two decades, Minnesota has taken a unique approach to this issue through its section 1115 waiver authority under PMAP+. This authority is necessary to continue a grant payment structure for facilities accepting trainees to support the care of the Medicaid population. Without this grant program, many facilities, especially in rural areas, may not be able to participate in training activities for medical education, which help attract new providers ready to serve low-income and underserved areas of the state.

Through Minnesota's PMAP+ waiver, the MERC program supports the objectives of the Medicaid program by strengthening the state's provider network through residency grants to facilities serving the Medicaid population that accept trainees who will support patient care. This program also serves a variety of health professions, including training for professions where shortages exist for the Medicaid population. The amount of the grant available to the facility is relative to their Medicaid-patient volume, providing an incentive for these facilities to serve a higher volume of the Medicaid population.

The key advantage of this approach is that MERC allows for a broader set of facilities to participate than just teaching hospitals, helping the state reach a larger portion of the state. Under the traditional fee-for-service system, medical education payments to teaching facilities are higher than those to non-teaching facilities. This is done in an effort to offset a portion of the higher costs faced by facilities that provide clinical medical education.

Hypothesis A:

Providing a dedicated trust fund for graduate medical education will maintain or increase training opportunities at facilities statewide to support the care of the Medicaid population in Minnesota.

Research Questions:

1. Were the number of students and residents at clinical training sites receiving MERC grant funds maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?
2. How did the MERC fund grantees use the payments?

Hypothesis A

Research Question(s)	Comparison Population(s)	Measures	Comparison Years28	Data Source(s)
1. Were the number of students and residents at training sites maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?29	Rural: Number of students and residents at training sites in rural areas of the state for Demonstration Year (DY) 1930 and DY 2031. Urban: Number of students or residents at training sites in urban areas of the state for DY 19 and DY 20.	Rural: Compare the number of students and residents at training sites in rural Minnesota for years 2016 through 2020 to the number of students and residents at training sites in rural Minnesota for DY 19 and DY 20. Urban: Compare the number of students and residents at training sites in urban areas of the state for the current waiver period to the number of students and residents at training sites in urban areas of the state in DY 19 and DY 20.	MY 2016-2020 RY 2014- 2015	MERC Program data

[28] Comparison Years are based on State Fiscal Years.

[29] Urban areas of the state include the seven-county metro area which includes the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Washington and Scott. The rural areas of the state include the remaining 80 counties in Minnesota.

[30] PMAP demonstration year 19 covers the period of July 1, 2013 through June 30, 2014.

[31] PMAP demonstration year 20 covers the period of July 1, 2014 through June 30, 2015.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years28	Data Source(s)
2. How did the MERC-funded grantees use the payments?	N/A	Of the total grant distribution for years 2016 through 2020, identify the percentage of funds that were used to support training in the following health professions: Medical training (physicians) Dental providers (including dental therapists) Psychologists Pharmacists Community Paramedics Other health professionals	MY 2016-2020	MERC Program Data

Hypothesis B:

Providing a dedicated trust fund for graduate medical education will support training activities which help to maintain or increase the number of primary care providers serving the Medicaid population in Minnesota.

Research Questions:

1. Was the ratio of primary care providers in rural Minnesota to primary care providers in urban Minnesota maintained or improved during this waiver period compared to the previous waiver period?
2. Was the ratio of rural primary care providers per 10,000 rural beneficiaries maintained or improved during this waiver period compared to the previous waiver period?
3. Was the ratio of urban primary care providers per 10,000 urban beneficiaries maintained or improved during this waiver period compared to the previous waiver period?

Hypothesis B

Research Question(s)	Comparison Population(s)	Measures	Comparison Years1	Data Source(s)
1. Was the ratio of rural, primary care providers to urban primary care providers maintained or improved during this waiver period compared to the previous waiver period?	Primary care providers in rural areas of the state in DY 19 and DY 20 who were enrolled in Medical Assistance. Primary care providers in urban areas of the state in DY 19 and DY 20 who were enrolled in Medical Assistance	For Medicaid enrolled providers only, compare the ratio of rural primary care providers to urban primary care providers for years 2016 through 2020 to the ratio of rural primary care providers to urban primary care providers for DY 19 and DY 20	MY 2016-2020 RY 2014- 2015	Medicaid Provider Enrollment Data for primary care providers.
2. Was the ratio of rural primary care providers per 10,000 rural beneficiaries maintained or improved during this	Primary care providers per 10,000 beneficiaries in rural areas of the state in DY 19 and	For Medicaid enrolled providers only, compare the ratio of rural primary care providers per	MY 2016-2020 RY 2014- 2015	Medicaid Provider Enrollment Data for primary care providers.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years1	Data Source(s)
waiver period compared to the previous waiver period?	DY 20 who were enrolled in Medical Assistance.	10,000 rural beneficiaries for the years 2016 through 2020 to the ratio of rural primary care providers per 10,000 rural beneficiaries for DY 19 and DY 20		
3. Was the ratio of urban primary care providers per 10,000 urban beneficiaries maintained or improved during this waiver period compared to the previous waiver period?	Primary care providers per 10,000 beneficiaries in urban areas of the state in DY 19 and DY 20 who were enrolled in Medical Assistance.	For Medicaid enrolled providers only, compare the ratio of urban primary care providers per 10,000 urban beneficiaries for the years 2016 through 2020 to the ratio of urban primary care per 10,000 urban beneficiaries for DY 19 and DY 20	MY 2016-2020 RY 2014- 2015	Medicaid Provider Enrollment Data for primary care providers.

1 Comparison Years are based on State Fiscal Years.

Statistical Methods:

The evaluation will use MERC program data to compare the annual number of students and residents at training sites in rural and urban areas of the state across the two waiver periods using chi-square tests for independence. The test will determine whether or not the number of students and residents change significantly over time or if they remain relatively constant. Grant fund distributions will be analyzed to determine utilization rates across health professions. Tests

for equality of proportions will be used to assess whether or not the proportion of funds allocated to the program changed over time. The evaluation will use two equality of proportions tests to determine if the proportion of providers in rural and urban areas changed over time. Ratios between providers in rural in urban areas will also be compared using chi square tests. Additional analysis will evaluate provider to beneficiary ratios within geographical regions of the state to determine if MERC has impacted ratios between the two waiver periods.

Pregnant Women in a Presumptive Eligibility Period

Goal/Objective:

The goal of the demonstration is to ensure at least comparable access and quality of prenatal and postpartum care to pregnant women enrolled in MA through the PMAP+ waiver authority as compared to national Medicaid averages.

Research Question:

1. Did the MA pregnant women waiver population experience comparable utilization of prenatal and postpartum care when compared to national Medicaid averages (i.e. prenatal visit within first trimester (or within 42 days of enrollment into MA) and postpartum visit between 21 and 56 days after delivery)?

Research Question(s)	Comparison Population(s)	Measures	Measurement Years (MY)/ Reference Years (RY)	Data Source(s)
Did the MA pregnant women waiver population experience comparable utilization of prenatal and postpartum care when compared to national Medicaid averages?	Pregnant women who are enrolled in Medicaid in the United States.	Prenatal visit within first trimester Postpartum visit between 21 and 56 days after delivery	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

Statistical Methods:

The evaluation will use selected HEDIS performance measures to evaluate care for the waiver population compared to national averages. A comparison and stratification of the selected HEDIS and other performance measures will be made between the waiver population and national Medicaid averages for pregnant women to show the ongoing improvement in care for pregnant women enrolled in MA in Minnesota. Minnesota Managed Care HEDIS Hybrid data will also be utilized to determine differences in administrative versus hybrid rates for this measure.

Each of the state's two overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these two areas relative to the other states in the nation.

Qualifications of Staff Conducting Evaluation

The qualifications of the staff conducting the evaluation include but are not limited to the following key personnel.

Kevan Edwards has been with DHS for nearly two years and is currently the Research Director of Health Care Research and Quality Division/Research and Data Analysis Section. Dr. Edwards has a Ph.D. in Sociology, Health Services Research Supporting area from the University of Minnesota. Prior to his work at DHS, he was the Research Director, Health Economics Program at the Minnesota Department of Health working with the All Payer Claims Database. Areas of expertise include risk adjustment of cost and quality measures, and disparities in health status, health access, and health care utilization.

Barbara Frank, a Research Supervisor in the Research and Data Analysis section, has twenty years of experience using health care claims data (Commercial/Medicare/Medicaid) including four years of experience in HEDIS reporting. Ms. Frank has over 15 years of SAS experience, primarily using SAS Base/EG with DHS data. She has a Masters of Public Health. Prior to coming to DHS, Ms. Frank was the Director of Assistance, and Director of Workshops, Outreach and Research for the CMS Contract Research Data Assistance Center (ResDAC).

James Kuiper, Agency Policy Specialist, has been with the DHS Research and Data Analysis team since 2014. He has twenty-eight years of SAS Base/Stat/Macro programming in a variety of health care research settings (DHS warehouse, commercial health plans, and disease management) and is experienced in database programming in MS SQL Server, Access, and Proc SQL. Mr. Kuiper holds a Bachelor of Science in Mathematics and Statistics.

Monica Patrin, Agency Policy Specialist, has been with DHS since December 2016. After graduating from the University of Minnesota with a Masters in Statistics in 2013, she worked in

education research and assessment as a data analyst/R programmer for almost three years. She has experience working with a variety of models used as the basis for teacher evaluations—(random effects models, error in variables models, multinomial logistic regression models, etc).

Diane Reger, State Program Administrator – Principal, has been with MDH since 2000. She has administered the MERC grant program for sixteen years. Prior to coming to MDH, she worked in the insurance industry for ten years, in underwriting and sales and marketing analysis.

Mark Schoenbaum, MSW, is Director of Minnesota's Office of Rural Health and Primary Care at the Department of Health. He has over 35 years of state government experience in program management, policy analysis and evaluation. He manages a portfolio of state health care workforce development and safety net programs that includes the MERC program.

Evaluation Implementation Strategy and Timeline

Waiver Populations under Sections 5.1, 5.2, and 5.4

Beginning in 2021, performance measurement data will be extracted from DHS' managed care encounter and fee-for-service database to allow for a sufficient encounter/claim run-out period. Performance measurement rates for the baseline period (CY 2014 and 2015) will be calculated for the targeted populations and compared to CY 2016, 2017, 2018, 2019, and 2020. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass to compare performance of Minnesota's populations with national and other states' performance.

The DHS Health Care Research and Quality Division will conduct this component of the waiver evaluation and review results over the second half of calendar year 2021, with the draft final report submitted to CMS in December 2021.

Below is an overview of evaluation activities and timelines:

August 2020: DHS will calculate measurement rates for baseline goals.

September-October 2020: DHS will calculate and stratify HEDIS 2015-2019 performance measures.

October 2021: HEDIS results will be reviewed and evaluated.

November-December 2021: Draft final waiver report is written, reviewed and submitted to CMS.

March 2022: CMS submits feedback to DHS.

May 2022: DHS incorporates CMS feedback. Final report is submitted to CMS.

Waiver Authority under Sections 5.3

The Minnesota Department of Health and DHS will conduct this component of the waiver evaluation. MERC Program data for the baseline period (DY 19 and DY 20) will be compiled and compared to CY 2016, 2017, 2018, 2019, and 2020. Medicaid provider enrollment data for CY 2016 through 2020 will be extracted and analyzed. The results will be incorporated into the draft final report.

Appendix E: Proposed Evaluation for Reform 2020

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 2013.

Minnesota'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) who are enrolled in MA and need long term care services are living in the community rather than in institutional settings.

Minnesota provides 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 in 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 (i.e., bathing, dressing, eating, transferring, toileting, mobility, grooming, positioning) or instrumental activities of daily living (e.g. cooking, cleaning, laundry, shopping). The PCA program has grown from 200 participants in 1986 to over 30,000 today. 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 170 people. At times, in an effort to get a specific service (such as special equipment or modifications to a person's home) or additional supports beyond traditional PCA services, persons 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)32, Community Alternatives for Disabled Individuals (CADI)33, Community Alternative Care (CAC)34, Brain Injury (BI)35 and Elderly Waiver (EW)36. Similar services to support individuals living in the community are offered under each waiver, but since each was developed over time and under different constraints, opportunities, and different populations, HCBS waivers 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.

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 may divert them from nursing facilities and encourage more efficient use of services when full

[32] DD: 2011 unduplicated enrollment was 15,761.

[33] CADI: 2011 unduplicated enrollment was 18,927 (reflects high turnover rate)

[34] CAC: 2011 unduplicated enrollment was 390

[35] BI: 2011 unduplicated enrollment was 1,513

[36] EW: 2011 unduplicated enrollment was 29,291 (managed care and fee-for-service)

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)37. 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

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

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.

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 Medicaid standards for aged, blind and disabled categorical eligibility.

Alternative Care is available to eligible individuals who meet all of the following financial requirements:

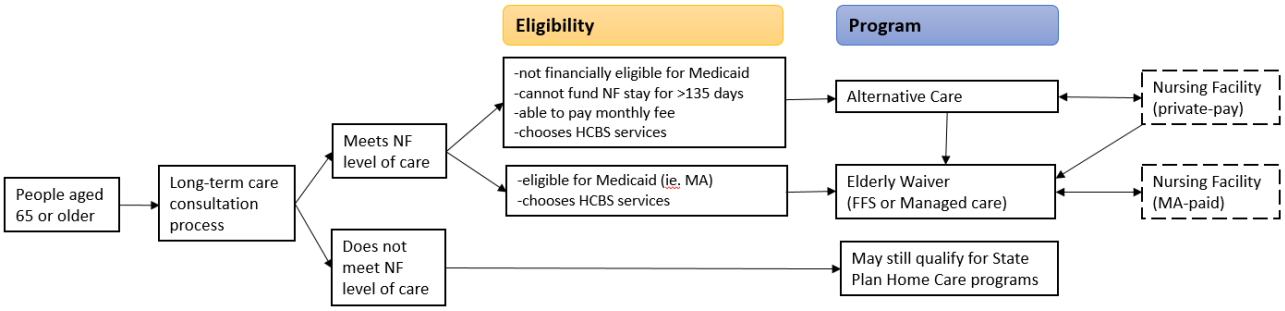
Those with combined income and assets insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate

Those not within an uncompensated transfer penalty period

Those with home equity 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 (see Figure 1).

Figure 1. Minnesota Health Care Program Options for the Elderly



AC, alternative care program; FFS, fee-for-service; HCBS, home and community-based services; MA, Medical Assistance (Minnesota's Medicaid program); NF, nursing facility; SNF, skilled nursing facility

If an Alternative Care beneficiary is admitted to a nursing facility, his/her stay is either paid by Medicare (if eligble), other long-term care insurance, or out-of-pocket. If the person spends-down and becomes eligible for Medicaid, he/she can transition to the Elderly Waiver program where nursing facility use is a MA benefit. For details on how a person transitions from Alternative Care to Elderly Waiver program, refer to the "AC Operational Protocol".

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 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:

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 additionally covers nutrition services and discretionary benefits

The comprehensive list of Alternative Care benefits is below:

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);

Non-medical transportation;

Tele-home care;

Discretionary services

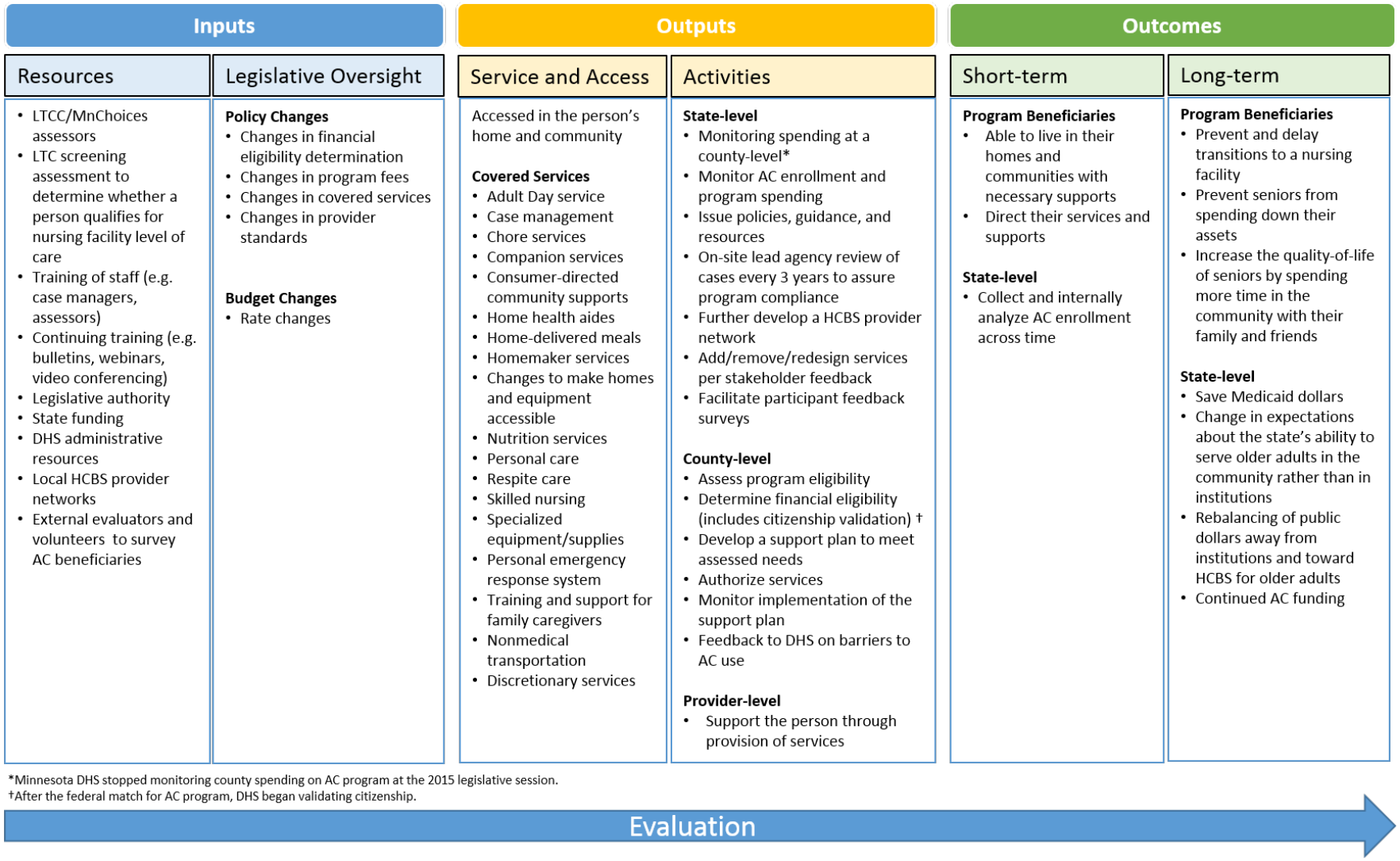
An overview of the Alternative Care program, services, and outcomes are provided in Figure 2.

Program Goals

The goals of the Alternative Care program are to:

1. Provide access to coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
2. Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
3. Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time.

Figure 2: Alternative Care Program Logic Model



Evaluation Strategy for Alternative Care

The Reform 2020 demonstration waiver is approved for the period October 18, 2013 through June 30, 2018. Since the federal waiver authorization has not resulted in any changes to the Alternative Care program structure, we propose the following hypotheses:

- the waiver will not change the fundamentals of the program: size and characteristics of the population with AC;
- the waiver will not change their conversion to Medicaid, particularly subsequent use of Elderly Waiver services; transition to and from nursing facilities; and health events
- the waiver will not change outcomes as indicated by use of acute care services.

To test these hypotheses, we will evaluate the AC program over time (i.e., 2010-2018) in order to examine changes if any in program behavior, particularly any unintended negative consequences and the expected benefits to program enrollees (see Figure 2). We will also compare the AC to the Elderly Waiver (EW) population over the same time period (Section 3.1). This comparison allows us to describe the degree of transitions between programs, i.e., AC clients converting to Medicaid and using the EW, and to assess the potential impact of secular trends that may be affecting both programs, such as other policy shifts or changes in the elderly population or their use of services.

The goals and associated metrics identified in section 2.1 will be evaluated by DHS and University of Minnesota using MMIS claims and beneficiary assessment data linked to Medicare data Although this will be an integrated effort, DHS will lead the descriptive component of the evaluation using readily available data sources, as part of its ongoing quality monitoring and management activities. The University will provide analyses of expanded data elements (including Medicare data) and employ more rigorous analysis methods.

AC and Comparison Population

The populations included in the evaluation consist of Alternative Care (AC) program enrollees and Elderly Waiver enrollees. Elderly Waiver enrollees are very similar to Alternative Care program enrollees. Both groups: 1) are aged 65 and above, 2) must have an assessed need for an institutional level of care, and 3) are using home and community-based services to meet their needs and remain living in the community instead of in a nursing facility.

Some Elderly Waiver beneficiaries will use residential services (i.e., customized living, adult foster care, and residential care services). We will identify Elderly Waiver beneficiaries in non-residential settings by excluding beneficiaries with any claims for residential services. For this evaluation, we will focus on these comparison populations: 1) Elderly Waiver beneficiaries in total, and 2) Elderly Waiver beneficiaries without residential services use, who are most directly comparable to the AC beneficiaries. As a sub-analysis we will also draw comparisons with Elderly Waiver beneficiaries who have residential use to see how they might differ the primary comparison group.

Internal program monitoring and evaluation show that in the state fiscal year (July 2008-June 2009), there were approximately 4800 unique beneficiaries in the AC program and 25,500 unique beneficiaries in the Elderly Waiver program (of which 75% did not use any residential services). The number of AC enrollees has been declining slightly, while the number of Elderly Waiver enrollees has been increasing.

Goals and Objectives

The objective of the evaluation is to determine if access, quality of care and program sustainability for Alternative Care recipients has changed before and after the introduction of the AC waiver. We also will draw comparisons over time to Elderly Waiver recipients in non-residential settings at each time point and trace program growth over time (Section 3.1). We will evaluate trends in the population served under the AC waiver, by exploring the level of need, ability to access and use consumer-directed services, rates of nursing facility admission and experience of negative health outcomes.

Hypotheses

Research questions of interest include: 1) To what extent did access, quality of care, and program sustainability for Alternative Care recipients change before and after federal match? and 2) How do care and outcomes for Alternative Care beneficiaries compare to Elderly Waiver beneficiaries? We will evaluate changes over time (2010 to 2018) to the AC program in itself and in comparison to the Elderly Waiver program.

The level of need, demographic characteristics, and service use patterns for Alternative Care beneficiaries will not change over time, neither alone nor in comparison to Elderly Waiver beneficiaries in non-residential settings. This will be evaluated using the following measures:

- Case-mix status (low-need vs. high-need)38
- ADL dependencies and health functions
- Acuity rate differences between AC and Elderly Waiver non-residential beneficiaries
- Use of home and community-based services
- Acute care services where available for AC beneficiaries and when there is comparability between AC and Elderly Waiver beneficiaries
- Alternative Care beneficiaries will experience equal or better access to consumer-directed service (CDS) options39 over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings. This will be evaluated using the following measures:

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[38] See section 3.42 for details on case-mix is determined and level of need is defined.

[39] Consumer directed services are available in the AC and Elderly Waiver programs. This measure will exclude discretionary services which are designed by the county (whereas the CDCS is a person's choice). Elderly Waiver beneficiaries in residential settings will not use CDCS.

- Authorized consumer-directed community supports
- Difference in CDS use between AC and Elderly Waiver non-residential beneficiaries
- Alternative Care beneficiaries will experience equal or less nursing facility use over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings. This will be evaluated using the following measures:
- Proportion of recipient days spent in nursing facilities
- Frequency of nursing facility admission, by length of stay
- Case-mix adjusted nursing facility admission
- Number of nursing facility days
- Return to AC or Elderly Waiver programs from nursing facility
- Alternative Care beneficiaries will remain in the community for as long or longer over time, when examined alone and in comparison to Elderly Waiver beneficiaries. This will be evaluated using the following measures
- Remaining enrolled in AC
- Transition from AC to Elderly Waiver
- Transition to Essential Community Supports[40]
- Days alive in the community and not on Medicaid
- Use of Medicare services

Metrics and Data Available

Data Sources

MMIS

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the county – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs, which provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill. MMIS contain the following variables that will be used for the current evaluation:

- Program begin and end date

[40] The Essential Community Supports Program (ECS) program was established by the Minnesota Legislature and became effective January 1, 2015. Initially designed to provide support for individuals who might lose their HCBS program eligibility as a result of changes to the nursing facility level of care criteria that also became effective January 1, 2015, it was also adopted as an ongoing program for individuals aged 65 and older with emerging needs for HCBS but who do not yet meet level of care criteria and who are not MA eligible but meet the AC financial eligibility criteria. This program has a relatively small basket of services and monthly budget.

- Claims for services (e.g. residential services, CDCS services)
- Death date
- Living arrangement
- In residential or non-residential setting

LTC Screening Document

This form is used to document pre-admission screening and long-term care consultation (LTC) activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. These assessments contain the following variables that will be used for the current evaluation:

- Program type (i.e., indicates waivered program, change to another waivered program)
- Entry and exit from waivered programs (including death) and exit reasons
- Continued use of waivered program at re-assessment
- Case-mix
- Health functions (e.g. activities of daily living (ADLs))
- Level of care
- Housing type (e.g. nursing facility, assisted living, foster care)
- Authorization of CDCS services

Minimum Data Set (MDS)

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. These assessments contain the following variables that will be used for the current evaluation:

- Admission and discharge date
- Admission source (e.g., acute care or community) and discharge destination (e.g. acute care transfer, community, or mortality)
- Post-acute Medicare stay, either alone or in combination with a subsequent long stay.
- Health and functional status at admission and the latest assessment before discharge back to the community, if applicable.

Medicare Claims (fee-for-service)

Medicare claims will provide utilization for non-Medicaid-covered services (particularly for AC recipients or for periods when a recipient is not covered by Medicaid), but otherwise will largely duplicate what we can learn from MMIS. We can also calculate HCC scores if we want to try to adjust for case-mix.

- Dates of acute hospital, emergency department, and home health use

- Utilization outside of periods of Medicaid eligibility or for services not covered by Medicaid
- Associated diagnoses and procedure codes

Metrics

Case-Mix

Case mix is a classification tool that is used in both AC and EW programs to establish monthly budget limits for HCBS services. A copy of the Case Mix Classification Worksheet describing the factors used to determine a case mix classification for all AC and EW recipients is at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG. The classification is based on assessed need in:

- Eight activities of daily living (ADLs): bathing, dressing, grooming, walking, toileting, positioning, transferring, and eating
- The need for clinical monitoring in combination with a physician-ordered treatment, and
- The need for staff intervention due to behavioral or cognitive needs.
- After assessment, the individual is assigned a case mix classification of A-L based on their combination of ADLs, clinical monitoring and behavioral/cognitive needs.
- Level of Need
- For purposes of this evaluation, the case mix classifications have been grouped as follows:
- Low Need (A, L): This group includes individuals with 0-3 ADL dependencies
- Moderate Need (B, D, E): This group includes individuals with 4-6 ADL dependencies and/or behavioral/cognitive needs.
- High Need (G, H, I, J): This group includes individuals with dependencies in 7 or 8 ADLs (G), and those with specific other needs in combination with 7-8 ADL dependencies.
- High Need Clinical (C, F, K, V): This group includes individuals with varying number of dependencies but who have an assessed need for clinical monitoring at least once every 8 hours.
- Other/Missing

Design Approaches

We propose the following methods to address the hypotheses within this evaluation. The sections below provide information about each approach, including the comparison group(s), metrics, and statistical methods. To compare efficiently across years (2010 through 2018), we will also report our measures as rates (e.g. per 1000 beneficiaries).

Cross-Sectional Analysis

To test hypothesis 3.31 and 3.32, we will compare individuals in Alternative Care program to individuals in Elderly Waiver served in non-residential settings. For each fiscal year, we will identify AC and Elderly Waiver beneficiaries using LTC screening assessment data (also available in MMIS). We will further identify Elderly Waiver beneficiaries in non-residential settings by excluding beneficiaries with any claims for procedure codes denoting residential services (i.e.,

customized living, adult foster care, and residential care services). While living in the community, if an AC beneficiary uses CDCS, this information will be recorded in the MMIS claims data, as well as the total dollars paid for CDCS in a fiscal year. We will categorize acuity into two categories: low-need and high-need and calculate differences in case-mix for each year between AC and Elderly Waiver beneficiaries by acuity type.

To test hypotheses 3.33 and 3.34, we will calculate the number of nursing facility admission per person and determine the number of days spent in a nursing facility (i.e., length of stay). The LTC screening document indicates when an AC beneficiary leaves the community to enter a nursing facility, and if and when the person can choose to re-enter a HCBS program. The MDS is an additional source of information on nursing facility use. We will compare nursing facility admission use for AC and Elderly Waiver non-residential beneficiaries.

To test hypothesis 3.34, we will define a cohort of AC users at the start of each fiscal year and follow the cohort until the end of the fiscal year and determine their outcomes. We will calculate the proportion of individuals that remain enrolled in AC, those that switched to Elderly Waiver, and the days alive in the community and not on Medicaid (i.e., not using residential services). We will account for death and loss of AC eligibility.

Statistical Analysis: For all measures, we will report the denominator, number and percent of beneficiaries, and utilization rates, as appropriate. We will test the difference in means, using t-tests for each fiscal year and compare the t-statistic across the years (e.g. a line graph). We will also compare the difference in means using ANOVA and post-hoc estimations. Covariates will include, but are not limited to, age, number of admissions to nursing facility in a given year, case-mix. We will stratify AC and EW users in each year according to categories of these covariates, and then draw comparisons and statistical tests within strata.

External Evaluation Strategy

Independent Evaluation

In addition to the designated activities to be conducted by DHS, DHS will contract with Center for 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.

Evaluation Objective and Comparison Population

This component of the evaluation will examine the same hypotheses as the internal evaluation but at a more granular beneficiary level and by using multivariable modeling and trend analysis (interrupted time series) to assess change over time and factors that may be accounting for change. It 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. It will utilize merged data files from Medicaid and Medicare to examine the use of acute care services.

Data Availability

For this evaluation, the following data sources will be utilized: Medicaid Management Information Systems (MMIS), Medicaid files, Minimum Data Set (MDS v3), Medicare claims, Board on Aging Title III service use records, Client surveys, Waiver recipient case studies, Program staff interviews, and long-term care consultation (LTC) assessment data.

Analysis Plan

In addition to the research questions listed in the paragraph above and in section 3.3, 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 (T0) predict future outcomes for service use (HCBS, Title III), medical use, nursing home use, and functional status at a subsequent point in time (T1).

The planned analysis strategies will consist of multiple strategies involving descriptive statistics, cross-sectional comparisons at different time points, and longitudinal analysis of beneficiary-level care transitions, program transitions, and health outcomes. Comparisons will be made between AC and Elderly Waiver beneficiaries.

Repeated cross-sectional beneficiary-level analysis. Descriptive statistics will be prepared on the beneficiary population each year during baseline (2010-2018). Characteristics described will include demographics, health and functional status, transitions between care settings (private home, residential care setting or nursing home) and programs (AC and Elderly Waiver), service use and Medicaid expenditures, acute care use (Medicare and Medicaid), and other variables. Multi-variable logistic regression models will be applied in comparing AC and Elderly Waiver beneficiaries. Other multivariable models using link functions and distributional assumptions appropriate to the outcome variable, e.g. gamma distribution or negative binomial, will be applied to count and cost data when drawing comparisons between groups.

Interrupted time series analysis. In order to assess changes in major variables over time in the AC and Elderly Waiver populations, we will conduct an interrupted time series analysis where:

Outcomes: AC and Elderly Waiver service use, Medicaid expenditures; transitions between care settings; movement in, out and between AC and Elderly Waiver programs; and acute care service use.

Time Periods: The time periods for the longitudinal analysis will be months for some outcomes, e.g. transitions between care settings and movement in and out of AC and Elderly Waiver programs, and calendar quarters or years for other outcomes, e.g., Medicaid expenditures

Covariates: demographics, health and functional status, length of time in the AC or Elderly Waiver program, and other variables found to be significant in analysis step 1.

Two approaches will be used for the analysis difference-in-difference equations and mixed-effect growth models. With both approaches the change in the outcomes for beneficiaries will be modeled as a function of time, AC waiver period (before or after), covariates (fixed or time-varying).

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

Variable	Description	Data Source
AC use	Amount and cost of AC services	MMIS, Medicare claims
Health and functional status	ADLs, cognitive impairment, service need	LTC Assessment, MDS for NH users
Financial characteristics		LTC Assessment
Living arrangement	Home alone, home with family, organized setting	LTC Assessment
Medicaid payments	By type of service	MMIS
Disability level, function	ADLs, IADLs	LTC Assessment
Prior LTC use		MDS and MMIS
NH use	Days, dollars	MDS and MMIS

Variable	Description	Data Source
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

Note: ADLs, activities of daily living; DME, durable medical equipment; ER, emergency room; IADLs, instrumental activities of daily living; NH, nursing home; SNF, skilled nursing facility.

UNDER DEVELOPMENT

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 services as needed. This service, designed to maintain and increase independence, will be modeled after the Community First Choice option.

Program Overview

The CFSS is intended to expand consumer choice in the types of services they receive and the way they are provided, while offering clients consultation and financial management support to assist them in service planning and budgeting. All clients will receive:

- Consultation services
- Worker training and development
- Ability to purchases goods and technologies
- Choice of caregivers – including relatives

Clients can choose from two basic models: 1) Agency Model - traditional agency staff and administration, and 2) Budget Model – with an emphasis on self-direction of care (details in Section 4.42).

The CFSS replaces these current programs:

- Personal Care Assistance (PCA) -- Approximately 27,000 current PCA recipients will be transitioned to CFSS. The PCA service recipients will have an expanded choice of services and supports and greater consumer direction.
- Community Service Grants (CSG) – These grants will be eliminated and approximately 1,000 current CSG recipients will become eligible for CFSS, presumably choosing the budget model. The CFSS has larger dollar limit than CSG but less flexibility. Also, spouses and parents of minors can be paid as support workers through CFSS.
- Consumer Directed Consumer Supports (CDCS) waiver – It is not clear how clients with this waiver will be affected. They may opt for CFSS; they would have less choice but better benefits.

Program Rationale

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. Similarly, in situations where technology or a home modification would enable a person to do more for him or herself and possibly substitute for a level of human assistance, people are unable to do so. This is because environmental modification services are only available today through the waivers. Therefore, some people apply for home and community-based waiver services in order to access technology, modifications or more flexible services, triggering an

administrative process to enroll. Consequently, some people who need these services cannot access the waiver when they need it due to: 1) not meeting institutional level of care requirements, or 2) 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 does not address core needs. For example, while PCA services can provide redirection and assistance when a person has significant behavioral issues (e.g. physical aggression to self or others, destruction of property), the service provider does not deal with the underlying issues nor were 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.

Currently, there is a need to improve service coordination for our program beneficiaries: 1) individuals who are eligible but are not connected with the appropriate service, and 2) people who are accessing many services across multiple systems. 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 10% 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 (e.g. emergency department visit, hospitalizations) and lead to poorer outcomes. Similarly, people who have high costs for avoidable services are often those who encounter the system at many points or have multiple needs. CFSS would allow people to access more useful services tailored to their needs.

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

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 increased flexibility 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.

The CFSS Benefit

Community First Services and Supports provides assistance with maintenance, enhancement or acquisition of skills to complete activities of daily living (ADLs), instrumental activities of daily living (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.

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. Like now, the amount of CFSS authorized will be based on the participant's home care rating (also determined at the time of assessment).

The home care rating is determined by identifying the total number of ADLs 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 (i.e., physical aggression towards self or others, 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.

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.

Agency-provider model. This 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.

Budget model. Under this 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.

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.

Eligibility for CFSS under Reform 2020 Waiver

The Reform 2020 waiver allows Minnesota to receive federal financial participation to provide CFSS services to the following eligibility groups (Table 1):

1915(i)-like CFSS recipients: People who do not meet the Medicaid financial eligibility criteria to be eligible for the Section 1915(i) state plan benefit but are categorically eligible for Medical Assistance (i.e., have an assessed need for personal care assistance).

Demonstration waiver authority is necessary for this group because they do not meet the Medicaid financial eligibility criteria.

1915(k)-like CFSS recipients: People who are financially eligible for Medical Assistance if they utilize the eligibility rules of one of Minnesota’s home and community-based waivers but have chosen CFSS services in lieu of home and community-based waiver services.

Minnesota has been granted authority to extend Medicaid eligibility to this group to encourage utilization of CFSS instead of home and community-based services where appropriate. This group includes people who are: 1) Age 65 or over and eligible without a spend-down with income at or below 300% of SSI and spousal impoverishment rules; 2) 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 3) Children under age 21 using eligible using special institutional rules including exemption from parental deeming.

Table 1. CFSS groups and characteristics

CFSS 1915 recipients (State Plan)		CFSS 1115 recipients (Waiver)	
1915-i group	1915-k group	1915 i-like group	1915 k-like group
Have incomes under 150% of the federal poverty level		Have income above 150% of the federal poverty level	Have income above a Medicaid state plan standard
			Meet all non-financial eligibility factors for eligibility for a home and community-based waiver
Enrolled in Medicaid	Enrolled in Medicaid	Are at or below the relevant state plan limit for categorical eligibility	Qualify for Medicaid using the rules of the special home and community-based waiver group under 42 CFR §435.217
Do not have an assessed need for an institutional level of care	Have an assessed need for an institutional level of care	Do not meet an institutional level of care for a NF, ICF-ID or hospital	Need an institutional level of care
		Meet the personal care assistance criteria*	Meet the personal care assistance criteria

* A person meets the personal assistance criteria if he/she: 1) Has an assessed need for assistance with at least one activity of daily living, or 2) Demonstrates physical aggression toward oneself or others, or 3) Destruction of property that requires immediate intervention by another person

Program Goals

The goals of the CFSS program under the Reform 2020 Waiver are to:

- Provide a comparable level of access to CFSS to the waiver populations as the other CFSS recipients in the state plan.
- Achieve comparable health outcomes after utilization of CFSS for the waiver populations as is achieved for the comparable state plan eligibility groups using CFSS.
- Achieve comparable consumer satisfaction and costs for consumers utilizing CFSS services under the waiver as compared to state plan CFSS participants.

Evaluation Strategy for Consumer First Services and Supports

The evaluation plan addresses both program processes and outcomes. It relies mainly on secondary data sources, such as Medicaid claims and administrative data gathered through the program. Primary data collection is proposed in areas not well covered by administrative systems, such as client quality of life or autonomy.

The goals and associated metrics identified in section 5.3 will be evaluated by DHS and University of Minnesota using MMIS claims and beneficiary assessment data. It is appropriate for DHS to conduct the descriptive component of the evaluation using readily available data sources, as part of its ongoing quality monitoring and management activities. External evaluation will include expanded data elements and more rigorous analysis methods.

The evaluation will focus on the transition period (first 24 months) from personal care and consumer support grants to CFSS, and the impacts on CFSS recipients and subgroups.

Goals and Objectives

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.”) We will determine if experiences of the 1115 subgroups (“i-like” and “k-like) is comparable to the CFSS state plan eligibility groups, in terms of health outcomes and program satisfaction, and their use of the flexible CFSS budget.

Evaluation Populations for CFSS

The waiver evaluation populations will consist of the following subgroups: CFSS 1915(i)-like group and CFSS 1915(k)-like group (Table 1).

The comparison groups will be people receiving CFSS under 1915(i) or 1915(k) state plan option, respectively. People in 1915(i) group are enrolled in Medicaid with incomes under 150% of the federal poverty level and do not have an assessed need for an institutional level of care. People

in 1915(k) group are enrolled in Medicaid and have an assessed need for an institutional level of care.41

Hypotheses:

In this evaluation, we want to understand experiences of the CFSS waiver beneficiaries compared to CFSS state plan eligibility groups, relative to health outcomes and program satisfaction, and use of the flexible CFSS budget.

CFSS waiver beneficiaries will experience comparable access to CFSS services, compared to CFSS beneficiaries under the state plan. Access will be evaluated using the following measures:

Number and percent of recipients using CFSS services

Percent of CFSS authorized units paid over time

CFSS waiver beneficiaries will experience similar health outcomes following use of CFSS services, compared to CFSS beneficiaries under the state plan. Health outcomes will be evaluated using the following measures:

- Percent of recipients admitted to nursing facilities or other long-term care institutions
- Amount of nursing facility use
- Number of people that move from nursing facility to CFSS program
- Use of emergency departments and acute care use
- Level of independence with activities of daily living

CFSS waiver beneficiaries will experience comparable satisfaction with CFSS services, compared to CFSS beneficiaries under the state plan. Satisfaction will be evaluated using the following measures:

- Percent of CFSS recipients reporting that they are the primary decision makers regarding their service plans (or their child's plan)
- Percent of CFSS participants reporting that support workers arrive when they are supposed to and perform the tasks requested
- Percent of CFSS participants reporting satisfaction with their service providers
- CFSS waiver beneficiaries will experience comparable average costs of CFSS services, as compared to CFSS beneficiaries under the state plan. Costs will be evaluated using the following measures:
- Average cost per recipient of LTC services, by geographic and demographic group

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[41] 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.

- Percent of CFSS participants also using institutional services, by amount of use
- Percent of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time

Data Sources

MMIS:

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the county – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs. State Medicaid management information system contains extensive data related to Medicaid recipients' eligibility and enrollment, as well as detailed claims data encompassing both traditional fee for service and managed care encounter records. It also records assessments of needs and service plans.

- Claims - cost and utilization for FFS population, diagnoses.
- Encounter data - utilization for managed care population, diagnoses; only partial cost data.
- Eligibility files - program enrollment, waiver status, demographics, reasons for eligibility, dual eligible status
- Assessment data - functional status, presence and extent of service needs
- Service agreements - specific authorized levels and types of service

LTC Screening Document:

This form is used to document pre-admission screening and long-term care consultation (LTC) activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. Variables include program type, entry and exit from waivered programs (including death) and exit reasons, case-mix, level of care, etc.

MnCHOICES:

- MnCHOICES is a single, comprehensive assessment and support planning Web-based application for long-term services and supports in Minnesota. MnChoices uses one assessment process for people of all ages, abilities and financial statuses, promotes choice and integrated community living, and provides a common data collection tool; it uses a person-centered planning approach to help people make decisions about long-term services and supports. It replaced the following assessment tools:
- Developmental Disability Screening, Long-Term Care Consultation, Personal Care Assistance Assessment.
- Consumer assessments
- Satisfaction surveys
- Other programmatic data

Minimum Data Set (MDS):

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. Variables include admission and discharge date, type of entry, and Medicare stay.

Design Approaches

The sections below provide information about the study design, the comparison group(s), metrics, and statistical methods.

Pre-Post Analysis

We will measure CFSS service access use, nursing facility use, satisfaction with CFSS service and providers, and average cost of service, before and after the PCA-to-CFSS transition. Authorized CFSS units will be available in MMIS. Program satisfaction and provider evaluation data will be extracted from MnChoices/MnSP questions.

Statistical Analysis: For all measures, we will report the denominator, number and percent of beneficiaries, and utilization rates, as appropriate. We will test the difference in means before and after, using t-tests. We will also compare the difference in means using ANOVA and post-hoc estimations. Covariates includes, but are not limited to, age, number of admissions to nursing facility in a given year, case-mix.

External Evaluation

In addition to the designated activities to be conducted by DHS, DHS will contract with Center for 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.

Evaluation Objective:

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.

Analysis Plan:

For this evaluation, the following data sources will be utilized: Medicaid Management Information Systems (MMIS), Medicaid files, Minimum Data Set (MDS v3), Medicare claims, MnChoices and MnSP data, and long-term care consultation (LTC) assessment data. The measures and comparison populations are listed in Table 2.

The planned analysis strategies will consist of multiple strategies involving descriptive statistics, cross-sectional comparisons at different time points, and longitudinal analysis of client level processes and outcomes. Comparisons will be made between the Budget and Agency Models and by client subgroups to determine differential use of services, costs, and program impacts.

Baseline characteristics. Descriptive statistics on the client population will be prepared during the 12-month period prior to CFSS implementation on client populations that are expected to transition into CFSS – PCA users, CS grant recipients, and CDCS recipients. Characteristics will include disability group, demographics, health and functional status, service use and expenditures.

Repeated cross-sectional analysis. To assess change in the program or its impact, descriptive statistics on characteristics of the CFSS population will be calculated for different time periods (quarterly or semi-annually). Characteristics will include disability group, demographics, health and functional status, service use and expenditures.

Longitudinal client-level analysis. In order to assess program processes and impact at the client level, clients will be tracked from baseline or program entry to program exit. Change will be analyzed in health and functional status, service use and expenditures, satisfaction with care, and independent living skills. The time points for the longitudinal analysis will vary from monthly (e.g. service use and costs) to semi-annual or annual (health and functioning or satisfaction with care).

Table 2. 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

Waiver Populations	Comparison Populations	Measures	Data Source
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	MnChoices/MnSP
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that whose paid to help them come when they are supposed to, compared by eligibility group	MnChoices/MnSP
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that whose paid to help them do the things you want them to	MnChoices/MnSP

Waiver Populations	Comparison Populations	Measures	Data Source
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that they satisfied with their service provider	MnChoices/MnSP
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

Evaluation Implementation Strategy

Coordination of the Alternative Care and CFSS Evaluations:

The goals and associated metrics identified in sections 3.3 and 5.3 will be evaluated by DHS using MMIS claims and assessment data. DHS conducts descriptive evaluations using readily available data sources, as part of its ongoing quality monitoring and management activities.

In addition, DHS will contract with Center for 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.

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 wavier 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.

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

Introduction

This is the Minnesota Department of Human Services' final report on the Minnesota Family Planning Program (MFPP) section 1115 demonstration waiver, and represents the results of the MFPP evaluation for the waiver period of July 2006 through December 2016, per the requirements under the MFPP waiver Special Terms and Conditions, paragraph 30.

Overview of the Minnesota Family Planning Program

The Minnesota Department of Human Services (DHS) began implementation of the Minnesota Family Planning Program on July 1, 2006. This program was initially approved by the Centers for Medicare and Medicaid Services (CMS) for a 5-year period, ending June 30, 2011. An extension of the MFPP waiver was approved by CMS in December 2011 for the period July 1, 2011 through December 31, 2013. On December 31, 2012, DHS submitted a request to extend the waiver for an additional three years. In June of 2013, CMS approved a one-year extension of the MFPP waiver through December 31, 2014. Since this initial one-year extension a series of temporary extensions have been approved by CMS. The most recent temporary extension was approved by CMS through December 31, 2016. This temporary extension allowed the State to conduct necessary activities related to the phase-out of the demonstration during the transition of the MFPP to state plan authority. Effective January 1, 2017, the MFPP was converted to state plan authority under the Family Planning State Plan option.

The goal of the Minnesota Family Planning Program is to provide access to family planning services to individuals who do not have access to those services through other programs. Increased access to family planning services is expected to lead to decreased expenditures by public health care programs by reducing the number of births resulting from unintended pregnancies.

Participants in the Minnesota Family Planning Program must be Minnesota residents 15 to 49 years of age, have income at or below 200 percent of the federal poverty guideline, be US citizens or qualified non-citizens eligible for Medicaid with federal financial participation, not be enrolled in other Minnesota Health Care Programs (MHCP) administered by DHS, not be pregnant, and not reside in a medical institution.

MFPP benefits include family planning office visits, exams, counseling, and education; contraceptive medications and supplies; voluntary sterilization; diagnosis, testing, and treatment of sexually transmitted infections found during family planning visits, HIV testing and counseling, and pharmacy services and laboratory tests related to these benefits.

Evaluation Plan

The demonstration objectives, and associated indicators for measurement of progress toward those objectives, are listed in the following table.

Evaluation Objectives and Indicators

OBJECTIVES	INDICATORS	PAGES
1. Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.	a) 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).	4-15
	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.	
2. Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.	a) Annual proportion of MHCP enrollees with a family planning service or pharmacy claim.	16 - 27
	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).	
3. Increase the average age of mother at first birth among MHCP enrollees.	a) Maternal age distribution for MHCP-financed births.	

	b) Annual average maternal age among MHCP-financed births.	28-32
4. Reduce the teen birth rate among MHCP enrollees.	c) Annual rate of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP.	33-35

Evaluation Findings

Objective 1:

Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.

Indicators:

1. Annual unduplicated count of individuals aged 15 to 49 ever enrolled in MHCP programs that offer family planning services (including MFPP) (July 2003– December 2016).
2. Annual unduplicated count of individuals ever enrolled in MFPP from program implementation to present (July 2006 – December 2016).
3. Percentage of MFPP enrollees who enroll in the program after the presumptive eligibility period (July 2006 – December 2016).

Data source:

Medicaid Management Information System (MMIS) eligibility data.

Definitions:

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

Results:

Figure 1a presents the number of individuals enrolled in MHCP offering family planning services SFY 2004-mid-SFY 2017. Figure 1b presents the percentage of MFPP enrollees who enrolled in the program after the presumptive eligibility period from SFY 2007-December 2017. Table 1a, 1b, and 1c, respectively, present counts of individuals enrolled, overall and by sex, age group, race/ethnicity and/or major program (if applicable) for objective 1a, 1b, and 1c.

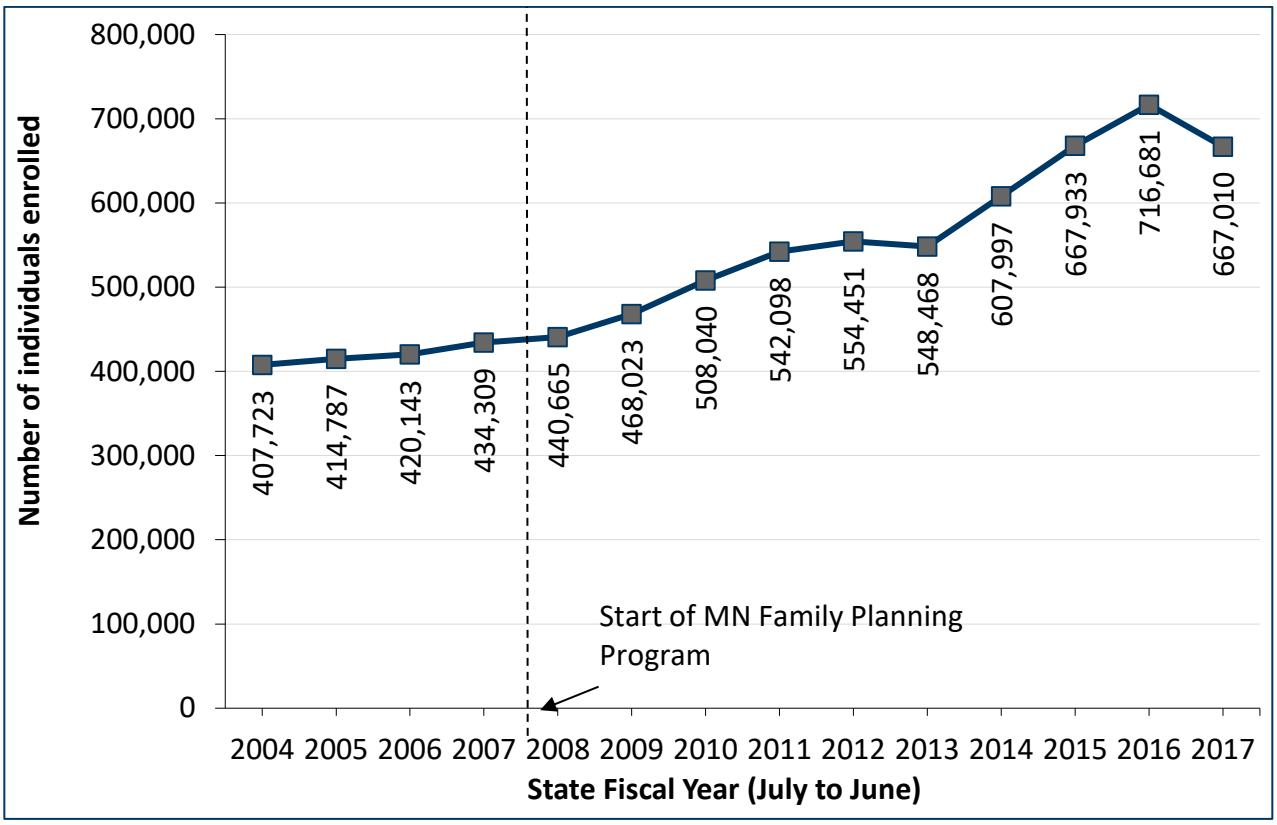
Discussion:

The number of individuals aged 15 to 49 enrolled in MHCP who have access to family planning services has increased from 407,723 in SFY 2004 to 440,665 in SFY 2009, 607,997 in SFY 2014, and 716,681 in SFY 2016. There is a drop in the number of enrollees from SFY 2016 to 2017 because SFY 2017 only includes health data from the early half of SFY 2017 (July 2016 to December 2016). A contributing factor to this general increase was the economic recession of 2007 to 2009. MHCP enrollment continued increasing after the economic recession due to slow economic recovery, and Minnesota's early expansion of the Medicaid program to include childless adults with incomes at or below 75 percent of the federal poverty level in SFY 2011. The launch of Minnesota's state health insurance exchange, MNSure, in October 2013, and the increased income limit for the Medicaid expansion population to 133 percent of the federal poverty level effective January 1, 2014, contributed to the increase in MHCP enrollment between 2013 and 2014. The increase observed in the SFY 2014, 2015, 2016 and 2017 is most likely associated with the increase in enrollment resulting from the insurance mandate of the Affordable Care Act.

In each SFY, the percentage of enrollment in either 'MHCP program which offers family planning service' or 'MFPP waiver programs' was highest among females (vs. males), younger age groups (15-29 yrs. vs. 29-49 yrs.), and non-Hispanic Whites (vs. other race/ethnic categories).

The percentage of MFFP enrollees who enrolled in the program after the presumptive eligibility period remained relatively constant from SFY 2011 to SFY 2016.

Figure 1a. Annual unduplicated count of individuals aged 15 to 49 ever enrolled in MHCP programs that offer family planning services, by state fiscal year 2004-2017.



Notes: SFY 2017: As the MFPP waiver ended on December 31, 2016, this data period only includes health care data from the early half of SFY 2017 (July 2016 to December 2016).

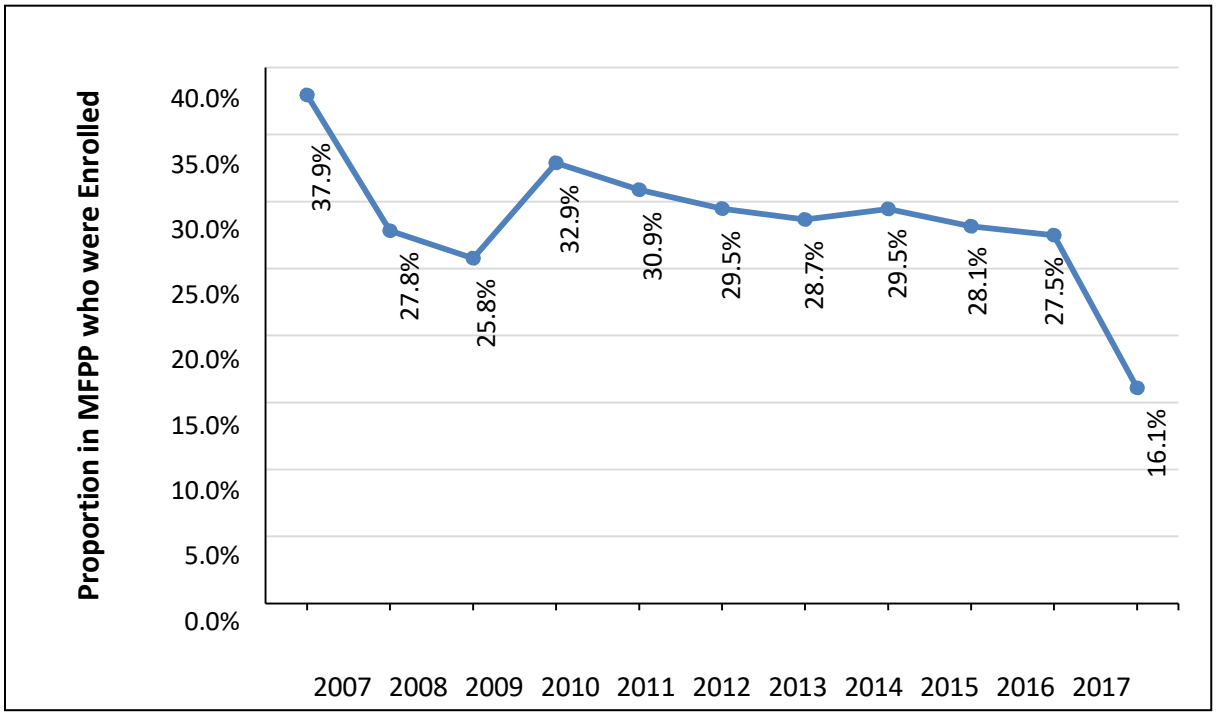


Figure 1b. Percentage of MFPP enrollees who enroll in the program after the presumptive eligibility period (July 2006 – December 2016), by state fiscal year, 2007-2017.

Notes: SFY 2017: As the MFPP waiver ended on December 31, 2016, this data period only includes health care data from the early half of SFY 2017 (July 2016 to December 2016).

Table 1a. Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2004-2007.

	SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex								
Female	238,869	58.6%	244,166	58.9%	247,591	58.9%	265,189	61.1%
Male	168,854	41.4%	170,621	41.1%	172,552	41.1%	169,120	38.9%
Age Group								
15 to 19	80,039	19.6%	82,128	19.8%	84,601	20.1%	90,897	20.9%
20 to 24	78,774	19.3%	79,817	19.2%	79,528	18.9%	86,279	19.9%
25 to 29	59,139	14.5%	62,066	15.0%	64,885	15.4%	68,821	15.8%
30 to 34	49,451	12.1%	49,593	12.0%	49,096	11.7%	49,039	11.3%
35 to 39	46,263	11.3%	46,451	11.2%	46,506	11.1%	45,662	10.5%
40 to 44	47,898	11.7%	47,166	11.4%	46,373	11.0%	43,843	10.1%
45 to 50	46,159	11.3%	47,566	11.5%	49,154	11.7%	49,768	11.5%
Race/ethnicity								
White	259,517	63.7%	259,802	62.6%	259,062	61.7%	269,084	62.0%
Black	69,330	17.0%	73,227	17.7%	77,405	18.4%	79,305	18.3%
Hispanic	23,211	5.7%	23,872	5.8%	24,622	5.9%	25,886	6.0%
Asian/Pacific Islander	21,958	5.4%	23,375	5.6%	23,655	5.6%	23,248	5.4%
American Indian	16,594	4.1%	16,960	4.1%	17,426	4.1%	17,773	4.1%
Two or more races	4,099	1.0%	4,538	1.1%	4,933	1.2%	5,432	1.3%
Unknown race	13,014	3.2%	13,013	3.1%	13,040	3.1%	13,581	3.1%
Major Program								
Medical Assistance	246,434	60.4%	259,989	62.7%	269,913	64.2%	274,460	63.2%
MinnesotaCare	113,539	27.8%	104,899	25.3%	97,765	23.3%	99,702	23.0%
General Assistance Medical Care	47,750	11.7%	49,899	12.0%	52,465	12.5%	36,815	8.5%
MN Family Planning Program	0	0.0%	0	0.0%	0	0.0%	23,332	5.4%
TOTAL number enrolled:	407,723	100.0%	414,787	100.0%	420,143	100.0%	434,309	100.0%

Table 1a (continued). Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2008-2011.

	SFY 2008		SFY 2009		SFY 2010		SFY 2011	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex								
Female	271,707	61.7%	286,179	61.1%	306,481	60.3%	323,796	59.7%
Male	168,958	38.3%	181,844	38.9%	201,559	39.7%	218,302	40.3%
Age Group								
15 to 19	91,635	20.8%	93,590	20.0%	97,075	19.1%	99,568	18.4%
20 to 24	88,251	20.0%	94,246	20.1%	103,295	20.3%	107,336	19.8%
25 to 29	71,466	16.2%	78,115	16.7%	86,489	17.0%	93,046	17.2%
30 to 34	50,554	11.5%	56,282	12.0%	64,147	12.6%	72,919	13.5%
35 to 39	45,506	10.3%	48,005	10.3%	51,862	10.2%	55,462	10.2%
40 to 44	42,360	9.6%	43,988	9.4%	47,323	9.3%	51,579	9.5%
45 to 50	50,893	11.5%	53,797	11.5%	57,849	11.4%	62,188	11.5%
Race/ethnicity								
White	272,871	61.9%	289,531	61.9%	314,182	61.8%	333,602	61.5%
Black	79,900	18.1%	83,915	17.9%	91,048	17.9%	98,060	18.1%
Hispanic	26,205	5.9%	28,390	6.1%	30,268	6.0%	30,677	5.7%
Asian/Pacific Islander	23,829	5.4%	25,851	5.5%	29,085	5.7%	32,267	6.0%
American Indian	17,850	4.1%	18,363	3.9%	18,953	3.7%	19,693	3.6%
Two or more races	5,969	1.4%	6,797	1.5%	7,669	1.5%	8,564	1.6%
Unknown race	14,041	3.2%	15,176	3.2%	16,835	3.3%	19,235	3.5%
Major Program								
Medical Assistance	280,843	63.7%	296,731	63.4%	314,743	62.0%	396,047	73.1%
MinnesotaCare	98,911	22.4%	101,780	21.7%	118,897	23.4%	97,733	18.0%
General Assistance Medical Care	30,369	6.9%	34,829	7.4%	34,985	6.9%	8,565	1.6%
MN Family Planning Program	30,542	6.9%	34,683	7.4%	39,415	7.8%	39,753	7.3%
TOTAL number enrolled:	440,665	100.0%	468,023	100.0%	508,040	100.0%	542,098	100.0%

Table 1a (continued). Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2012-2014.

	SFY 2012		SFY 2013		SFY 2014	
	Number	Percent	Number	Percent	Number	Percent
Sex						
Female	328,927	59.3%	326,061	59.4%	354,073	58.2%
Male	225,524	40.7%	222,407	40.6%	253,924	41.8%
Age Group						
15 to 19	99,667	18.0%	99,280	18.1%	106,772	17.6%
20 to 24	106,401	19.2%	102,298	18.7%	105,349	17.3%
25 to 29	94,604	17.1%	92,373	16.8%	105,598	17.4%
30 to 34	78,848	14.2%	80,877	14.7%	92,251	15.2%
35 to 39	57,677	10.4%	58,995	10.8%	69,105	11.4%
40 to 44	54,060	9.8%	53,393	9.7%	59,665	9.8%
45 to 50	63,194	11.4%	61,252	11.2%	69,257	11.4%
Race/ethnicity						
White	335,063	60.4%	324,583	59.2%	353,759	58.2%
Black	103,338	18.6%	106,047	19.3%	113,105	18.6%
Hispanic	32,067	5.8%	32,482	5.9%	35,815	5.9%
Asian/Pacific Islander	33,910	6.1%	34,593	6.3%	40,233	6.6%
American Indian	20,317	3.7%	20,152	3.7%	20,016	3.3%
Two or more races	9,189	1.7%	9,687	1.8%	11,674	1.9%
Unknown race	20,567	3.7%	20,924	3.8%	33,395	5.5%
Major Program						
Medical Assistance	419,947	75.7%	418,544	76.3%	507,696	83.5%
Minnesota Care	94,596	17.1%	90,866	16.6%	67,262	11.1%
General Assistance Medical Care	0	0.0%	0	0.0%	0	0.0%
MN Family Planning Program	39,908	7.2%	39,058	7.1%	33,039	5.4%
TOTAL number enrolled:	554,451	100.0%	548,468	100.0%	607,997	100.0%

Table 1a (continued). Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2015-2017.

	SFY 2015		SFY 2016		SFY 2017	
	Number	Percent	Number	Percent	Number	Percent
Sex						
Female	383,507	57.4%	406,022	56.7%	382,435	57.3%
Male	284,426	42.6%	310,659	43.3%	284,575	42.7%
Age Group						
15 to 19	117,117	17.5%	125,118	17.5%	125,480	18.8%
20 to 24	112,552	16.9%	116,862	16.3%	107,055	16.0%
25 to 29	120,590	18.1%	131,281	18.3%	120,093	18.0%
30 to 34	105,765	15.8%	115,336	16.1%	105,606	15.8%
35 to 39	81,463	12.2%	90,935	12.7%	86,351	12.9%
40 to 44	66,569	10.0%	69,771	9.7%	65,309	9.8%
45 to 49	63,877	9.6%	67,378	9.4%	57,116	8.6%
Race/ethnicity						
White	355,764	53.3%	368,562	51.4%	332,090	49.8%
Black	105,399	15.8%	110,893	15.5%	103,021	15.4%
Hispanic	34,933	5.2%	37,838	5.3%	34,431	5.2%
Asian/Pacific Islander	40,196	6.0%	43,310	6.0%	40,504	6.1%
American Indian	19,021	2.8%	19,507	2.7%	17,957	2.7%
Two or more races	16,186	2.4%	18,252	2.5%	17,392	2.6%
Unknown race	96,434	14.4%	118,319	16.5%	121,615	18.2%
Major Program						
Medical Assistance	553,300	82.8%	586,454	81.8%	552,014	82.8%
MinnesotaCare	87,362	13.1%	106,082	14.8%	93,452	14.0%
General Assistance Medical Care	0	0.0%	1	0.0%	2	0.0%
MN Family Planning Program	27,271	4.1%	24,144	3.4%	21,542	3.2%
TOTAL number enrolled:	667,933	100.0%	716,681	100.0%	667,010	100.0%

Notes: Age group was determined based on age calculated at end of each State Fiscal Year (June 30th).

Major program was determined based on enrollment data during the last month of enrollment for each person during each State Fiscal Year. Enrollees may have been enrolled in more than one major program over the course of a year.

Race/ethnicity - Hispanics can be of any race; all other groups are non-Hispanic.
SFY 2017 includes July 2016-December 2016 data only.

Table 1b. Enrollment in MFPP programs that offer family planning services overall, and by sex, age, race/ethnicity, and state fiscal years 2007-2012.

	SFY 2007		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex												
Female	25,293	99.0%	33,861	99.0%	38,762	98.7%	44,486	98.5%	44,842	98.2%	44,476	98.0%
Male	258	1.0%	349	1.0%	496	1.3%	691	1.5%	806	1.8%	906	2.0%
Age Group												
15 to 19	7,610	29.8%	9,454	27.6%	10,220	26.0%	10,919	24.2%	11,021	24.1%	10,873	24.0%
20 to 24	12,199	47.7%	16,444	48.1%	18,498	47.1%	21,413	47.4%	21,411	46.9%	20,725	45.7%
25 to 29	3,777	14.8%	5,453	15.9%	6,734	17.2%	8,101	17.9%	8,270	18.1%	8,394	18.5%
30 to 34	1,124	4.4%	1,605	4.7%	2,158	5.5%	2,698	6.0%	2,897	6.3%	3,146	6.9%
35 to 39	486	1.9%	761	2.2%	1,004	2.6%	1,226	2.7%	1,198	2.6%	1,286	2.8%
40 to 44	242	0.9%	343	1.0%	432	1.1%	565	1.3%	586	1.3%	665	1.5%
45 to 49	113	0.4%	150	0.4%	212	0.5%	255	0.6%	265	0.6%	293	0.6%
Race/ethnicity												
White	20,639	80.8%	26,969	78.8%	29,498	75.1%	34,321	76.0%	34,194	74.9%	32,782	72.2%
Black	903	3.5%	1,432	4.2%	1,988	5.1%	2,413	5.3%	2,567	5.6%	2,903	6.4%
Hispanic	1,776	7.0%	2,398	7.0%	3,396	8.7%	3,587	7.9%	3,350	7.3%	3,636	8.0%
Asian/Pacific Islander	622	2.4%	881	2.6%	1,080	2.8%	1,297	2.9%	1,355	3.0%	1,480	3.3%
American Indian	216	0.8%	255	0.7%	278	0.7%	320	0.7%	360	0.8%	367	0.8%
Two or more races	217	0.8%	344	1.0%	430	1.1%	493	1.1%	527	1.2%	609	1.3%
Unknown race	1,178	4.6%	1,931	5.6%	2,588	6.6%	2,746	6.1%	3,295	7.2%	3,605	7.9%
TOTAL number enrolled:	25,551	100.0%	34,210	100.0%	39,258	100.0%	45,177	100.0%	45,648	100.0%	45,382	100.0%

Table 1b (continued). Enrollment in MFPP programs that offer family planning services overall, and by sex, age, race/ethnicity, and state fiscal years 2013-2017.

	SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex										
Female	43,711	97.7%	39,593	96.9%	31,038	96.3%	26,801	96.0%	22,822	95.2%
Male	1,041	2.3%	1,284	3.1%	1,203	3.7%	1,131	4.0%	1,148	4.8%
Age Group										
15 to 19	10,177	22.7%	8,837	21.6%	7,251	22.5%	6,669	23.9%	6,825	28.5%
20 to 24	19,957	44.6%	18,111	44.3%	14,568	45.2%	12,622	45.2%	10,135	42.3%
25 to 29	8,491	19.0%	7,792	19.1%	5,805	18.0%	4,648	16.6%	3,707	15.5%
30 to 34	3,572	8.0%	3,554	8.7%	2,497	7.7%	2,121	7.6%	1,764	7.4%
35 to 39	1,429	3.2%	1,504	3.7%	1,257	3.9%	1,128	4.0%	894	3.7%
40 to 44	762	1.7%	715	1.7%	586	1.8%	518	1.9%	473	2.0%
45 to 49	364	0.8%	364	0.9%	277	0.9%	226	0.8%	172	0.7%
Race/ethnicity										
White	31,790	71.0%	27,828	68.1%	20,809	64.5%	17,356	62.1%	14,572	60.8%
Black	3,090	6.9%	3,212	7.9%	2,472	7.7%	2,425	8.7%	2,321	9.7%
Hispanic	3,671	8.2%	3,721	9.1%	3,162	9.8%	2,828	10.1%	2,454	10.2%
Asian/Pacific Islander	1,553	3.5%	1,556	3.8%	1,278	4.0%	1,174	4.2%	1,073	4.5%
American Indian	430	1.0%	404	1.0%	297	0.9%	269	1.0%	237	1.0%
Two or more races	664	1.5%	708	1.7%	617	1.9%	577	2.1%	474	2.0%
Unknown race	3,554	7.9%	3,448	8.4%	3,606	11.2%	3,303	11.8%	2,839	11.8%
TOTAL number enrolled:	44,752	100.0%	40,877	100.0%	32,241	94.2%	27,932	71.1%	23,970	53.1%

Notes: Age group was determined based on age calculated at end of each State Fiscal Year (June 30th).

Major program was determined based on enrollment data during the last month of enrollment for each person during each State Fiscal Year. Enrollees may have been enrolled in more than one major program over the course of a year.

Race/ethnicity - Hispanics can be of any race; all other groups are non-Hispanic.
SFY 2017: MFPP waiver ended on December 31, 2016.

Table 1c. Counts and Percentage of Enrollees in MFPP programs, who were Presumptively Enrolled, overall and by sex, age, race/ethnicity, and state fiscal years 2007-2012.

	SFY 2007		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex												
Female	9,655	38.2%	9,491	28.0%	10,073	26.0%	14,708	33.1%	13,929	31.1%	13,169	29.6%
Male	43	16.7%	25	7.2%	47	9.5%	147	21.3%	175	21.7%	210	23.2%
Age Group												
15 to 19	3,184	41.8%	3,157	33.4%	3,358	32.9%	5,057	46.3%	4,822	43.8%	4,570	42.0%
20 to 24	4,732	38.8%	4,569	27.8%	4,661	25.2%	6,789	31.7%	6,277	29.3%	5,841	28.2%
25 to 29	1,224	32.4%	1,257	23.1%	1,399	20.8%	2,044	25.2%	1,978	23.9%	1,874	22.3%
30 to 34	314	27.9%	288	17.9%	386	17.9%	535	19.8%	611	21.1%	664	21.1%
35 to 39	131	27.0%	139	18.3%	185	18.4%	222	18.1%	248	20.7%	234	18.2%
40 to 44	79	32.6%	67	19.5%	86	19.9%	144	25.5%	115	19.6%	134	20.2%
45 to 49	34	30.1%	39	26.0%	45	21.2%	64	25.1%	53	20.0%	62	21.2%
Race/ethnicity												
White	8,482	41.1%	8,039	29.8%	8,215	27.8%	12,228	35.6%	11,139	32.6%	10,282	31.4%
Black	214	23.7%	253	17.7%	401	20.2%	681	28.2%	742	28.9%	726	25.0%
Hispanic	189	10.6%	213	8.9%	256	7.5%	399	11.1%	473	14.1%	503	13.8%
Asian/Pacific Islander	221	35.5%	242	27.5%	279	25.8%	429	33.1%	424	31.3%	448	30.3%
American Indian	64	29.6%	57	22.4%	58	20.9%	97	30.3%	107	29.7%	107	29.2%
Two or more races	79	36.4%	92	26.7%	106	24.7%	161	32.7%	176	33.4%	193	31.7%
Unknown race	449	38.1%	620	32.1%	805	31.1%	860	31.3%	1,043	31.7%	1,120	31.1%
TOTAL number enrolled:	9,698	38.0%	9,516	27.8%	10,120	25.8%	14,855	32.9%	14,104	30.9%	13,379	29.5%

Table 1c (continued). Counts and Percentage of Enrollees in MFPP programs, who were Presumptively Enrolled, overall and by sex, age, race/ethnicity, and state fiscal years 2013-2017.

	SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex										
Female	12,619	28.9%	11,756	29.7%	8,836	28.5%	7,408	27.6%	3,737	16.4%
Male	215	20.7%	290	22.6%	243	20.2%	274	24.2%	137	11.9%
Age Group										
15 to 19	4,183	41.1%	3,649	41.3%	2,971	41.0%	2,790	41.8%	1,656	24.3%
20 to 24	5,541	27.8%	5,327	29.4%	4,285	29.4%	3,479	27.6%	1,522	15.0%
25 to 29	1,933	22.8%	1,831	23.5%	1,144	19.7%	859	18.5%	421	11.4%
30 to 34	727	20.4%	730	20.5%	404	16.2%	328	15.5%	157	8.9%
35 to 39	251	17.6%	300	19.9%	158	12.6%	147	13.0%	69	7.7%
40 to 44	138	18.1%	137	19.2%	82	14.0%	53	10.2%	36	7.6%
45 to 49	61	16.8%	72	19.8%	35	12.6%	26	11.5%	13	7.6%
Race/ethnicity										
White	9,794	30.8%	8,692	31.2%	6,393	30.7%	5,267	30.3%	2,589	17.8%
Black	784	25.4%	980	30.5%	669	27.1%	691	28.5%	354	15.3%
Hispanic	461	12.6%	559	15.0%	395	12.5%	369	13.0%	177	7.2%
Asian/Pacific Islander	460	29.6%	457	29.4%	371	29.0%	349	29.7%	165	15.4%
American Indian	118	27.4%	126	31.2%	93	31.3%	66	24.5%	40	16.9%
Two or more races	200	30.1%	252	35.6%	211	34.2%	173	30.0%	88	18.6%
Unknown race	1,017	28.6%	980	28.4%	947	26.3%	767	23.2%	461	16.2%
TOTAL number enrolled:	12,834	28.7%	12,046	29.5%	9,079	28.2%	7,682	27.5%	3,874	16.2%

Notes: Age group was determined based on age calculated at end of each State Fiscal Year (June 30th).

Major program was determined based on enrollment data during the last month of enrollment for each person during each State Fiscal Year. Enrollees may have been enrolled in more than one major program over the course of a year.

Race/ethnicity - Hispanics can be of any race; all other groups are non-Hispanic.
SFY 2017: MFPP waiver ended on December 31, 2016.

Objective 2

Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.

Indicators:

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

Data source:

Numerator - MMIS paid claims data.

Denominator - MMIS eligibility data.

The denominator is the unduplicated count of individuals enrolled in MHCP offering family planning services for each SFY (reported in results for Objective 1).

Definitions:

Family planning service claim includes claims for 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). Claims with an ICD- 9-CM diagnosis code in the V25.xx range and a HCPCS/CPT code on the list of covered services for MFPP were included. These claims included CMS-1500 claims for professional services, outpatient claims, and Medicare crossover claims.

Family planning pharmacy claim includes pharmacy claims for drugs or devices with a therapeutic class code indicating a contraceptive.

The reference population for calculation of proportion came from MHCP beneficiaries who are enrolled in an MHCP program that offers family planning service.

Results:

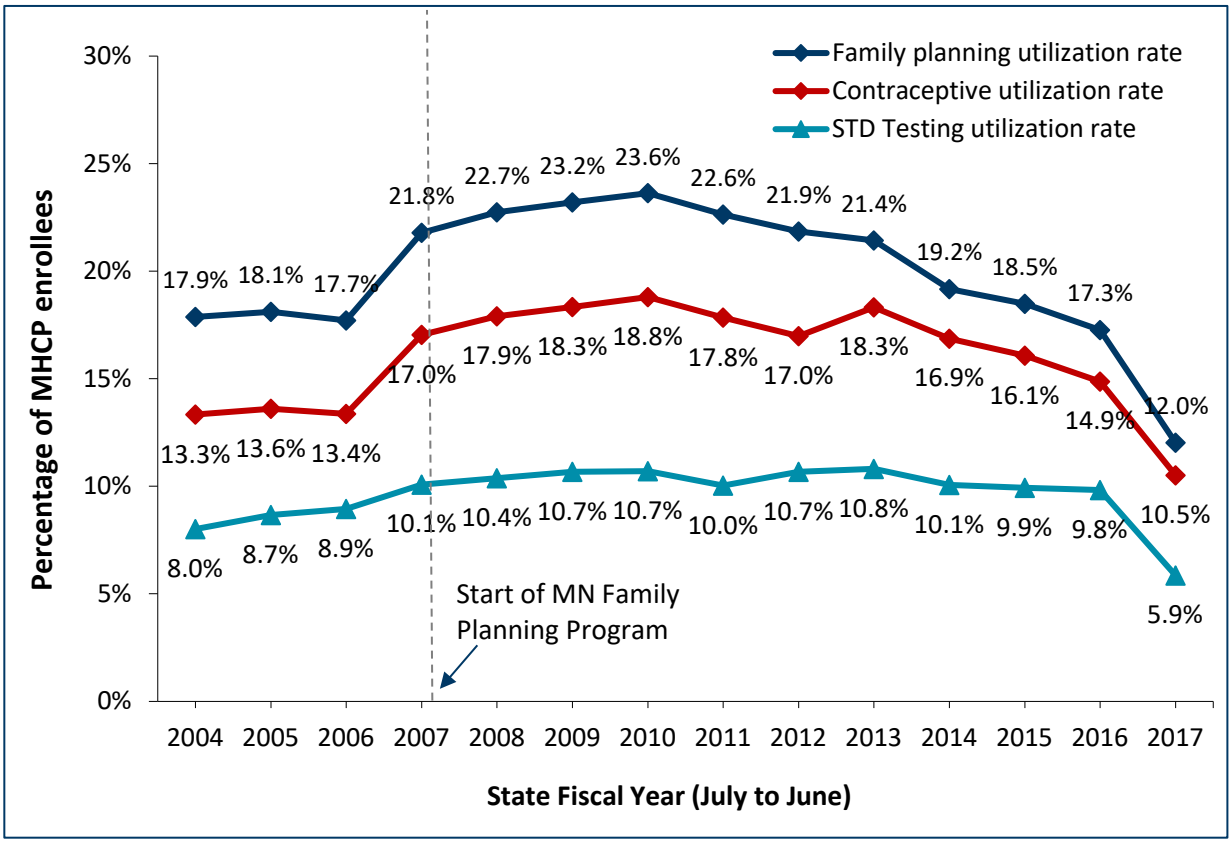
Figure 2 presents the overall, and contraceptive use and STD testing-specific family planning utilization rates of MHCP enrollees for SFY 2004 to mid-2017. Table 2a presents the number of MHCP enrollees with a family planning service or pharmacy claim, and the family planning utilization rates by sex, age group, race/ethnicity, and major program of enrollment, for SFY 2004 to mid- 2017. Table 2b presents utilization rate specific to two family planning service categories, - contraceptive service/supplies use, and STD testing- among MHCP beneficiaries.

Discussion:

The family planning utilization rate rose from about 17.9 percent of MHCP enrollees before the start of the waiver program, to 23.2 percent of MHCP enrollees in SFY 2010 and waning slightly in

later years, with 17.3 percent of MHCP enrollees in the SFY 2016, and 12.0% in SFY 2017. A similar utilization pattern was noted for the contraceptive use. STD testing utilization increased steadily from SFY 2004 to SFY 2013 and remained relatively steady till SFY 2016. Family planning utilization rates vary by sex, age, race/ethnicity, and major program. Before the start of the waiver, about 30 percent of females and less than 1 percent of males enrolled in MHCP used family planning services or had family planning pharmacy claims. After the start of the waiver, utilization rates increased for females, to 37.4 percent in SFY 2011, but remained under 1 percent for males, with a gradually tapering off for females to 29.8 percent in SFY 2016.

Figure 2. Family planning utilization rates of Minnesota Health Care Programs enrollees, state fiscal years 2004-2017.



Notes: SFY 2017: As MFPP program ended in December 31, 2016, this data period will only include health care data from early half of SFY 2017 (July 2016 to December 2016).

Table 2a. Number of MHCP enrollees with family planning service or pharmacy claims, and family planning utilization rates, overall and by sex, age group, race/ethnicity, and major program, SFY 2004-2007.

	SFY 2004			SFY 2005			SFY 2006			SFY 2007		
	Number enrollees with FP claims	Number enrolled	Utilization Rates	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims
Sex												
Female	71,697	238,869	30.0%	73,991	244,166	30.3%	73,369	247,591	29.6%	93,417	265,189	35.2%
Male	1,162	168,854	0.7%	1,116	170,621	0.7%	1,021	172,552	0.6%	1,193	169,120	0.7%
Age Group												
15 to 19	13,041	80,039	16.3%	13,254	82,128	16.1%	13,270	84,601	15.7%	20,372	90,897	22.4%
20 to 24	24,167	78,774	30.7%	24,861	79,817	31.1%	23,908	79,528	30.1%	33,099	86,279	38.4%
25 to 29	16,000	59,139	27.1%	16,953	62,066	27.3%	17,627	64,885	27.2%	20,864	68,821	30.3%
30 to 34	9,354	49,451	18.9%	9,484	49,593	19.1%	9,243	49,096	18.8%	9,968	49,039	20.3%
35 to 39	5,412	46,263	11.7%	5,664	46,451	12.2%	5,587	46,506	12.0%	5,760	45,662	12.6%
40 to 44	3,238	47,898	6.8%	3,183	47,166	6.7%	3,117	46,373	6.7%	2,955	43,843	6.7%
45 to 49	1,647	46,159	3.6%	1,708	47,566	3.6%	1,638	49,154	3.3%	1,592	49,768	3.2%
Race/ethnicity												
White	48,287	259,517	18.6%	48,781	259,802	18.8%	47,746	259,062	18.4%	64,060	269,084	23.8%
Black	11,051	69,330	15.9%	11,977	73,227	16.4%	12,174	77,405	15.7%	12,713	79,305	16.0%
Hispanic	4,974	23,211	21.4%	5,502	23,872	23.0%	5,602	24,622	22.8%	7,228	25,886	27.9%
Asian/Pacific Islander	2,844	21,958	13.0%	2,918	23,375	12.5%	2,925	23,655	12.4%	3,178	23,248	13.7%
American Indian	2,557	16,594	15.4%	2,620	16,960	15.4%	2,651	17,426	15.2%	2,899	17,773	16.3%
Two or more races	1,002	4,099	24.4%	1,114	4,538	24.5%	1,165	4,933	23.6%	1,429	5,432	26.3%
Unknown race	2,144	13,014	16.5%	2,195	13,013	16.9%	2,127	13,040	16.3%	3,103	13,581	22.8%
Major Program												
Medical Assistance	49,217	246,434	20.0%	52,339	259,989	20.1%	53,413	269,913	19.8%	53,998	274,460	19.7%
MinnesotaCare	20,977	113,539	18.5%	19,911	104,899	19.0%	17,993	97,765	18.4%	16,806	99,702	16.9%
General Assistance Medical Care	2,665	47,750	5.6%	2,857	49,899	5.7%	2,984	52,465	5.7%	1,681	36,815	4.6%
MN Family Planning Program	0	0	0.0%	0	0	0.0%	0	0	0.0%	22,125	23,332	94.8%
TOTAL number with FP claims:	72,859	407,723	17.9%	75,107	414,787	18.1%	74,390	420,143	17.7%	94,610	434,309	21.8%

Table 2a (continued). Number of MHCP enrollees with family planning service or pharmacy claims, and family planning utilization rates, overall and by sex, age group, race/ethnicity, and major program, SFY 2008-2011.

	SFY 2008			SFY 2009			SFY 2010			SFY 2011		
	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims
Sex												
Female	98,956	271,707	36.4%	107,167	286,179	37.4%	118,250	306,481	38.6%	120,977	323,796	37.4%
Male	1,258	168,958	0.7%	1,399	181,844	0.8%	1,790	201,559	0.9%	1,740	218,302	0.8%
Age Group												
15 to 19	21,995	91,635	24.0%	23,457	93,590	25.1%	24,865	97,075	25.6%	24,958	99,568	25.1%
20 to 24	35,042	88,251	39.7%	37,421	94,246	39.7%	41,048	103,295	39.7%	40,732	107,336	37.9%
25 to 29	22,042	71,466	30.8%	24,049	78,115	30.8%	27,012	86,489	31.2%	27,904	93,046	30.0%
30 to 34	10,523	50,554	20.8%	11,984	56,282	21.3%	13,882	64,147	21.6%	15,138	72,919	20.8%
35 to 39	5,959	45,506	13.1%	6,478	48,005	13.5%	7,346	51,862	14.2%	7,683	55,462	13.9%
40 to 44	3,030	42,360	7.2%	3,335	43,988	7.6%	3,805	47,323	8.0%	4,043	51,579	7.8%
45 to 49	1,623	50,893	3.2%	1,842	53,797	3.4%	2,082	57,849	3.6%	2,259	62,188	3.6%
Race/ethnicity												
White	67,661	272,871	24.8%	72,446	289,531	25.0%	80,568	314,182	25.6%	81,863	333,602	24.5%
Black	13,200	79,900	16.5%	14,657	83,915	17.5%	16,313	91,048	17.9%	16,883	98,060	17.2%
Hispanic	7,731	26,205	29.5%	8,525	28,390	30.0%	9,015	30,268	29.8%	8,581	30,677	28.0%
Asian/Pacific Islander	3,325	23,829	14.0%	3,701	25,851	14.3%	4,218	29,085	14.5%	4,587	32,267	14.2%
American Indian	2,911	17,850	16.3%	3,046	18,363	16.6%	3,221	18,953	17.0%	3,190	19,693	16.2%
Two or more races	1,655	5,969	27.7%	1,876	6,797	27.6%	2,111	7,669	27.5%	2,293	8,564	26.8%
Unknown race	3,731	14,041	26.6%	4,315	15,176	28.4%	4,594	16,835	27.3%	5,320	19,235	27.7%
Major Program												
Medical Assistance	56,567	280,843	20.1%	60,298	296,731	20.3%	65,337	314,743	20.8%	71,598	396,047	18.1%
MinnesotaCare	15,762	98,911	15.9%	16,147	101,780	15.9%	18,477	118,897	15.5%	17,070	97,733	17.5%
General Assistance Medical Care	1,416	30,369	4.7%	1,712	34,829	4.9%	1,677	34,985	4.8%	140	8,565	1.6%
MN Family Planning Program	26,469	30,542	86.7%	30,409	34,683	87.7%	34,549	39,415	87.7%	33,909	39,753	85.3%
TOTAL number with FP claims:	100,214	440,665	22.7%	108,566	468,023	23.2%	120,040	508,040	23.6%	122,717	542,098	22.6%

Table 2a (continued). Number of MHCP enrollees with family planning service or pharmacy claims, and family planning utilization rates, overall and by sex, age group, race/ethnicity, and major program, SFY 2012-2014.

	SFY 2012			SFY 2013			SFY 2014		
	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims
Sex									
Female	119,172	328,927	36.2%	115,527	326,061	35.4%	114,296	354,073	32.3%
Male	1,997	225,524	0.9%	2,025	222,407	0.9%	2,261	253,924	0.9%
Age Group									
15 to 19	24,185	99,667	24.3%	22,686	99,280	22.9%	21,711	106,772	20.3%
20 to 24	38,507	106,401	36.2%	36,134	102,298	35.3%	33,668	105,349	32.0%
25 to 29	27,251	94,604	28.8%	26,622	92,373	28.8%	26,633	105,598	25.2%
30 to 34	16,353	78,848	20.7%	16,852	80,877	20.8%	17,922	92,251	19.4%
35 to 39	8,020	57,677	13.9%	8,284	58,995	14.0%	9,120	69,105	13.2%
40 to 44	4,463	54,060	8.3%	4,561	53,393	8.5%	4,799	59,665	8.0%
45 to 49	2,390	63,194	3.8%	2,413	61,252	3.9%	2,704	69,257	3.9%
Race/ethnicity									
White	78,825	335,063	23.5%	75,226	324,583	23.2%	72,643	353,759	20.5%
Black	17,711	103,338	17.1%	17,888	106,047	16.9%	18,269	113,105	16.2%
Hispanic	8,721	32,067	27.2%	8,629	32,482	26.6%	9,066	35,815	25.3%
Asian/Pacific Islander	4,813	33,910	14.2%	4,807	34,593	13.9%	5,107	40,233	12.7%
American Indian	3,193	20,317	15.7%	3,146	20,152	15.6%	3,063	20,016	15.3%
Two or more races	2,431	9,189	26.5%	2,466	9,687	25.5%	2,624	11,674	22.5%
Unknown race	5,475	20,567	26.6%	5,390	20,924	25.8%	5,785	33,395	17.3%
Major Program									
Medical Assistance	71,116	419,947	16.9%	69,532	418,544	16.6%	81,667	507,696	16.1%
MinnesotaCare	16,910	94,596	17.9%	16,032	90,866	17.6%	9,306	67,262	13.8%
General Assistance Medical Care	0	0	0.0%	0	0	0.0%	0	0	0.0%
MN Family Planning Program	33,143	39,908	83.0%	31,988	39,058	81.9%	25,584	33,039	77.4%
TOTAL number with FP claims:	121,169	554,451	21.9%	117,552	548,468	21.4%	116,557	607,997	19.2%

Table 2a (continued). Number of MHCP enrollees with family planning service or pharmacy claims, and family planning utilization rates, overall and by sex, age group, race/ethnicity, and major program, SFY 2015-2017.

	SFY 2015			SFY 2016			SFY 2017		
	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims
Sex									
Female	120,844	383,507	31.5%	120,967	406,022	29.8%	78,860	382,435	20.6%
Male	2,597	284,426	0.9%	2,770	310,659	0.9%	1,365	284,575	0.5%
Age Group									
15 to 19	22,348	117,117	19.1%	22,533	125,118	18.0%	16,306	125,480	13.0%
20 to 24	33,626	112,552	29.9%	32,053	116,862	27.4%	20,235	107,055	18.9%
25 to 29	28,689	120,590	23.8%	28,673	131,281	21.8%	18,134	120,093	15.1%
30 to 34	19,833	105,765	18.8%	20,385	115,336	17.7%	12,546	105,606	11.9%
35 to 39	10,612	81,463	13.0%	11,328	90,935	12.5%	7,347	86,351	8.5%
40 to 44	5,399	66,569	8.1%	5,674	69,771	8.1%	3,665	65,309	5.6%
45 to 49	2,934	63,877	4.6%	3,091	67,378	4.6%	1,992	57,116	3.5%
Race/ethnicity									
White	70,562	355,764	19.8%	68,334	368,562	18.5%	44,482	332,090	13.4%
Black	16,784	105,399	15.9%	16,594	110,893	15.0%	10,223	103,021	9.9%
Hispanic	8,284	34,933	23.7%	8,067	37,838	21.3%	4,804	34,431	14.0%
Asian/Pacific Islander	5,206	40,196	13.0%	5,413	43,310	12.5%	3,527	40,504	8.7%
American Indian	2,813	19,021	14.8%	2,798	19,507	14.3%	1,688	17,957	9.4%
Two or more races	3,608	16,186	22.3%	3,850	18,252	21.1%	2,649	17,392	15.2%
Unknown race	16,184	96,434	16.8%	18,681	118,319	15.8%	12,852	121,615	10.6%
Major Program									
Medical Assistance	90,731	553,300	16.4%	91,923	586,454	15.7%	60,037	552,014	10.9%
MinnesotaCare	12,571	87,362	14.4%	14,324	106,082	13.5%	9,455	93,452	10.1%
General Assistance Medical Care	0	0	0.0%	0	1	0.0%	0	2	0.0%
MN Family Planning Program	20,139	27,271	73.8%	17,490	24,144	72.4%	10,733	21,542	49.8%
TOTAL number enrolled:	123,441	667,933	18.5%	123,737	716,681	17.3%	80,225	667,010	12.0%

Notes: Age group was determined based on age calculated at end of each State Fiscal Year (June 30th).

Major program was determined based on enrollment data during the last month of enrollment for each person during each State Fiscal Year. Enrollees may have been enrolled in more than one major program over the course of a year.

Race/ethnicity - Hispanics can be of any race; all other groups are non-Hispanic.
SFY 2017: MFPP waiver ended in December 31, 2016.

Table 2b. Proportion of MHCP enrollees who used two sub-categories of family planning services - contraceptive services and supplies, or STD testing, overall and by sex, age group, race/ethnicity, and major program, SFY 2004-2007.

	SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims
Sex								
Female	22.4%	23.2%	22.9%	24.3%	22.5%	25.0%	27.7%	27.1%
Male	0.4%	5.3%	0.4%	5.9%	0.3%	6.2%	0.3%	6.6%
Age Group								
15 to 19	11.6%	13.7%	11.7%	14.3%	11.5%	14.6%	17.9%	16.5%
20 to 24	23.3%	24.9%	23.9%	26.4%	23.3%	26.8%	31.5%	29.2%
25 to 29	20.8%	21.6%	21.2%	22.7%	21.0%	23.7%	23.7%	25.5%
30 to 34	14.3%	16.2%	14.4%	17.3%	14.2%	17.7%	15.0%	19.8%

35 to 39	8.4%	12.1%	8.9%	12.7%	8.6%	13.3%	8.8%	14.4%
40 to 44	4.8%	8.7%	4.6%	9.6%	4.6%	9.9%	4.3%	10.7%
45 to 49	2.5%	7.3%	2.5%	7.5%	2.3%	8.1%	2.0%	8.8%
Race/ethnicity								
White	14.3%	12.1%	14.7%	12.8%	14.4%	13.4%	19.4%	15.8%
Black	10.3%	27.4%	10.7%	27.9%	10.3%	28.0%	10.4%	28.6%
Hispanic	15.5%	25.5%	16.7%	26.0%	16.8%	26.4%	20.6%	28.8%
Asian/Pacific Islander	10.1%	13.2%	9.9%	17.9%	10.0%	15.6%	10.8%	15.2%
American Indian	10.3%	15.2%	10.3%	15.1%	10.5%	15.2%	11.5%	17.1%
Two or more races	17.7%	23.6%	18.0%	24.7%	17.5%	24.4%	19.9%	26.5%
Unknown race	13.0%	13.1%	13.3%	14.1%	13.0%	15.2%	18.9%	17.1%
Major Program								
GAMC	4.0%	11.5%	4.2%	12.3%	4.2%	12.6%	3.3%	12.9%
MA	14.4%	19.0%	14.6%	19.7%	14.4%	20.3%	14.2%	21.3%

MFPP							84.7%	30.5%
MNCare	15.0%	10.7%	15.7%	11.5%	15.4%	11.4%	14.1%	12.8%
Overall	13.3%	8.0%	13.6%	8.7%	13.4%	8.9%	17.0%	10.1%

Table 2b. Proportion of MHCP enrollees who used two sub-categories of family planning services - contraceptive services and supplies, or STD testing, overall and by sex, age group, race/ethnicity, and major program, SFY 2008-2011.

	SFY 2008		SFY 2009		SFY 2010		SFY 2011	
	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims
Sex								
Female	28.8%	28.4%	29.8%	29.6%	30.9%	30.1%	29.6%	29.2%
Male	0.3%	6.8%	0.3%	7.1%	0.4%	7.5%	0.5%	6.8%
Age Group								
15 to 19	19.3%	17.0%	20.5%	17.6%	21.2%	17.4%	20.4%	17.0%
20 to 24	32.9%	30.4%	32.9%	31.3%	33.3%	31.1%	31.6%	29.7%
25 to 29	24.1%	26.9%	24.3%	27.4%	24.6%	27.6%	23.5%	26.5%
30 to 34	15.5%	20.4%	15.8%	21.2%	16.1%	21.6%	15.4%	20.9%

35 to 39	9.1%	15.8%	9.4%	16.1%	9.8%	17.2%	9.7%	16.3%
40 to 44	4.6%	11.7%	4.9%	12.2%	5.3%	12.7%	5.1%	12.0%
45 to 49	2.0%	9.3%	2.1%	9.8%	2.2%	9.8%	2.3%	8.9%
Race/ethnicity								
White	20.5%	17.0%	20.9%	17.5%	21.4%	17.8%	20.2%	17.0%
Black	10.3%	28.5%	11.0%	29.5%	11.7%	30.4%	11.1%	28.7%
Hispanic	21.4%	30.1%	21.2%	31.3%	21.6%	30.1%	20.5%	28.1%
Asian/Pacific Islander	11.0%	16.8%	11.4%	17.7%	11.5%	18.3%	11.0%	19.5%
American Indian	11.3%	19.2%	11.5%	20.5%	11.6%	20.5%	10.9%	18.9%
Two or more races	20.9%	27.3%	20.9%	27.2%	21.2%	27.6%	20.6%	26.8%
Unknown race	22.4%	18.4%	24.1%	19.4%	23.0%	19.6%	23.6%	19.0%
Major Program								
GAMC	3.2%	15.1%	3.5%	15.6%	3.4%	15.5%	1.4%	0.5%
MA	14.6%	21.9%	14.8%	22.3%	15.2%	22.9%	13.1%	21.0%

MFPP	77.6%	30.8%	77.8%	33.0%	78.8%	32.4%	76.5%	31.1%
MNCare	13.4%	13.3%	13.3%	14.2%	13.0%	14.4%	14.6%	14.4%
Overall	17.9%	10.4%	18.3%	10.7%	18.8%	10.7%	17.8%	10.0%

Table 2b. Proportion of MHCP enrollees who used two sub-categories of family planning services - contraceptive services and supplies, or STD testing, overall and by sex, age group, race/ethnicity, and major program, SFY 2012-2014.

	SFY 2012		SFY 2013		SFY 2014	
	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims	Percentage of Enrolled– with Contraceptive Services or Supplies	Percentage of Enrolled with STD Test Claims
Sex						
Female	28.3%	29.0%	30.5%	28.9%	28.6%	26.9%
Male	0.5%	8.0%	0.5%	8.3%	0.5%	7.9%
Age Group						
15 to 19	19.7%	16.7%	20.6%	16.5%	18.7%	15.3%
20 to 24	29.8%	29.6%	31.1%	29.7%	28.9%	27.9%
25 to 29	22.1%	26.6%	24.2%	27.1%	22.1%	24.0%
30 to 34	15.1%	21.3%	17.1%	21.6%	16.5%	19.9%

35 to 39	9.5%	17.3%	11.1%	17.3%	10.9%	16.2%
40 to 44	5.4%	12.9%	6.7%	13.3%	6.6%	12.6%
45 to 49	2.4%	10.1%	3.1%	10.2%	3.3%	10.1%
Race/ethnicity						
White	19.2%	17.0%	20.5%	17.2%	18.6%	15.8%
Black	10.8%	29.8%	12.8%	29.5%	13.3%	28.4%
Hispanic	19.9%	26.9%	21.2%	27.2%	21.1%	24.9%
Asian/Pacific Islander	10.9%	19.1%	11.7%	17.8%	11.0%	16.1%
American Indian	10.4%	20.0%	12.1%	20.3%	12.2%	20.0%
Two or more races	20.2%	27.5%	21.7%	26.3%	20.1%	24.4%
Unknown race	22.6%	19.4%	22.9%	19.6%	15.4%	15.2%
Major Program						
GAMC						
MA	12.1%	20.7%	13.6%	20.6%	13.9%	18.9%

MFPP	73.9%	32.4%	75.6%	35.1%	71.8%	35.8%
MNCare	14.8%	14.4%	15.6%	14.3%	12.3%	11.2%
Overall	17.0%	10.7%	18.3%	10.8%	16.9%	10.1%

Table 2b. Proportion of MHCP enrollees who used two sub-categories of family planning services - contraceptive services and supplies, or STD testing, overall and by sex, age group, race/ethnicity, and major program, SFY 2015-2017.

	SFY 2015		SFY 2016		SFY 2017	
	Percentage - Contraceptive Services or Supplies	Percentage - STD Tests	Percentage - Contraceptive Services or Supplies	Percentage - STD Tests	Percentage - Contraceptive Services or Supplies	Percentage - STD Tests
Sex						
Female	27.6%	28.3%	25.9%	28.9%	18.1%	17.5%
Male	0.6%	8.2%	0.5%	8.1%	0.3%	4.7%
Age Group						
15 to 19	17.5%	14.3%	16.1%	14.0%	11.7%	8.6%
20 to 24	26.6%	27.2%	24.3%	26.1%	16.8%	16.3%
25 to 29	20.6%	24.3%	18.7%	23.1%	13.2%	14.4%
30 to 34	15.7%	21.6%	14.8%	22.5%	10.2%	13.8%

35 to 39	10.6%	17.8%	10.2%	19.5%	7.1%	11.2%
40 to 44	6.7%	14.6%	6.5%	16.2%	4.7%	9.3%
45 to 49	3.7%	12.4%	3.8%	13.9%	3.0%	7.7%
Race/ethnicity						
White	17.7%	16.6%	16.4%	16.9%	12.1%	10.1%
Black	13.0%	28.7%	12.1%	28.4%	8.0%	17.7%
Hispanic	19.5%	24.3%	17.5%	23.6%	11.6%	14.3%
Asian/Pacific Islander	11.0%	16.3%	10.5%	16.2%	7.5%	9.6%
American Indian	11.8%	21.0%	11.4%	22.9%	7.4%	14.4%
Two or more races	19.6%	25.2%	18.5%	25.4%	13.2%	16.1%
Unknown race	14.6%	20.1%	13.5%	20.2%	9.2%	11.8%
Major Program						
GAMC						
MA	14.1%	19.8%	13.4%	20.4%	9.4%	12.3%

MFPP	67.3%	32.3%	64.9%	31.7%	45.8%	19.5%
MNCare	12.6%	15.2%	11.7%	14.7%	9.0%	8.8%
Overall	16.1%	9.9%	14.9%	9.8%	10.5%	5.9%

Notes: Age group was determined based on age calculated at end of each State Fiscal Year (June 30th).

Major program was determined based on enrollment data during the last month of enrollment for each person during each State Fiscal Year. Enrollees may have been enrolled in more than one major program over the course of a year.

Race/ethnicity - Hispanics can be of any race; all other groups are non-Hispanic.
SFY 2017: MFPP waiver ended on December 31, 2016.

Objective 3

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

Indicator:

1. Maternal age distribution for MHCP-financed births.

2. Annual average maternal age among MHCP-financed births.

Data source:

Linked MN resident birth certificates and MMIS enrollment and claims data.

Definitions:

MHCP-financed births are defined as births for which the birth certificate has been matched to MHCP enrollment and claims data.

Results:

Table 3a presents the maternal age distribution for MHCP-financed births for CY 2003-2015. Table 3b presents the average maternal age at first birth among MHCP-financed births, for CY 2003-2015, with this information represented graphically in Figure 3.

Discussion:

In general, the categories that are populated and representative of early live births on the part of the mother have been gradually decreasing over time. Specifically, females age 15 to 19 have seen a decrease in representation from 33.0 percent of all live births in CY 2003, to 27.6 percent of all live births in CY 2008, 23.5 percent in CY 2012, and 18.5 percent in CY 2015. The category of 20 to 24 years of age saw a similar, if more modest trend, with 46.2 percent of all live births in CY 2003, to 45.2 percent of all live births in CY 2008, 43.0 percent in CY 2012, and 41.8 percent in CY 2015.

Conversely, the age categories of 25 to 29 and 30 to 34 have seen corresponding trends upwards in terms of representation of all live births. For example, the 30 to 34 category only made up 4.7 percent of all live births in CY 2003, but made up 5.7 percent of all live births in CY 2008, 8.3 percent of live births in CY 2012, and 10.7 percent of live births in CY 2015.

The average age of mother at first birth has gradually increased as well, with the average age at first birth starting at 21.8 years in CY 2003, to 22.5 years in CY 2008, 23.2 years in CY 2012, and most recently 24.0 years in CY 2015.

These changes in the maternal age distribution at first birth are reflective of national trends of delayed childbearing over the past several years. It is difficult to determine whether MFPP specifically contributed to this trend; however, it is reassuring that these results among MHCP enrollees are consistent with trends in the general population.

Table 3a. Maternal age distribution for MHCP-financed births calendar years 2003-2007.

Age Group	CY 2003		CY 2004		CY 2005		CY 2006		CY 2007	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Less than 15	43	0.5%	60	0.7%	39	0.4%	40	0.4%	51	0.5%
15 to 19	2,843	33.0%	2,864	31.5%	2,782	28.8%	2,955	28.5%	3,044	28.8%
20 to 24	3,980	46.2%	4,240	46.6%	4,618	47.7%	4,921	47.4%	4,879	46.2%
25 to 29	1,159	13.5%	1,299	14.3%	1,554	16.1%	1,752	16.9%	1,803	17.1%
30 to 34	405	4.7%	433	4.8%	480	5.0%	491	4.7%	547	5.2%
35 to 39	148	1.7%	173	1.9%	168	1.7%	186	1.8%	194	1.8%
40 to 44	28	0.3%	23	0.3%	30	0.3%	38	0.4%	39	0.4%
45 to 49	1	0.0%	1	0.0%	1	0.0%	0	0.0%	3	0.0%

Table 3a (continued). Maternal age distribution for MHCP-financed births calendar years 2008-2012.

Age Group	CY 2008		CY 2009		CY 2010		CY 2011		CY 2012	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Less than 15	46	0.4%	33	0.3%	41	0.4%	39	0.4%	41	0.4%
15 to 19	2,866	27.7%	3,180	27.6%	2,957	26.6%	2,603	24.1%	2,490	23.5%
20 to 24	4,681	45.2%	5,074	44.1%	4,797	43.1%	4,634	42.9%	4,550	43.0%
25 to 29	1,904	18.4%	2,246	19.5%	2,276	20.4%	2,379	22.0%	2,283	21.6%
30 to 34	594	5.7%	688	6.0%	773	6.9%	836	7.7%	882	8.3%
35 to 39	228	2.2%	246	2.1%	235	2.1%	243	2.3%	280	2.6%
40 to 44	33	0.3%	41	0.4%	51	0.5%	53	0.5%	55	0.5%
45 to 49	0	0.0%	5	0.0%	5	0.0%	7	0.1%	1	0.0%

Table 3a (continued). Maternal age distribution for MHCP-financed births calendar years 2013-2015.

Age Group	CY 2013	CY 2014	CY 2015

	Number	Percent	Number	Percent	Number	Percent
Less than 15	29	0.3%	23	0.2%	20	0.2%
15 to 19	2,243	22.1%	2,017	20.5%	1,764	18.5%
20 to 24	4,359	43.0%	4,201	42.6%	3,991	41.8%
25 to 29	2,298	22.7%	2,257	22.9%	2,361	24.7%
30 to 34	881	8.7%	1,019	10.3%	1,025	10.7%
35 to 39	271	2.7%	285	2.9%	326	3.4%
40 to 44	54	0.5%	46	0.5%	65	0.7%
45 to 49	3	0.0%	6	0.1%	4	0.0%

Notes: A trivial percentage of births occurred for females over the age of 49. These births were excluded for the purposes of presentation.

Figure 3. Annual average maternal age among MHCP-financed births calendar years 2003-2015.

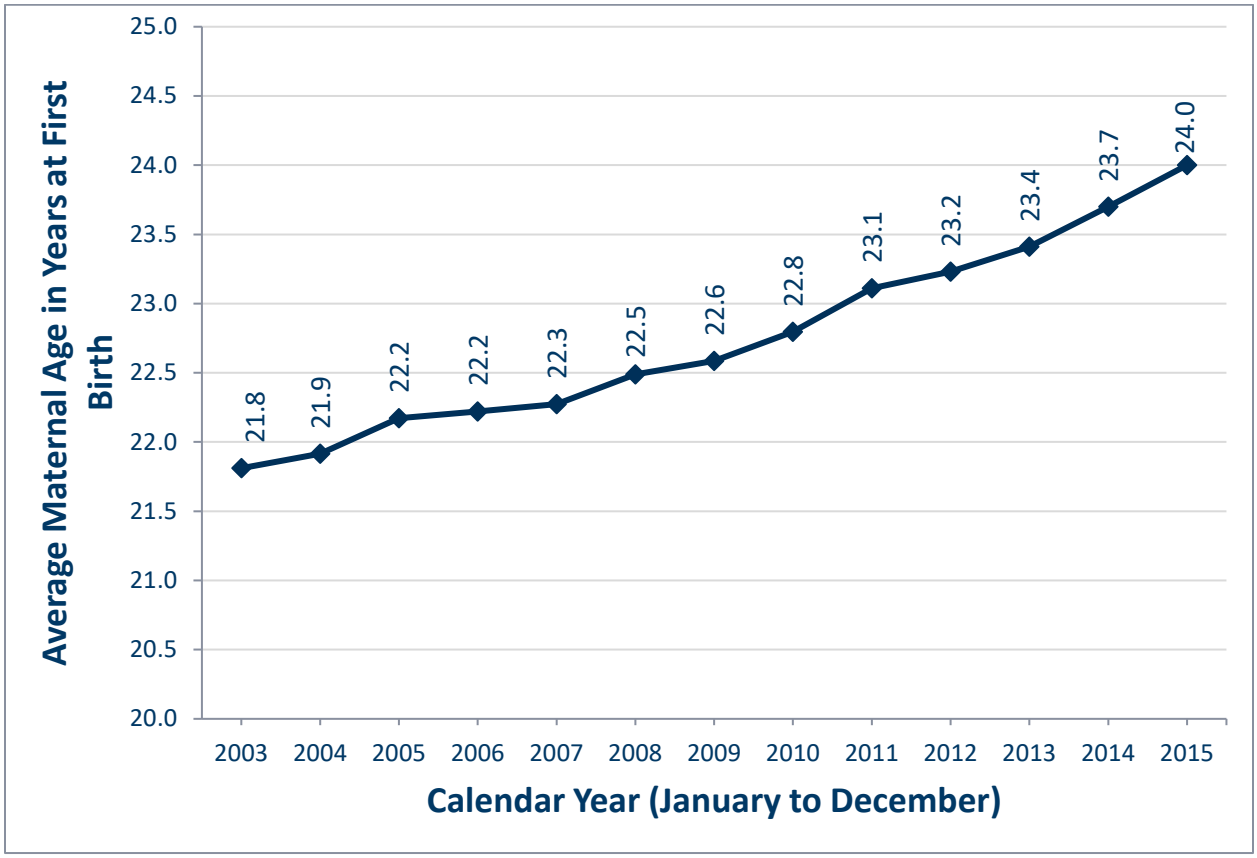


Table 3b. Annual average maternal age among MHCP-financed births calendar years 2003-2015.

CY	Mean	Standard Deviation	Lower 95% Confidence Interval	Upper 95% Confidence Interval
2003	21.8	4.4	21.7	21.9
2004	21.9	4.4	21.8	22.0
2005	22.2	4.4	22.1	22.3
2006	22.2	4.4	22.1	22.3
2007	22.3	4.5	22.2	22.4
2008	22.5	4.6	22.4	22.6
2009	22.6	4.7	22.5	22.7
2010	22.8	4.8	22.7	22.9
2011	23.1	4.9	23.0	23.2
2012	23.2	4.9	23.1	23.3
2013	23.4	4.9	23.3	23.5
2014	23.7	5.0	23.6	23.8
2015	24.0	5	23.9	24.1

Notes: Birth data is not available for calendar years 2013 and 2014.

Objective 4

Reduce the teen birth rate among MHCP enrollees.

Indicator:

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

Data source:

Linked MN resident birth certificates and MMIS enrollment and claims data.

Definitions:

MHCP-financed births are defined as births for which the birth certificate has been matched to MHCP enrollment and claims data. Denominator for this rate included MFPP enrollees in the previous SFY.

Results:

Figure 4 presents the annual proportion of adolescent female MHCP enrollees with a live birth financed by MHCP for CY 2003-2012. Table 4 presents these proportions for CY 2003-2015.

Discussion:

The teen birth rate within the population of MHCP enrollees has been steadily decreasing since the inception of the waiver program, and has been especially small in recent years. For example, while teen birth rate was 6.7 per 100 MFPP enrollees in CY 2007, it reduced to 2.8 per 100 MFPP in CY 2015.

This finding is consistent with the trend found under Objective 3, showing an increase over time in the average age of first birth among MHCP enrollees. Teen birth rates have been decreasing throughout the United States during this time period for all racial and ethnic groups.

Figure 4. Annual proportion of adolescent female MHCP enrollees with a live birth financed by MHCP, calendar year 2003-2015.

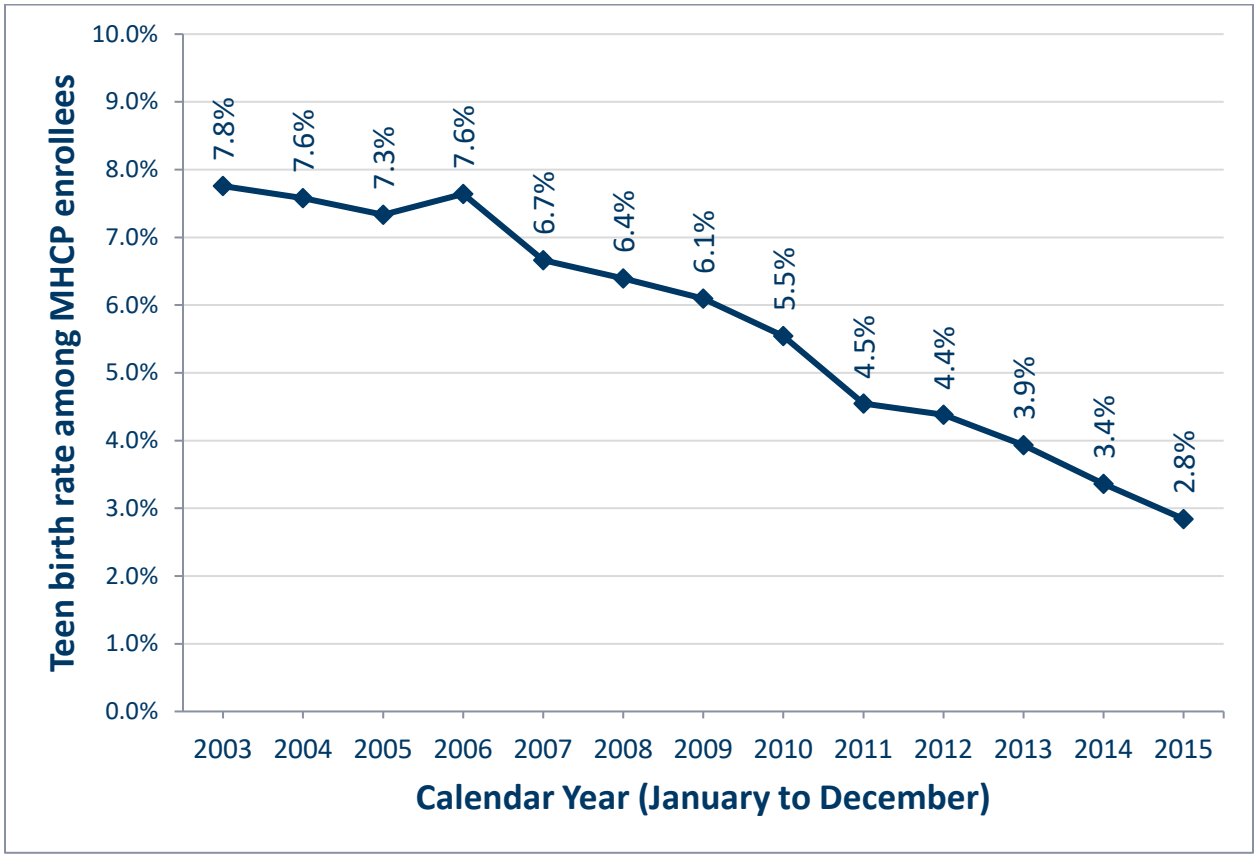


Table 4. Annual proportion of adolescent female MHCP enrollees with a live birth financed by MHCP, calendar year 2003-2015.

CY	Adolescences without a Live Birth	Adolescences with a Live Birth	Adolescent Female MHCP Enrollees	Proportion with Live Birth
2003	37,045	3,115	40,160	7.8%
2004	38,296	3,141	41,437	7.6%
2005	39,260	3,107	42,367	7.3%
2006	40,102	3,318	43,420	7.6%
2007	46,538	3,322	49,860	6.7%
2008	47,714	3,260	50,974	6.4%
2009	48,672	3,159	51,831	6.1%
2010	50,614	2,969	53,583	5.5%
2011	52,158	2,483	54,641	4.5%
2012	51,937	2,378	54,315	4.4%
2013	51,522	2,108	53,630	3.9%
2014	54,858	1,906	56,764	3.4%
2015	59,451	1,739	61,190	2.8%

Appendix G: Medicaid Tribal Consultation Policy

DHS will designate a staff person in the Medical Director's office to act as a liaison to the Tribes regarding consultation. Tribes will be provided contact information for that person.

The liaison will be informed about all contemplated state plan amendments and waiver requests, renewals, or amendments.

The liaison will send a written notification to Tribal Chairs, Tribal Health Directors, and Tribal Social Services Directors of all state plan amendments and waiver requests, renewals, or amendments.

Trial staff will keep the liaison updated regularly regarding any change in the Tribal Chair, Tribal Health Director, or Tribal Social Services Director, or their contact information.

The notice will include a brief description of the proposal, its likely impact on Indian people or Tribes, and a process and timelines for comment. At the request of a Tribe, the liaison will send more information about any proposal.

Whenever possible, the notice will be sent at least 30 days prior to the anticipated submission date. When a 30-day notice is not possible, the longest practical notice will be provided.

The liaison will arrange for appropriate DHS policy staff to attend the next Quarterly Tribal Health Directors meeting to receive input from Tribes and to answer questions.

When waiting for the next Tribal Health Directors meeting is inappropriate, or at the request of a Tribe, the liaison will arrange for consultation via a separate meeting, a conference call, or other mechanism.

The liaison will acknowledge all comments received from Tribes. Acknowledgement will be in the same format as the comment, e.g. email or regular mail.

The liaison will forward all comments receives from the Tribes to appropriate state policy staff for their response.

The liaison will be responsible for ensuring that all comments received responses from the State.

When a Tribe has requested changes to a proposed state plan amendment or waiver request, renewal, or amendment, the liaison will report whether the change is included in the submission, or why it was not included.

The liaison will inform Tribes when the State's waiver or state plan changes are approved or denied by CMS, and will include CMS' rationale for denials.

For each state plan or waiver change, the liaison will maintain a record of the notification process; the consultation process, including written correspondence from Tribes and notes of meetings or other discussions with Tribes; and the outcome of the process.

Appendix H: State Public Notice Process

Public Notice and Comment Period

The State must provide a 30-day public notice and comment period prior to submission of initial/extension application.

The Public Notice must include comprehensive descriptions of initial/extension application:

- Program description, goals, and objectives
- Current/New beneficiaries to be impacted
- Proposed healthcare delivery system
- Eligibility requirements
- Benefit coverage
- Cost sharing (premiums, co-pays, deductibles)
- Enrollment and expenditure data, historical and projected
- Hypothesis and evaluation parameters
- Waiver and expenditure authorities requested
- Locations and Internet address where copies of application are available for public review and comment
- Postal and Internet addresses where written public comments may be sent and reviewed, indicate the 30-day time period in which comments will be accepted
- Location, date, and time of two public hearings convened by the State of Minnesota

Statement of Public Notice and Public Input Procedures

The State must publish the following on the main page of the DHS public website or on a demonstration-specific webpage linked to the main page of the DHS public website:

- Public notice process
- Public input process
- Planned hearings
- Demonstration application/extension request
- Link to the Medicaid demo page on CMS website

The State must maintain and keep current the public website throughout the public comment and review process

The State must also publish abbreviated public notice (State Register Notice) 30 days prior to submission. The State Register notice must include:

- Summary description of demonstration
- Location and times of two public hearings
- A link to the full public notice document on the State’s website

The State must utilize additional mechanisms such as an email distribution list to notify interested parties of the demonstration application.

Public Hearings

The State must conduct two public hearings, on separate dates, and separate locations at least 20 days prior to submission.

The State must use telephonic and/or web conference capabilities for at least one hearing to assure statewide accessibility.

The State must use at least two of the following forums:

- Medical Care Advisory Committee that operates in accordance with 431.12
- Commission open to the public
- State legislative process that affords public review and comment on demonstration content
- Any other similar process that affords public review and comment on demonstration content

Tribal Consultation

The review must be conducted in accordance with consultation processes outlined in July 17, 2001 letter or the State's formal Tribal Consultation Process (Appendix G) as outlined in the State's approved Medicaid State Plan.

Documentation of Tribal consultation activities must be included in the demonstration/extension application, including:

- Description of notification process
- Entities involved in consultation
- Dates
- Locations
- Issues raised and potential resolution of issues

Appendix I: Ongoing DHS Performance Measurement

Calculated annually by DHS using claims data submitted to the State by MCOs

Table 1: HEDIS Performance Measures

No.	Measure	HEDIS Identifier	ATR Measure#	IHP 2.0 Measure
1	Adults' Access to Preventative/Ambulatory Health Services (20-44, 45-64, 65+ years & Total)	AAP	X	
2	Follow-up Care for Children prescribed ADHD medication (6-12 years)	ADD		
3	Annual Dental Visit (2-3, 4-6, 7-10, 11-14, 15-18, Total for children, 2-18, 19-21, 22-64, 65+, & Total for adults 19+)	ADV		X
4	Antidepressant Medication Management (18-64, 65+ years, & Total) • Acute Treatment • Continuous Treatment	AMM	X	X
5	Asthma Medication Ratio (5-11, 12-18, 19-50, 51-64 years)	AMR	X	
6	Use of multiple concurrent antipsychotics in children and adolescents (1-5, 6-11, 12-17, & Total 1-17(	APC		
7	Adolescent Well-Care Visits (12-21 years)	AWC	X	X
8	Breast Cancer Screening (52-64 years, 65-74 years, & Total)	BCS	X	X
9	Children and Adolescents' Access to Primary Care Practitioners (12-24 months, 25 months-6 years, 7-11 years, 12-19 years, & Total)	CAP	X	
10	Cervical Cancer Screening (CCS) (24-64 years)	CCS	X	X
11	Diabetes Screening (18-64, 65-75 years, & Total) • HbA1c Testing	CDC	X	X
12	Chlamydia Screening (16-20 years, 21-24 years, and Total)	CHL	X	X
13	Childhood Immunizations (Total 2 year olds) all Combinations	CIS	X	X
14	Colorectal Cancer Screening (50-64, 65-75, & Total)	COL		X
15	Mental Discharge and FU – 7 & 30 days (6-18, 19-64, 65+, & Total) / Follow-Up After Hospitalization for Mental Illness 7/30 Days (FUH) (6-17, 18-64, 65+ years)	FUH		X

No.	Measure	HEDIS Identifier	ATR Measure#	IHP 2.0 Measure
16	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (13-64, 65+ years, & Total)	IET		X
17	Immunizations for Adolescents (Total 13 years old)	IMA		X
18	Asthma Medications (5 – 11, 12-18, 19-50, 51-64, Total) • Medication Compliance 50% • Medication Compliance 75%	MMA	X	X
19	Annual Monitoring for Patients on Persistent Medications (18-64, 65+, & Total)	MPM		
20	Osteoporosis Care After Fracture (67+)	OMW		
21	Plan All Cause Readmission (18 – 64, 65+years, & Total)	PCR		
22	Prenatal & Postpartum Care (all ages)	PPC		
23	Adherence to Antipsychotic medications for individuals with schizophrenia (19-64 years)	SAA		X
24	COPD Spirometry Testing (40-64, 65+, & Total)	SPR		
25	Children with Appropriate Treatment with Upper Respiratory Infection (3 months – 18 years)	URI		
26	Well-Child Visits First 15 Months (zero, 1, 2, 3, 4, 5, 6 or more visits)	W15	X	X
27	Well-Child Visits (3 – 6 years)	W34	X	X
28	Adult Body Mass Index Assessment (18-74)	ABA		
29	Ambulatory Care – Emergency Dept. Visits (<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, 85+, Unknown)	AMB		
30	Flu Vaccines for Adults (18-64)	FVA		
31	Medical Assistance with Smoking and Tobacco Cessation (18+)	MSC		
32	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (3-11, 12-17, total)	WCC		X
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics (1-5, 6-11, 12-17, total)	APM		
34	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	FUA		
35	Follow Up after ED visit for Mental Illness	FUM		
36	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD		
37	Identification of Alcohol and Other Drug Services	IAD		

No.	Measure	HEDIS Identifier	ATR Measure#	IHP 2.0 Measure
38	Inpatient Utilization – General Hospital/Acute Care	IPU		
39	Mental Health Utilization	MPT		
40	Opioid New Chronic User	NCU		
	Total	40	13	17

ATR measures must be calculated by August 1st or sooner of each year.

Table 2: AHRQ Prevention Quality Indicators (PQI)

No.	Prevention Quality Indicator	CY 2015,-CY 2016, and CY 2017
PQI 01	Diabetes Short Term Complication Admission Rate	X
PQI 02	Perforated Appendix Admission Rate	X
PQI 03	Diabetes Long-term Complication Admission Rate	X
PQI 05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	X
PQI 07	Hypertension Admission Rate	X
PQI 08	Heart Failure Admission Rate	X
PQI 10	Dehydration Admission Rate	X
PQI 11	Bacterial Pneumonia Admission Rate	X
PQI 12	Urinary Tract Infection Admission Rate	X
PQI 13	Angina Without Procedure Admission Rate	X
PQI 14	Uncontrolled Diabetes Admission Rate	X
PQI 15	Asthma in Younger Adults Admission Rate	X
PQI 16	Lower-Extremity Amputation among Patients with Diabetes Rate	X
PQI 90	Prevention Quality Overall Composite	X
PQI 91	Prevention Quality Acute Composite	X
PQI 92	Prevention Quality Chronic Composite	X
	Total	16

Appendix J: Directed Payment Arrangements

DHS contracts with MCOs include provisions for directed payments in three categories: Integrated Health Partnerships, Behavioral Health Homes, and State Operated Dental Services. The following discusses these contract components and how they align with the goals of the Quality Strategy.

1. Integrated Health Partnerships

The Integrated Health Partnership is a Medicaid service delivery reform demonstration that is based on an integrated care model. The goal of the demonstration is to improve the health of the target population by delivering care of higher quality and lower cost through innovative approaches to both care and payment. In this effort, the state contracts with a consortium of health partnerships, each of whom works with an associated group of Medicaid providers. The providers work together to coordinate their efforts, and achieve a demonstrable level of savings when compared to targets developed by the state. Providers that demonstrate an overall savings across their population, while maintaining or improving quality of care, may receive a portion of the savings. Providers that cost more over time may be required to pay back a portion of the losses.

Providers in the Integrated Health Partnership program receive a base payment for services just like other Medicaid providers. In addition, the state calculates a target payment amount that is based past utilization and cost data for the population served. If a provider is able to deliver service at a lower cost than the calculated target, an incentive (directed) payment may be made to the provider. Lower costs may be the result of better coordination, greater efficiency, or reduced utilization of medical services.

The classes of providers participating in this arrangement include the following: Physician services; nurse midwife; nurse practitioner; Child & Teen Check-up (EPSDT); public health nurse; rural health clinic; federally qualified health center; laboratory; radiology; chiropractic; pharmacy; vision; podiatry; physical therapy; speech therapy; occupational therapy; audiology; mental health; chemical dependency; outpatient hospital; ambulatory surgical center; inpatient hospital; anesthesia; hospice; home health (excluding personal care assistant services); and private duty nursing.

The methods used to determine savings and quality are the same for all providers, except when a provider's patient population differs measurably from the average Medicaid population. In those instances, the state may apply quality measures that are more appropriate to the type of patients served by the provider. For example, a quality measurement related to the provision of cancer screening for adults may be substituted for child and teen checkups when evaluating quality for a provider of pediatric services.

Providers are given incentive to improve value and quality through a payment arrangement that is directly tied to the objectives of the Quality Strategy. Providers receive an incentive payment

when they can demonstrate savings beyond a threshold established by the state, and only when they've met or exceeded performance measures. Providers who fail achieve certain measures of quality or savings may owe the state money, which provides them with further incentive.

Performance is reviewed annually. Costs are evaluated relative to the estimated payment targets. Quality of service is measured under several categories: prevention and screening, care for at-risk populations, behavioral health, access to care, patient safety, and meaningful use of electronic health record technology.

All enrollees are eligible with the following exceptions: individuals dually eligible for Medicare and Medicaid; qualified Medicare beneficiaries who are not otherwise receiving Medical Assistance; non-citizens receiving only emergency Medical Assistance; individuals eligible for Medical Assistance on a spenddown basis; individuals enrolled in specialized Medical Assistance managed care programs; and individuals whose Medical Assistance is supplemented by a third party's liability.

The Integrated Health Partnership is a voluntary, direct-contract payment model that serves both managed care and fee-for-service Medicaid enrollees. Incentive (directed) payments are made under the same conditions for each provider, and all providers within a given class are subject to the same terms of performance and participation requirements.

The metrics and methodology used for measuring performance of providers participating in the IHP program are discussed on pages 12-13 of the Quality strategy and Appendices J and K.

2. Behavioral Health Homes

Behavioral health homes provide integrated medical care for adults with serious and persistent mental illness, and children with emotional disturbance. Recipients receive comprehensive care management through a collaborative process designed to more effectively manage medical, social, and behavioral health conditions. Providers draft a patient-centered action plan based on a template developed by the state Medicaid agency. The plan requires providers to maintain regular contact with the recipient, coordinate services among other providers involved in the recipient’s care, and monitor progress towards achieving the goals outlined in the plan. When the recipient is child, all activities must include the consent of the child’s parent or guardian. All Behavioral Health Homes are certified by the state.

These provider include: Integration specialists (which include registered nurses, and mental health professionals); Behavioral Health Home Navigators (which include case managers and mental health professionals); Qualified Health Home Specialists (including community health workers, peer specialists, and certified health education specialists); and other specialists as necessary. Providers are paid a monthly bundled rate for each Medicaid enrollee receiving services through the behavioral health home. Payment for each behavioral health home provider is determined using the same metrics and terms of performance.

In order to receive services, an individual must meet the criteria for serious mental illness or emotional disturbance and have a current diagnostic assessment performed or reviewed by a mental health professional employed by or contracted by the behavioral health home. The evaluation plan will examine outcomes based on age, race, ethnicity, and mental health diagnosis. The state will also conduct individual interviews and focus groups with enrollees receiving services through behavioral health homes.

All behavioral health homes must be certified by the state. Payment for each behavioral health home provider is determined using the same metrics and terms of performance.

3. State Operated Dental Services

State-operated dental providers are paid a rate based on the cost of service. This payment rate is intended to recognize the higher cost of providing care to patients who require this level of service. Providers are paid an interim rate according to the state's Medicaid fee schedule for dental services. Following payment of the interim rate, the state Medicaid agency calculates a final payment based on a cost reporting protocol approved by CMS. The final payment is equal to the cost of providing service minus the interim payment amount. If the interim payment amount exceeds the cost of providing service, the state Medicaid agency recovers the excess and adjusts the federal claim. Individual payments are calculated according to the documented cost of providing service to a single enrollee during the benefit year. Provider included in this arrangement include: State-owned, or operated, dental providers participate in this arrangement. Services may be provided by a dentist, or an enrolled dental therapist.

All payments are based on the cost of providing service, and determined according to a cost report developed by the state Medicaid agency. The payment arrangement applies only to enrollees receiving dental services through state-operated providers. State-operated providers serve enrollees whose physical or developmental disabilities present unique challenges to the administration of care that other providers may not be suited to address.

Appendix K: IHP Specific Measures

Table 1. Additional IHP 2.0 Measures

Patient-centered Care	Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)	AHRQ	Core IHP 2.0 Set

	HCAHPS Communication with Nurses	CMS	Core IHP 2.0 Set
	HCAHPS Communication with Physicians		Core IHP 2.0 Set
	HCAHPS Responsiveness of Hospital Staff		Core IHP 2.0 Set
	HCAHPS Communication about Medications		Core IHP 2.0 Set
	HCAHPS Cleanliness of Hospital Environment		Core IHP 2.0 Set
	HCAHPS Quietness of Hospital Environment		Core IHP 2.0 Set
	HCAHPS Discharge Education		Core IHP 2.0 Set
	HCAHPS Care Transitions		Core IHP 2.0 Set
	HCAHPS Overall Hospital Rating		Core IHP 2.0 Set
	HCAHPS recommend the Hospital as 9 or 10		Core IHP 2.0 Set
Medicaid Meaningful Use of E.H.R Technology*	Health Information Exchange	CMS, Medicaid EHR Incentive Program Stage 2, Objective 5	Core IHP 2.0 Set
	Patient Electronic Access	CMS, Medicaid EHR Incentive Program Stage 2, Objective 8	Core IHP 2.0 Set

	Secure Electronic Messaging	CMS, Medicaid EHR Incentive Program Stage 2, Objective 9	Core IHP 2.0 Set
Care for at risk populations	Optimal asthma control: ACT 20+, < 2 admissions/ER/	MNCM	IHP-specific
Behavioral Health	Adolescent Mental Health and/or Depression screening with use of a depression screening tool annually for patients 12yr and older	MNCM	IHP-specific
Patient-centered Care	Timely appointments, care, and information: Was your child seen by this provider in a timely manner?	AHRQ	IHP-specific
	How providers communicate with patients: Did this provider listen carefully to you? [No. Yes, somewhat. Yes, mostly. Yes, definitely]	AHRQ	IHP-specific
	Providers' use of information to coordinate patient care: Did this provider give you enough information about your child's health and treatment? [No. Yes, somewhat. Yes, mostly. Yes, definitely]	AHRQ	IHP-specific
	Helpful, courteous, and respectful office staff: How often were the staff at the provider's office as helpful as you though they should be? [Never. Sometimes. Usually. Always]	AHRQ	IHP-specific
	Patients' rating of the provider: Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what	AHRQ	IHP-specific

	number would you use to rate this provider?		
	Child HCAHPS: Willingness to Recommend	AHRQ	IHP-specific
	Child HCAHPS: Overall Positive Experience	AHRQ	IHP-specific
Pilot Measure, Patient Engagement	Well visits in years 7-11 yr	HEDIS	IHP-specific
	Application of fluoride varnish at Well visits annually through age 5 yr	CDC	IHP-specific

Table 2. IHP Legacy Measures

Measure Category	Measure Name	Measure Specification Organization	Core Set or IHP specific
Clinical Quality	Optimal Diabetes Care Composite	MNCM	Core IHP Legacy Set
	Optimal Vascular Care Composite	MNCM	Core IHP Legacy Set
	Depression Remission at 6 Months	MNCM	Core IHP Legacy Set

	Optimal Asthma Care Composite	MNCM	Core IHP Legacy Set
	Optimal Asthma Control Composite – Adults and Children	MNCM	Core IHP Legacy Set
	Asthma Education and Self-Management - Adults and Children	MNCM	Core IHP Legacy Set
	Child Immunization Status (HEDIS)	HEDIS	IHP-specific
	Well Visits in First 15 Months (HEDIS	HEDIS	IHP-specific
	Well Child Visits in years 3-6 (HEDIS)	HEDIS	IHP-specific
	Adolescent Well Care Visits 12 -21 (HEDIS)	HEDIS	IHP-specific
	Maternity Care: Cesarean Section Rate	MNCM	IHP-specific
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), CMS138v5	HRSA, UDS	IHP-specific
	Asthma: Use of Appropriate Medications: (Line 16), CMS126v5	HRSA, UDS	IHP-specific
	CAD: Lipid Therapy:	HRSA, UDS	IHP-specific

	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (Line 18), CMS164v5	HRSA, UDS	IHP-specific
	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v6	HRSA, UDS	IHP-specific
	Uncontrolled Diabetes	HRSA, UDS	IHP-specific
	Hypertension Control	HRSA, UDS	IHP-specific
Clinical Patient Experience	HRSA Patient Satisfaction Survey	HRSA, UDS	IHP-specific
	Pediatric CG-CAHPS	AHRQ	IHP-specific
	Patient Experience (CG-CAHPS)	AHRQ	IHP-specific
Hospital Quality	Patient Safety Composite	AHRQ	IHP-specific
	Venous Thromboembolism Prophylaxis (VTE-1)	CMS/Joint Commission	IHP-specific
	Stroke: Discharged on Antithrombotic Therapy (STK-2)	CMS/Joint Commission	IHP-specific
Hospital Patient Experience	NRC Picker		IHP-specific
	Patient Experience (HCAHPS)	CMS	IHP-specific

Appendix L: Initiatives under Development

To ensure compliance with recent changes to 42 CFR Section 438, DHS is actively developing additional reporting tools that will aid in monitoring the performance of partner MCOs and communicating MCO performance to public program enrollees. The State Monitoring Report is being developed by a cross-functional team in DHS and will include measurements and metrics that compliment and contribute to the Annual Technical Report and inform the State Quality Strategy. DHS' Quality Rating system is also in development and will provide a public-facing reporting tool, which will assist enrollees in making coverage decisions based on their needs. Summaries of these initiatives are provided below:

1. State Monitoring Report

Annually, the Minnesota Department of Human Services (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 the state and federal requirements, enrollee satisfaction, and improvements in the care and services provided to all enrollees.

The State Monitoring Report is pursuant to 42 C.F.R Part 438 Section 66, in accordance with Centers for Medicare and Medicaid Services Final Rule published on May 6th 2016. In compliance with 42 CFR §438.66 (b), the purpose of the report is to provide an overview of Minnesota Department of Human Services (DHS) current monitoring efforts and performance for all managed care programs in the following areas:

- Administration and management
- Appeal and grievance system
- Claims management
- Enrollee materials and customer services, including the activities of the beneficiary support system
- Finance, including medical loss ratio reporting
- Information systems, including encounter data reporting
- Marketing
- Medical management, including utilization management and case management
- Program integrity
- Provider network management, including provider directory standards
- Availability and accessibility of services, including network adequacy standards
- Quality improvement
- Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program
- All other provisions of the contract as appropriate

An internal workgroup has been created to establish content editors among the Department Human Services Staff, to ensure that the appropriate department(s) and/or division(s) are involved to provide pertinent content. Internal and/or external stakeholders and the Medical Advisory Committee will be reviewing the document prior to posting the final version of the State Monitoring Report on the DHS Website.

2. State Quality Rating System

Medicaid Managed Care: Star Quality Rating System (QRS) DRAFT Plan for MN-DHS

Background

As per CMS's final rule on Medicaid Managed Care regulations (§438.334), states are required to develop and implement a Star Quality Rating System (QRS) over the next three years to measure Medicaid Managed Care (MMC) beneficiaries' health services as well as experience and satisfaction with their health plans.

According to the rule, states will be able to use an alternative methodology or adopt additional measures in the rating system, as long as it is "substantially comparable" to the CMS's recommended QRS and is approved by CMS. The rule also requires states to "prominently display" the health plan ratings on the website, in a manner that complies with the standards in §438.10(d), and ensure that beneficiaries have access to the quality ratings annually at the time of the enrollment so that they can use QRS to compare and choose a health plan.

The "stars" ratings will be implemented after CMS provides further guidance, potentially as soon as late 2018.

Goal

Enable beneficiaries on market based selection of MCOs based on quality and services provided

Objectives

Develop a Medicaid Managed Care Star QRS to be published annually on MN-DHS webpage

Publish summary Star QRS annually in open enrollment packet or MHCP Enrollee's Handbook

Primary Audience

MN-DHS Medicaid Managed Care Enrollees

Stakeholders

- External Stakeholders: CMS, MHCP Enrollees, and other Stakeholders (e.g. HSAG)
- Internal Stakeholders: MN DHS – Directors (Medical, Medicaid, HRQ Division), Managers (Healthcare Program, Contract, Federal Relations, HRQ)
- MCOs: Blue Plus, HealthPartners, IMCare, Medica, Hennepin Health, PrimeWest, SCHA, UCare

Timeline

Tentatively, state implementation by 2021 (assuming CMS QRS publication in 2018).

Vision and Scope

The overall goal of the current project (e.g. HRQ Managed Care Regulation Compliance Work Plan) is to design and implement an alternative Medicaid Managed Care Star QRS, which is robust yet simple to understand; aligned with CMS's QRS yet specific to MN-DHS Medicaid Managed Care products. The objective of the QRS is to serve as an aid for meaningful health plan comparison by potential and current enrollees, similar to other star rating systems developed by CMS.

In Phase I of the QRS project, the HRQ Managed Care Regulation Compliance Work Group will focus on "Clinical Care" domain only. Subsequently, other domains will be evaluated (e.g. Member Experience and Satisfaction, Plan Administration).

- As the first step of Phase 1 of the project, the Medicaid Marketplace QRS framework was reviewed as our first QRS methodology option for "Clinical Care" domain. DHS' QRS methodology uses the National Percentile Ranks for measures standardization and weight point assignment.
- In the next step, the QRS methodologies used for Medicare Star Rating system were evaluated, as they use different methods for measures standardization and for determining star cut-off points. Then, the pros and cons of each methodology for the "Clinical Care" domain were considered, followed by the development of a proposed / draft version of a Medicaid QRS methodology.
- In future phases, the "Member Experiences and Satisfaction" domain will be explored. The CAHPS survey follows a different methodology for standardizing and scoring of these measures. If it is decided to include a third domain ("Plan Administration"), the components from the State Monitoring Report may be used to rate the plan administration.

QRS Hierarchy and Methodology (draft)

The Star QRS program is a hierarchical model composed of the following: four Summary Indicators / Population (e.g. Children, Adults, Senior, SNBC); three Domains (e.g. Clinical Care, Member Satisfaction or Experience of Care, and Plan Administrations); and six Composite Scores (e.g. five composites in Clinical Care domain and one composite in Member Satisfaction domain). The Plan Administration domain may rely some or all components of the State Monitoring Report to demonstrate performance in this domain.

Summary Indicators

- Population: DHS expects that it will have various Medicaid Managed Care products offered at MN-DHS. For example, CHILDREN and ADULTS population will have enrollees from "Families and Children MA", as well as "MinnesotaCare" products, Senior population will have enrollees enrolled in MSHO and MSC+ products, SNBC population will have enrollees enrolled in SNBC product.
- Clinical Care domain will have various CMS's Adult and Child Core Set performance measures, grouped into five composites (e.g. Preventive and Well Care Composite, Maternal and Perinatal Health Composite, Acute and Chronic Care Composite, Behavioral Health and Substance Use Composite, Dental / Oral Health Composite).
- Member Satisfaction or Experience of Care domain will have one composite, called "Member Satisfaction Composite" which has the following six components (e.g. Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Cultural Competence, and Plan Administration). The survey questions in the QRS measure set will be collected as part of the QHP

Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Overview of example QRS Hierarchy

- Population: Children (Age 0-17); Adults (Age 18-64); seniors (Age 65+); SNBC (Age 18-64)
- Products: F&C MA + MinnesotaCare; MSHO; MSC+; SNBC;
- Domains: A. Clinical Care, B. Member Satisfaction, C. Plan Administration
- Clinical Care Composite:
- Preventive and Well Care Composite,
- Maternal and Perinatal Health Composite,
- Acute and Chronic Care Composite,
- Behavioral Health and Substance Use Composite,
- Dental / Oral Health Composite
- Member Satisfaction / Experience of Care Composite:
- Member Satisfaction Composite

Appendix M: Catalog of Past Quality Improvement Efforts

Wellness, Prevention, and Early Detection

Reducing Avoidable Readmissions Effectively (RARE) Campaign

The Reducing Avoidable Readmissions Effectively (RARE) Campaign was established as a payer-provider initiative aimed at improving transitions of care from the inpatient hospital setting in order to prevent potentially preventable readmissions. The legislature tied performance of hospitals in preventing these kinds of readmission to the mediation of a 10 percent hospital rate reduction. The rate reduction could be reduced to as low as 5 percent from the 10 percent for every percentage point the statewide readmissions rate was reduced. The hospital rate reduction was lowered to 6 percent based on hospitals' performance.

RARE engaged hospitals and care providers across the continuum of care to prevent 6,000 avoidable hospital readmissions within 30 days of discharge across Minnesota between July 1, 2011 and Dec. 31, 2013. The original goal of collectively reducing 4,000 readmissions by Dec. 31, 2012 was exceeded. Reducing readmissions will alleviate the burden placed on patients and their families and will allow them the comfort and well-being of staying in their own beds. The fourth quarter 2013 data showed that RARE Campaign participants have helped prevent 7,975 readmissions and allowed Minnesotans to spend 31,900 nights of sleep in their own beds instead of in the hospital. In the last quarter of 2013, Minnesota hospitals reached a collective reduction in readmissions of 19 percent.

Participating hospitals are continuing to work to reduce their own readmission rates by 20%, from the 2009 baseline, as measured by the MHA's Potentially Preventable Readmissions (PPR) data. According to the Health Research and Education Trust, unplanned readmissions cost Medicare $17.5 billion. Currently, 85 hospitals and 93 community partners are participating in RARE. The RARE Campaign builds upon and expands work that has been going on for several years by many hospitals, medical groups, health plans and the campaign's operating, supporting and community partners. The campaign focuses on five key areas that, if not managed well, are known to be main contributors to avoidable hospital readmissions:

- Comprehensive discharge planning
- Medication management
- Patient and family engagement
- Transition care support
- Transition communications

Numerous tools for providers and hospitals have been developed around these issues and are available on the MHA web site (MHA > Patient Safety > Collaboratives > Reducing Avoidable Readmissions Effectively (RARE)). MHA quarterly updates hospitals participating in the program of their progress. MHA will soon begin to share the results with all hospitals to share the learnings from the program.

Evidence Based Child Birth Program

Research has shown that delaying delivery to 39 weeks results in fewer admissions to NICU for respiratory complications – RDS, Apnea, TTN, and Infection. Delaying delivery also reduces the rate of early neonatal jaundice, perinatal mortality, incidence of long-term behavior problems, and re-hospitalization rates for all causes. In Minnesota, almost 40 percent of all births are covered by public health care programs, providing the Minnesota Department of Human Services (DHS), which administers the public health care programs, a significant opportunity to address this issue.

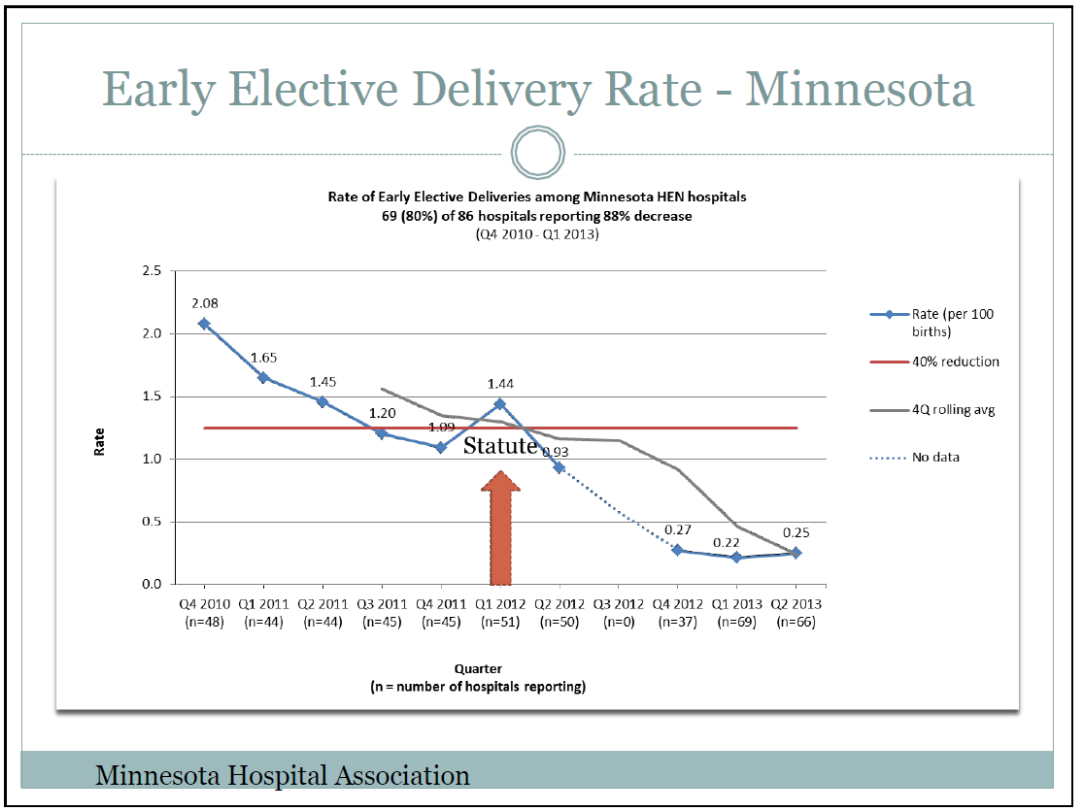
Legislation passed in 2009 directed the Department's Health Services Advisory Council "to develop best practice policies related to the minimization of cesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities. (Minnesota Statutes 256B.0625, subdivision 3c). The Council issued a 2010 report which recommended quality improvement efforts to reduce elective inductions before 39 weeks. Subsequently, the Department worked with the state legislature to pass a bill, effective January 1, 2012, that requires the implementation of an Evidence-based Childbirth Program to reduce the number of elective inductions of labor prior to 39 weeks' gestation (Minnesota Statute 256B.0625 subdivision 3g).

As a result of the legislation, hospitals were required to develop a hard stop policy regarding non-medically necessary early elective inductions prior to 39 weeks and to implement a quality improvement (QI) process for this issue. The Department's policy set the following parameters for the QI process:

- Defined medical indications for inductions in policy with any deviation from this policy reviewed by the QI process
- Authorization for hospital staff to not schedule inductions before 39 weeks of gestation

- Requirements for providers to get permission from physician leadership (e.g., the head of the OB department) prior to performing inductions before 39 weeks gestation
- Provider documentation of final estimated date of delivery (EDD) by 20 weeks gestation (including data from any ultrasound measurement) and sharing the information with the recipient
- Guidelines for recipient education about inductions, and documentation of the education recipients receive
- Ongoing QI review and facility-level reporting of the number of induction births at 37 to less than 39 weeks gestation
- Ongoing audits if the proportion of births using induction at gestations less than 39 weeks is above 25%
- Analysis of provider variation regarding use of inductions
- Peer review of all inductions at less than 39 weeks for appropriateness of indication
- Required delivering providers to include a form with each delivery claim when the delivery is in a hospital that does not have policies and processes in place for non-medically necessary inductions before 39 weeks.

For a hospital that does not have policies and processes in place for non-medically necessary inductions before 39 weeks, completion of a form collecting data on the induction with each delivery claim. Hospitals submitted their policy to the Department for review and verification. The Department created a form to be used when submitting a hospital's plan to meet the legislative requirements. The legislature subsequently passed a bill to suspend the reporting requirement when more than 90 percent of deliveries were covered. Results were quite dramatic as displayed in the table below.



With reporting requirements currently suspended, the Department has several collaborative efforts ongoing.

- The Department is working collaboratively with the Minnesota Hospital Association (MHA) to collect data on EEDs.
- Minnesota hospitals, two state agencies and the March of Dimes are collaborating in the "Healthy Babies are Worth the Wait" campaign, targeting parents who might assume their baby will be fine if born a few weeks early.
- The state is a member of the federal MCHB Collaborative Improvement & Innovation Network (CoIIN) for reducing Infant Mortality including EEDs.
- In addition, MHA has focused on 1:1 contact with the remaining hospitals to achieve 100% compliance with the “hard stop” policy.
- MHA collaborated with the state and health plans to develop and implement a new data collection tool to expand data collection to reduce low birth weight deliveries and collaborates with OB providers and hospitals in an active learning network.
- Minnesota participated in the Medicaid Medical Director Network (MMDN) perinatal project, which analyzed trends in early elective deliveries and other birth outcomes using birth certificate data.

Strengths and Difficulties Questionnaire (SDQ); Child and Adolescent Service Intensity Instrument (CASII); and Early Childhood Service Intensity Instrument (ECSII)

The Children's Mental Health Division (CMHD) administers policy and practice to ensure effective and accessible mental health services and supports for children and families in Minnesota. CMHD guides numerous strategic initiatives to more successfully meet and treat the needs of children and youth struggling with or at risk for mental health issues. The division invests resources toward transforming the children's mental health system with the goals to:

- Increase earlier identification and intervention
- Improve access to the right services at the right time
- Establish best practices and improve standards of care
- Coordinate mental health care with school, medical and community environments
- CMHD promotes standardized diagnostic assessments and evidence-based practices to ensure accountability in the mental health system to produce the best possible results with existing resources for children and youth. Outcome measures determine success in meeting the mental health needs of children and their families.

There are several initiatives which include a continuous monitoring system for individual-level outcomes for those receiving services in both MHCP and through grant funds. The outcome measures (Strengths and Difficulties Questionnaire (SDQ); Child and Adolescent Service Intensity Instrument (CASII); and Early Childhood Service Intensity Instrument (ECSII)] were chosen by a quality and performance workgroup of a large stakeholder process known as the Mental Health Action Group (MMHAG), which functioned from 2003-2009. Parents of child enrollees, providers, health plan administrators, representatives of major health systems and at least three state agencies participated in this process. In 2009, the Minnesota Department of Human Services (DHS) commissioner and Minnesota Council of Health Plans recommended adopting the CASII in conjunction with SDQ as the statewide outcome measures for children and youth receiving public and private mental health services.42

Mental health professionals who receive public reimbursement for services to children, birth to age 5, must complete two evaluation instruments: the Strengths and Difficulties Questionnaire (SDQ) and the Early Childhood Service Intensity Instrument (ECSII). Under the auspices of MMHAG, Minnesota chose to evaluate publicly funded mental health services so that families and consumers would have information for selecting services for their children and this outcomes data could improve results and practices in the delivery of childhood mental health services.

For CMHD, the appropriateness of services is assessed by matching the levels of service intensity received by recipients with indications of need demonstrated on the CASII or ECSII, described above. We have limited

[42] To view Outcome Measures Pilot: SDQ and CASII, please visit: http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs16_146281.pdf.

mechanisms for assessing the quality of services, and have focused primarily on children's rehabilitative services, known as Children's Therapeutic Services and Supports (CTSS), a program in which programs are site-visited and their documentation reviewed on a rotating basis.

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire used to identify behavioral and emotional problems in children and adolescents age 3-16 years old. The first section examines emotional symptoms, conduct problems, inattention-hyperactivity, peer problems and prosocial behavior. The second section assesses the impact of these symptoms on the child and the family or school environment. The test takes on average 5 minutes to complete and there is a follow-up section that asks whether the intervention has reduced problems and helped in other ways. Children, parents and teachers can complete separate versions of the SDQ. It exists in several versions to meet the needs of researchers, clinicians and educationalists.

The Child and Adolescent Service Intensity Instrument (CASII) is a standardized assessment tool to determine the appropriate level of care placement for a child or adolescent age 6-17. The CASII links a clinical assessment with standardized "levels of care" and has a method for matching the two. Mental health providers rate children and youth on eight dimensions in terms of the strengths and problems. In addition to these ratings, the CASII provides a composite score with a level of care recommendation.

The Early Childhood Service Intensity Instrument (ECSII) focuses on the service needs of infants, toddlers and children from ages 0 to 5 years in the context of their families and communities. These young children and their families may need services from a variety of providers and natural supports to meet behavioral, emotional or developmental needs. Based on a developmental and systems perspective, the ECSII recognizes the changing capacities and needs of children over this rapid period of development as well as the range of individual variations among children in normal development. The ECSII considers the relationship of risk and protective factors embedded in the children's communities and families to children's temperaments and abilities.

The American Academy of Child and Adolescent Psychiatry developed the CASII and ECSII as tools to objectively determine the service needs of children and adolescents and evaluate their overall functioning across various settings regardless of the diagnosis or system. Both the CASII and ECSII consider child development and the importance of family and community. They apply to a wide variety of treatment environments as well as child and adolescent needs.

With funding from the Centers for Medicare and Medicaid, the Department of Human Services began to develop an outcome measurement system in 2007. Statewide training[43] and implementation began the summer of 2009. The system allows for scoring and reporting on the CASII, ESCII, and the SDQ. Mental health providers access this

[43] For information on training, please visit website link below, click on "Training" option at the bottom of page: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_144859.

system through MN-ITS, the DHS billing system for Minnesota Health Care Programs (MHCP). This system will later become part of a larger performance management system for all children's mental health services.

Acute Care and Interventions

Women's Recovery Services in Minnesota

The Minnesota Department of Human Services Alcohol and Drug Abuse Division (ADAD) contracted with eleven grantees in 2011 and nine grantees in 2013-2014 to provide treatment support and recovery services for pregnant and parenting women who have substance use disorders. The Women's Recovery Services initiative began in July 2011 and will continue through June 2016. Through this initiative, grantees provide comprehensive, gender-specific, family-centered services for the clients in their care. Services offered are related to treatment and recovery, basic needs and daily living, mental and physical health, and parenting.

The primary goals of the Women's Recovery Services initiative are to help program participants remain alcohol and drug free, obtain or retain employment, remain out of the criminal justice system, find and secure stable housing, access physical and mental health services for themselves and their children, and deliver babies who test negative for substances at birth for pregnant participants. Additionally, the initiative aims to provide participants with information and support with regard to parenting.

Currently funded grantees include:

- American Indian Family Center
- Fond du Lac Reservation
- St. Cloud Hospital Recovery Plus
- Wayside House
- Meeker-McLeod-Sibley Community Health Services
- Ramsey County Community Human Services, Recovery Resource Center
- Recovery Resource Center
- St. Stephens Human Services
- Hope House of Itasca County

In order to be eligible to receive grant-funded services, women must be pregnant or parenting dependent children under age 19. In addition, they must be enrolled in a substance abuse treatment program, have completed treatment within the six months prior to program enrollment, or commit to entering treatment within three months of program enrollment. Women who are pregnant and actively using alcohol or drugs are also eligible to receive program services, regardless of treatment status.

Treatment and recovery services and supports include:

- Ongoing case management (including home and office visits);
- Chemical dependency brief intervention, screening, assessment, and referrals for treatment;
- Comprehensive needs assessments and individualized care plans;
- Trauma-informed approaches to providing services; and

- Ongoing urinalyses (UAs).

Basic needs and daily living services and supports (offered directly or by referral) include:

- Housing;
- Financial education;
- Emergency funds;
- Transportation;
- Job training; and
- Child care.

Mental and physical health services and supports (offered directly or by referral) include:

- Medical and mental health assessments and services for women and children;
- Fetal Alcohol Spectrum Disorders education and screening for children;
- Prenatal and postnatal health care and nutrition consultation for pregnant women;
- Toxicology testing for mothers and infants;
- Safe sleep education for infants;
- Monitoring immunization status for children; and
- Tobacco cessation services.

Parenting services and supports include:

- Parenting education using an evidence-based parenting curriculum;
- Parenting support;
- Recreational activities for families; and
- Children's programming.

Wilder Research was contracted to evaluate the five-year initiative, which includes the following components: a process evaluation; an outcome evaluation; and cost-benefit analysis. This evaluation report summarizes program activities from June 2013 through May 2014 (year three of the initiative). Wilder Research found that nine programs served a total of 954 clients with 1,932 children in year three. Women clients served represented diverse racial backgrounds, including 50% white, 26% American Indian, 14% and African American/Black. Children's backgrounds were equally diverse.

In general, the programs served a very high-risk population. At program intake:

- More than half (56%) had used alcohol and/or other drugs in the past 30 days.
- Almost all clients (93%) had incomes at or below the federal poverty line.
- About 4 in 10 clients (41%) were involved with child protection, while nearly half (46%) were involved with the criminal justice system.
- Just 1 in 10 clients (12%) were employed either full time or part time.
- One in 10 clients (10%) was homeless, while two-thirds (68%) had experienced homelessness at some point in their lives.
- One-third (33%) indicated that they had a severe or chronic physical health problem.
- Three-quarters of clients (75%) had at least one mental health diagnosis.

- More than one-third (36%) had a diagnosis of PTSD.44

Wilder Research conducted analysis of the data entered by grantee staff into the Women's Recovery Services database, for activities that occurred between June 2013 and May 2014 (year three of the grant). Wilder used the database to conduct basic analysis such as frequencies (number of clients) and percentages. Additional analyses were conducted using statistical software (SPSS) in order to assess changes in outcomes over time. This includes pretest/posttest and pretest/posttest/six-month follow-up matched analysis, which generally reflects clients who were closed during year three and had matching intake information available (intakes may have occurred in years one, two, or three). Follow-up interview data are based on all available data through May 2014 (for six-month interviews) or June 2014 (for 12-month interviews). Clients who were served less than 15 days in the program were excluded from all outcome analysis, as it is not expected that clients with such limited program exposure will benefit from the program to the same degree as longer-term clients.45

Outcomes and findings in year three were positive. Compared to program entry, when clients left the program they were less likely to be using substance abuse, more likely to be in Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA), more likely to be employed, more likely to be housed, more likely to have medical insurance, and more likely to have housing that was supportive of their recovery. In addition, 84% of infants born during the reporting period had negative toxicology results.

Year four of the evaluation will include program specific evaluation activities, ongoing data collection (including the follow up interviews), continued technical assistance provided by Wilder Research, and Wilder Research will work with staff from Minnesota Department of Human Services to gather treatment data from the Drug and Alcohol Abuse Normative Evaluation System (DAANES) as a way to supplement existing data about clients served through this grant and gather comparative data about women in treatment/recovery across Minnesota.

The Women's Recovery Services Evaluation Reports can be found on Wilder Foundation's website: https://www.wilder.org/Wilder-Research/Publications/Studies/Forms/Study/docsethomepage.aspx?ID=1447&RootFolder=%2FWilder-Research%2FPublications%2FStudies%2FWomen's%20Recovery%20Services.

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[44] *Women's Recovery Services in Minnesota: Year Three Findings*, Jan. 2015, Wilder Research, https://www.wilder.org/Wilder-Research/Publications/Studies/Women's%20Recovery%20Services/Women's%20Recovery%20Services%20in%20Minnesota%20-%20Year%20Three%20Findings.pdf.

[45] More information about data analysis can be found in *Women's Recovery Services in Minnesota: Year Three Findings*, Jan. 2015, Wilder Research, https://www.wilder.org/Wilder-Research/Publications/Studies/Women's%20Recovery%20Services/Women's%20Recovery%20Services%20in%20Minnesota%20-%20Year%20Three%20Findings.pdf.

Chronic Disease Management

Minnesota Medicaid Incentives for Diabetes Prevention Project

In 2011 the Centers for Medicare and Medicaid Services announced the availability of competitive research funding through Section 4108 of the Affordable Care Act: Medicaid Incentives for the Prevention of Chronic Diseases. CMS allowed latitude for states to focus on any of several disease prevention activities, including weight loss, tobacco cessation, diabetes prevention and lowering cholesterol or blood pressure. This opportunity captured the attention of leadership from the Minnesota Departments of Human Services and Health, and planning quickly got underway to identify and refine a Minnesota-based proposal. With advice from community partners, DHS proposed an approximately $10 million project to test the effectiveness of fiscal incentives to support successful participation in the evidence-based Diabetes Prevention Program. In September 2011 CMS chose Minnesota as one of ten states to receive Medicaid Incentives for the Prevention of Chronic Diseases funding. The project commenced in 2012 and will be completed in 2016. DHS is the fiscal agent, oversees and coordinates reporting and participates fully in the research team. MDH's diabetes unit provides substantive leadership and expertise.

The study's intervention is participation in a program that will teach up to 1,900 Medical Assistance recipients how to eat healthier, be active and lose weight to prevent diabetes. The study will try to figure out if giving incentives, including a free program to attend classes and lose weight, will help them prevent diabetes. Individuals who sign up for the study will be signing up to get 12 months of support to help them lose weight. During the first four months, individuals will attend a one hour session each week for 16 weeks. After the first 16 weeks, they will attend a one hour session once a month for eight months. There will be 10-15 people in each participant group, which will be led by a trained Lifestyle Coach. By the end of CY 2014, 890 participants have been enrolled in the study and 11 clinics are active in the study.

Individuals will be asked to keep track of the foods they eat, how active they are, and what their weight is each week. Individuals' progress in the program will be shared with their doctor once or twice during the study. The classes are free to participants and help with transportation to the sessions and child care is available. Participants will also get free weight loss tools, including a bathroom scale; measuring cups and spoons; food scale; cookbook; portion plate; pedometer; and resistance band. Regular attendance will earn participants free passes to the YMCA during the study period.

Each participant group will be randomly assigned to one of three groups, each of which will receive different types of incentives. The control group will receive the training sessions, supports for childcare, transportation, etc., weight loss tools, an enrollment incentive, and compensation for their time when they come for a follow-up office visit. They will receive no monetary incentives for attendance or weight-loss. The individual incentives group will receive all the same benefits as the control group, but in addition they will be eligible for monetary incentives for program participation and weight loss. Each patient's incentives are dependent on his or her own actions. The group incentive participants will receive all the same benefits as the individual incentives group, but they will also be eligible for monetary incentives for tiered class incentives. If the entire class of 10-15

participants reaches milestone participation or weight loss goals, then everyone in the group will receive an additional monetary incentive.

It is expected that Medicaid population participation rates for the control condition will be around 60%. With additional individual incentives an increase of 15% in participation rates and another 10% with the addition of group-based incentives is anticipated. For the Control condition, it is anticipated twelve-month weight loss will be 8 pounds, compared to 15 pounds in the Individual Incentives condition and 20 pounds in the Group Incentives condition. Study reports including enrollment, diabetes prevention program adherence, disbursement of incentives, lessons learned during the course of the study, and required CMS study metrics, will be produced semi-annually. Evaluation analysis began in earnest October, 2014. The current focus is on assuring the completeness and accuracy of the data reported.

Drug Utilization and Management

The Drug Utilization and Management Program started in the late 1990s, and the program was established to monitor the rate of generic drug utilization for the fee-for-service population and the effectiveness of policies in driving the prescribing of preferred drugs. The program was initiated to contain the cost of prescription drugs, and ensure that the Medical Assistance population has access to the prescriptions they need.

This program includes utilization management (prior authorization and utilization limits), and drug utilization review of educational activities, reimbursement policy, and clinical programs. This program focuses on increasing management of opioids, improving the prior authorization process, and incorporating managed care into the program.

The program's goal is to ensure appropriate, safe, and cost-effective use of prescription drugs in the Minnesota Health Care Programs. The program's priorities include:

- Reducing the number of new chronic users of opiates by at least 5% by Calendar Year 2017;
- Catching up on all rebate invoices for Calendar Year 2014;
- Developing (or contracting for) online portal to allow submission of prior authorization forms by January 2016;
- Reducing the amount of rebate disputes by at least 10% by Calendar Year 2016; and
- Continuing and improving generic drug utilization.

Two formal processes are used to involve beneficiaries and other stakeholders: Drug Formulary Committee (DFC), and Drug Utilization Review (DUR). DFC meets approximately three times a year, and this group includes pharmacists, physicians, and consumer representatives. DFC meetings include up to one hour of a public forum. DUR meets approximately three times a year, and this group includes physicians, pharmacists, health care professionals, and consumer representatives.

The program reviews all new drugs as approved by the Food and Drug Administration (FDA). This includes the Drug Effectiveness Use Project, in which data is collected for comparative purposes. DHS also manages opioid users and rate of generic drug utilization by analyzing internal data on an annual basis. The data collected for this program is compared to national data, data from other states, and private plan data.

The Drug Utilization and Management Program faces a challenge with managing opioid users. Under State law, DHS does not have access to prescription drug monitoring program and therefore does not have an effective way of tracking opioid consumption. Additionally, data from the Foster Kids database is undependable and inconsistent due to software interface problems.

Continuum of Care (COC) Pilot

The COC Pilot (MN Statutes, Chapter 254B.14)46 is an effort to permit direct client access to treatment and improve the effectiveness and efficiency of the service continuum. This effort is a paradigmatic shift with changes to policy, statute language, funding, Medicaid benefit set, and stakeholder involvement with counties, tribes, providers, and state contracted managed care organizations. The Continuous Quality Improvement (large scale) would focus on how access is improved (increased numbers, decrease in time between request and admission), and the use of care coordination and peer recovery support services to support long term recovery.

The pilot project will be conducted over two years and will be measuring direct client access to, and utilization of, Substance Use Disorder (SUD) treatment services in the selected pilot areas. These pilot areas will focus on:

- Improving access to treatment and the assessment process for SUD treatment
- Using care coordination to improve continuing care for people with SUD
- Using trained peer support specialists to provide enhanced community support for people with SUD
- Promoting telehealth technologies to improve access and as one SUD treatment and recovery support strategy

Effective for dates of service October 27, 2014, and after, the Consolidated Chemical Dependency Treatment Fund (CCDTF) began covering the COC Pilot for eligible providers and recipients.

Eligible Providers

To be eligible to participate in the COC Pilot a provider must be residing and doing business in White Earth or Red Lake reservation, have a contract to participate on file with MHCP, and complete the COC Pilot training. The participating tribal nations are White Earth Nation (Implementation, October 27, 2014) and Red Lake Nation (Implementation, February 19, 2015). At this time no counties are enrolled in the pilot project.

Eligible Recipients

Consolidated Chemical Dependency Treatment Fund (CCDTF) and MA recipients residing in the tribal pilot areas and not enrolled in an MCO are eligible to participate. American Indians on CCDTF, MA or an MCO are eligible to participate.

[46] To view Minn. Statutes Chapter 254B.14, visit: https://www.revisor.mn.gov/statutes/?id=254B.14.

CCDTF Eligibility Determination

Eligibility for CCDTF is based on two criteria: clinical need and financial eligibility. If a person is determined to have both a clinical need for treatment and be financially eligible for the CCDTF, then the CCDTF can pay for the person's chemical dependency (CD) treatment services.

Clinical Eligibility

Clinical eligibility is based on the comprehensive assessment result. This is an in-person face-to-face or telehealth interview that follows the approved guidelines and is conducted by a qualified assessor. A qualified assessor is a member of the staff of an Eligible Provider who meets requirements in Rule 31 or applicable tribal standards.

Covered Services

Covered services are the following:

- Comprehensive Substance Use Disorder Assessment (chemical dependency assessment) – this assessment is a face-to-face or approved telehealth interview, conducted by a qualified assessor to determine both the proper placement in treatment services and the ongoing individual treatment plan. The assessment creates a full clinical picture of treatment needs and leads to referral to the appropriate level of care with the appropriate provider using the Minnesota Matrix criteria.
- Care coordination – services designed to help the client obtain other services and to support the client's need and efforts to establish a lifestyle free of the harmful effects of substance use disorders. Alcohol and drug abuse counselors qualified according to Minnesota Rules must provide these services, unless the person providing the service is specifically qualified according to the accepted standards of that profession.
- Peer recovery support services – services provided by a person who has received training, usually from the existing Recovery Community Organizations, to connect the clients with peer-based, community-involved, ongoing support. Staff can receive this training on the job. These services can link the client to strong recovery-oriented resources in their local environment that will nurture their growth.
- Care coordination and peer recovery support are covered for recipients who are currently receiving treatment services and were admitted for that treatment prior to the organization's implementation date. Telehealth may be used in the pilot project to help clients access treatment throughout the course of their care.

Pilot Data Collection

Pilot providers are required to report and maintain current client records on the Chemical Health Assessment Treatment Services (CHATS) system and the Pilot Outcomes Monitoring System (POMS). Providers use the CHATS and POMS data collection systems to participate in the pilot program and receive reimbursement for the Comprehensive Substance Use Disorder Assessment, care coordination and peer support services. CHATS is a web-based system used for monitoring delivery of assessments and treatment services. POMS is a paper-based data collection system that is intended to assess overall outcomes, performance and client change over the time the client is participating in the Continuum of Care Pilot project.

Long-term Care

Own Your Future

Own Your Future (OYF) is a joint federal and state initiative of the Dayton Administration, sponsored by the Department of Human Services (DHS) with assistance from the Departments of Commerce, Health, and Revenue. The purpose of OYF is to encourage and enable Minnesotans to create a plan for their long-term care, including how to pay for long-term care. Long-term care includes a wide range of services to meet health and personal care needs such as bathing, dressing, and house cleaning. People may need help as they grow older or have a chronic illness or disability. There are a number of long-term care options available for care in the home, in the community, and in assisted living and nursing facilities.

In 2011, the leading edge of the baby boom generation began to turn 65 and by 2030, Minnesota will have 1.3 million persons over the age of 65. People over the age of 65 have a 70% risk of needing long-term care at some point in their lives. The estimated annual cost of long-term care is $57,000 which is roughly the same as the median household income in Minnesota of $59,000. Many individuals have not saved enough to pay for long-term care, and without additional private financing for long-term care the State of Minnesota could see unsustainable increases in its elderly long-term care budget. The State's projected cost of $1 billion in 2010 will rise to an estimated $5 billion by 2030.

Programs and most financing options including private health insurance, disability insurance, Medicare, and Medicaid (Medical Assistance) do not pay for most long-term care. Medicare only covers skilled short-term care in a nursing home following a three-day hospital stay. Medicare payments are limited to 100 days per episode, and there is a hefty co-payment for days 21 through 100. Medical Assistance (MA) is a major payer of long-term care; however, people become eligible for MA only after they spend down most of their resources paying for health and long-term care, or if they have very limited income and assets.

Between 2005 and 2009, 26 states sponsored an Own Your Future campaign in their state to educate individuals about their risk for long-term care and encourage them to create a long-term care plan as part of their retirement planning. Minnesota's Own Your Future began in 2012, launching the public awareness component of OYF in October 2012. Minnesota's OYF includes three interlocking phases:

- Implement public awareness effort about the need to plan for long-term care (2012-present);
- Identify more affordable insurance and financial products for use by middle-income households (2013-2015); and
- Evaluate ways to change Medicaid to better incent private payment for long-term care (2014-2016).

As part of the public awareness effort, planning guides are distributed and posted on a website at http://mn.gov/ownyourfuture. Feedback cards are included with planning guides, so that the reader can evaluate the information and provide feedback. Additionally, each year a survey is conducted at the Minnesota State Fair. The survey questions are focused on retirement and long-term care plans. This provides a "slice in time" and allows for a collection of longitudinal data on how individuals are doing in preparing for their retirement and long-term care. Approximately 2,500 people complete this survey each year.

Minnesota added two additional components to the public awareness campaign to enhance the desired outcome of increasing the number of Minnesotans using private resources to pay for their long-term care. If more affordable and suitable options were available and used, households would be more likely to pay for their long-term care. Furthermore, if MA provided more incentives for individuals to use private financing, this would also increase the interest in using these options.

To assist the State in this effort, the sponsors appointed an Advisory Panel. This group provides guidance and direction to the State on the implementation of Minnesota's OYF efforts; assists with development of policy options related to the greater availability of affordable and suitable products and MA reforms that would benefit middle income households; and act as a liaison between the OYF initiative and various stakeholder groups including employers, grassroots organizations, consumer advocacy groups, health and long-term care sectors, and insurance and financial service sectors. The panel uses subgroups to focus on specific assignments, and includes both members and external experts in these groups to draw in needed expertise.

The Advisory Panel meets quarterly and it is convened by the Commissioner of DHS. The panel's membership includes: long-term care insurance representatives, AARP of Minnesota, Citizens League, Minnesota Council of Health Plans, county representative, elder law representative, financial advisor representative, Minnesota HomeCare Association, insurance representatives, LeadingAge Minnesota, Care Providers of Minnesota, Minnesota Area Agencies on Aging, Minnesota Business Partnership, Minnesota Chamber of Commerce, labor representative, Minnesota State Retirement System, Minnesota Board of Aging, Twin Cities Medical Society, Twin Cities Public Television, United Way, University of Minnesota, and Wilder Foundation.

The Own Your Future initiative's greatest challenge is to increase the number of people who know how they will pay for long-term care. This number has remained stubbornly constant for several years. However, additional outreach strategies and policy efforts are currently being worked on to help individuals develop a plan.

Minnesota Nursing Home Report Card

In 2006, the Minnesota Department of Health (MDH) and Minnesota Department of Human Services (DHS) collaborated with the University of Minnesota to publish the state's first-ever Nursing Home Report Card website (http://nhreportcard.dhs.mn.gov/). The Nursing Home Report Card was in response to a series of state legislative actions starting in 2001. The report card provides comprehensive quality information in areas that matter to consumers (based on a culmination of years of measure development and stakeholder input). The report card includes information about 368 nursing homes in the state that are certified to participate in the Medical Assistance (MA) Program.

In October 2012, these agencies introduced a new and improved report card. New features include:

- Bubbles that explain technical terms that open when the user moves their mouse over those terms;
- More options for selecting the facilities that the user is interested in--
- Flexibility in selecting the quality measures that are important to the user,
- Ability to get a list by city, and
- Ability to select facilities by looking at a map of the state;

- Side-by-side facility displays;
- Print or download an Excel file for any page;
- Almost two years of performance history shown for each facility;
- More detailed information easily available showing the exact scores that underlie the star ratings;
- Detailed tables showing Quality of Life and clinical Quality Indicators results;
- Links from facility report cards to Google maps showing their locations; and
- Tables showing daily cost information for each facility, including private pay charges for private rooms.

The Nursing Home Report Card was established to help compare facilities on the following seven quality measures:

- Resident Satisfaction and quality of life
- Quality Indicators- clinical quality
- Hours of direct care
- Staff retention
- Use of temporary nursing staff
- Proportion of beds in single bedrooms
- State inspection results

New measures have been developed and the report card will reflect these additional measures in the near future:

- Family satisfaction
- Hospitalization rates
- Community discharge rates

No national performance measures are used; however, Minnesota's report card is comprehensive in that it includes resident satisfaction and quality of life information for nearly every nursing home in the state. The quality measures were specifically chosen for the following reasons:

- Credibility- based on research;
- Transparency- methods are clear and easily defined;
- Understandable to providers and other stakeholders (education resources and assistance are available);
- Comprehensive- multidimensional, with 26 quality indicators and 12 quality of life domains;
- Relevant- items and topics are important to consumers; and
- Actionable- DHS works with facilities to find their opportunities for most improvement, through consultation and user-friendly facility performance reports.

Nursing homes have unique information asymmetry, and report cards offer this needed transparency to potential and current consumers. In addition, they can provide benchmarking for providers, quality improvement, and a "healthy competition." Each nursing home can receive from one to five stars on each measure; thus, providing information to help consumers choose a nursing home. Additionally, it promotes a high standard of quality in all nursing homes across the state. The report card uses a state inspection results measure unique to Minnesota, which assigns stars in a tiered decision tree based on the following five criteria:

- If the facility's most-recent available health and life-safety code survey had actual harm, substandard quality of care, or immediate jeopardy.
- If the facility had a confirmed complaint or facility self-report of actual harm, substandard quality of care, or immediate jeopardy over the past year.
- If the facility's prior health survey had substandard quality of care or immediate jeopardy.
- If the facility is on the Special Focus list of providers judged by MDH and the federal Centers for Medicare and Medicaid Services as needing additional oversight.
- If the facility has a high number of health deficiencies, defined using the formula [(Minnesota's average deficiencies plus ½ standard deviation for previous calendar year) + (survey district's average deficiencies plus ½ standard deviation for previous calendar year)] / 2.

DHS has a standing advisory committee with members representing the nursing home industry, consumers and workers. This group advises DHS on quality initiatives for all three initiatives: Nursing Home Report Card, Performance-based Incentive Payment program (PIPP), and Quality Improvement Incentive Payment Program (QIIP). Quality initiatives are typically developed with smaller groups of stakeholders and experts first, and then final versions of these programs are fleshed out with the advisory committee. The full committee typically meets annually with more frequent meetings during legislative session and with ad hoc meetings of the smaller subgroups when initiatives are in progress.

The national Informed Patient Institute (IPI) has given the Report Card an A grade, joining just California and New York in that category. IPI assigned that grade for the breadth of information included, particularly singling out the quality of life results; the ability to individualize the site to the user's preferences; and the use of star ratings. The three additional measures important to consumers (family satisfaction, hospitalization, and community discharge) should make the Report Card more relevant and useful.

Maintaining the Report Card is a challenge, requiring several staff to do ongoing quarterly data analysis and reporting. This doesn't include additional personnel who are contracted annually to conduct the face-to-face resident quality of life interviews in all Medicaid-certified facilities statewide, as well as family surveys with every primary responsible party via mail or phone. The uses of multiple quality measures requires considerable attention to data integrity, necessitating audit and quality assurance processes on a scheduled basis and as issues arise.

Minnesota Performance-based Incentive Payment Program

The Minnesota Performance-based Incentive Payment Program (PIPP) was established by the Minnesota Legislature in 2006 and managed by the Nursing Facility Rates and Policy Division of the Department of Human Services (DHS). PIPP strives to improve nursing home quality and to increase the quality improvement (QI) capacity of nursing facility providers. PIPP has $18 million annually, available in increased payments given to nursing facilities that develop and successfully implement QI projects after a competitive selection process. Total funding amount includes state funds, federal matching funds, and private payments. Individual facility improvement targets are negotiated with the DHS, establishing a portion of incentive payments at risk for achieving the performance targets.

As of 2014, nursing facility providers have focused on a wide variety of topics for their QI projects:

- Clinical Quality (73 projects): Fall reduction, strength training, sleep, pain management, osteoporosis, bathing, skin care, congestive heart failure, wound care, pressure sore prevention, incontinence, and targeted therapy.
- Psychosocial (39 projects): Dance program, music therapy, art therapy, healing touch, behavior management, cognitive care, and hearing loss.
- Transitions (19 projects): Community transition skills, rehabilitation, and Alzheimer's-related community caregiver support.
- Organizational Change (33 projects): Person-centered care, culture change, and nursing assistant mentoring.
- Technology (22 projects): Safe patient handling, call or alarm systems, environmental modifications, and electronic health records.

The average statewide risk-adjusted composite clinical quality score in nursing facilities has improved 12% based on a 2011 baseline. The overall goal is to improve statewide clinical quality score at a rate of approximately 1% per year. Individual projects use performance goals specific to their baseline, timeline, and other considerations. DHS' goals for PIPP are to:

- Provide more efficient, higher quality care within the long-term care community;
- Encourage nursing facilities to experiment and innovate;
- Equip facilities with organizational tools and expertise to improve their quality of care;
- Motivate facilities to invest in better care; and
- Share successful PIPP strategies throughout the nursing home industry.

All individual facility improvement projects agree to achieve improvement targets after each year of intervention with projects one to three years in length. DHS assesses whether each individual project meets its performance goals at least annually. Throughout the course of each project year, facilities are encouraged to track their progress using DHS quality reports posted on a secure state Provider Portal website. Additionally, facilities are encouraged to develop audit tools for their own use. All facilities are required to submit a six-month status report to share their successes and challenges. DHS compiles and analyzes the data to determine patterns using qualitative software.

DHS recently collaborated with the University of Minnesota to study patterns on the annual resident quality of life and satisfaction survey by race and ethnicity of participants. This is information available on participants' related Minimum Data Set (MDS) assessment record, which DHS uses to risk adjust results before posting on the Report Card. MDS is an extensive assessment of the resident completed by facility staff. MDS assessment includes many items such as: diagnoses, the ability to do activities of daily living, clinical conditions, use of certain types of medication, and certain cares and treatment provided to the resident. Results from this study indicate that most of the racial differences in quality of Life (QOL) were not based on individuals' race/ethnicity but reflect facility differences in how they serve the needs of minority older adults. Plans are underway to develop interventions to be directed at facilities. Additional studies are planned with intentioned oversampling of minority race/ethnic groups in future QOL surveys.

Most projects choose the Minnesota risk-adjusted quality indicators and/or risk-adjusted quality of life measures, both of which are unique to Minnesota. DHS uses 26 quality indicators to calculate quality indicator

scores. The quality indicators have been risk-adjusted to account for differences between the types of residents served in nursing homes. Examples of the adjustors used are: age, gender, cognitive performance, and stroke. Projects focusing on care transitions use the newly-developed state hospitalization measure, which is similar to national measures. Projects also use national measures when no state measure is available or when it is the best fit for the topic. The Minnesota clinical quality indicators are audited by Minnesota Department of Health case-mix review staff. Additionally, the resident quality of life interviews include a process to appropriately refer any complaints to the State Office for Health Facility Complaints.

DHS has a standing advisory committee with members representing the nursing home industry, consumers and workers. This group advises DHS on quality initiatives for all three initiatives: PIPP, Quality Improvement Incentive Payment Program (QIIP), and Nursing Home Report Card. A separate stakeholder selection committee is used to select facility PIPP project proposals every year. The stakeholder committee includes representatives of consumers, quality improvement organizations, the state regulatory agency, providers, and DHS.

DHS offers a PIPP mentorship option, in which successful facilities help other facilities that are new to the program. DHS also hosts an annual PIPP Boot Camp, a multi-day workshop guiding and allowing facilities to learn from each other as they develop their QI project(s). PIPP has been independently evaluated through an Agency for Healthcare Research and Quality (AHRQ) grant, with the conclusion that PIPP leads to successful outcomes in areas specifically targeted by PIPP-funded projects and closely associated with more improved quality overall at participating nursing facilities. The use of state-maintained quality measures has improved data efficiency and integrity, but the process is still a major challenge requiring substantial knowledge of measures and resources to administer the program.

Minnesota Quality Improvement Incentive Payment Program

The Minnesota Quality Improvement Incentive Payment Program (QIIP) was established by the Minnesota Legislature in 2013 and managed by the Nursing Facility Rates and Policy Division of the Department of Human Services (DHS). QIIP's purpose is to recognize quality improvement efforts, and to ensure that all Medical Assistance-certified nursing facilities (NFs) in the state have the opportunity to receive financial rewards for improving their quality of care or quality of life. NFs select a Minnesota Nursing Home Report Card measure in the area of quality of care or quality of life to improve using their choice of intervention(s). After one year, DHS calculates the QIIP payment based on the amount of improvement achieved from this established baseline. This cycle is repeated annually.

Currently, the report card has seven quality measures:

- Resident Satisfaction and quality of life
- Quality Indicators- clinical quality
- Hours of direct care
- Staff retention
- Use of temporary nursing staff
- Proportion of beds in single bedrooms
- State inspection results

To earn the maximum incentive payment of $3.50 per day, NFs must improve their performance one standard deviation over the baseline or reach the statewide 25th percentile, whichever goal represents more improvement. Facilities must maintain improvement at or above their performance target for the full project year in order to receive full payment. On an annual basis, measureable goals are evaluated to see how many NFs were successful or unsuccessful. In the first year of this new program, DHS achieved the following milestones:

All but three NFs are participating in QIIP;

72% of those NFs have achieved their target or are improving in the quality indicators;

40 NFs or about 11% statewide are working on resident quality of life (QOL); and

62.5% of those NFs have achieved their QOL target or achieved some improvement.

DHS has a standing advisory committee with members representing the nursing home industry, consumers and workers. This group advises DHS on quality initiatives for all three initiatives: QIIP, Performance-based Incentive Payment program, and Nursing Home Report Card.

There is significant interest among NFs to participate in QIIP suggesting potential progress in quality improvement efforts. While more challenges will likely emerge as the program continues, this first year has emphasized the need for statewide education efforts for providers who may not be as familiar with the measures as others who have participated in other DHS quality improvement programs. The data management needs are lessened by the streamlined nature of the program, and the ability to automate many more components of the reporting and tracking compared to other programs. However, the statewide participation of all facilities simultaneously over each year makes it a challenge to communicate.

Administrative

The National Correct Coding Initiatives in Medicaid

The NCCI is a CMS program that consists of coding policies and edits. Providers report procedures/services performed on beneficiaries utilizing Healthcare Common Procedure Coding System (HCPCS) codes. These codes are submitted on claim forms to Fiscal Agents for payment. NCCI policies and edits identify procedures/services performed by the same provider for the same beneficiary on the same date of service. This program was originally implemented in the Medicare program in January 1996 to ensure accurate coding and reporting of services by physicians. The coding policies of NCCI are based on coding conventions defined in the American Medical Association's Current Procedural Terminology Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. NCCI compliance is required in the state agency's contracts with MCOs.

The National Correct Coding Initiative (NCCI) is a program that uses methodologies to reduce overpayments to providers due to incorrect coding on claims. Accurate coding and reporting of services are critical aspects of proper billing. Service denied based on NCCI code pair edits or MUEs may not be billed to Medical Assistance

beneficiaries. The NCCI program tools help providers avoid coding and billing errors and subsequent payment denials.

Section 6507 of the Affordable Care Act directs State use of NCCI methodologies. States were notified that all five Medicare NCCI methodologies were compatible with Medicaid. The Affordable Care Act required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010. The Medicaid NCCI program has significant differences from the Medicare NCCI program.

Minnesota implemented the NCCI edits effective January, 2, 2011 after various notices to providers. The DHS public web contains a page with FAQs concerning the NCCI program.

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_160244

Types of NCCI Edits

The National Correct Coding Initiative (NCCI) contains two types of edits:

NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

The NCCI Methodologies in Medicaid

The Medicaid NCCI program consists of six methodologies. These are:

- A methodology with PTP edits for practitioner and ambulatory surgical center (ASC) services.
- A methodology with PTP edits for outpatient hospital services (including emergency department, observation, and hospital laboratory services).
- A methodology with PTP edits for durable medical equipment.
- A methodology with MUEs for practitioner and ASC services.
- A methodology with MUEs for outpatient hospital services for hospitals.
- A methodology with MUEs for durable medical equipment.

The Medicaid NCCI methodologies apply only to claims that are reimbursed on the basis of HCPCS / CPT codes.

Each of the Medicaid NCCI methodologies has four components. These are:

A set of edits;

- definitions of types of claims subject to the edits;

- A set of claim adjudication rules for applying the edits; and
- A set of rules for addressing provider appeals of denied payments for services based on the edits.

Mental Health Information System

The Minnesota Department of Human Services (DHS) requires regular reporting of client outcomes information for publicly funded services. This information is used by DHS in the analysis of those services to assist in policy making, program management, services administration and federal mandated reporting. DHS will focus on its mental health data reporting on client and program outcomes with a special focus on recovery for clients receiving more intensive mental health services.

Minnesota received a Substance Abuse and Mental Health Services Administration (SAMHSA) – Data Infrastructure Grant (DIG) to assist in the development of a new outcome client-level data system. Efforts were also made to eliminate duplicate reporting by utilizing demographic information from the DHS data systems. The Adult Mental Health Division (AMHD) has created a Mental Health Information System (MHIS) to track individual outcome data on adults receiving MHCP and grant-funded services. MHIS is a system used to report the demographic, clinical, and outcomes of clients who received publicly funded Assertive Community Treatment (ACT), Adult Rehabilitative Mental Health Services (ARMS), and other mental health services.[47] AMHD is also currently at work with the County Performance Measurement Project to identify population-level outcomes which will be monitored for all recipients.

The MHIS is a secure web-based reporting system that uses the Minnesota Department of Human Services, IT Services (MN-ITS) security system for web-access. An online resource, the MHIS Manual, has been created to assist mental health providers in understanding how to report on their required client-level data.[48]

All enrolled MHCP providers and billing agencies have secure access to MN-ITS. MHIS provides two methods of reporting: 1) an individual web-based data entry (real-time); and 2) batch submissions of data. Reported data are used to inform the mental health National Outcome Measures (NOMS) covered under the SAMHSA federal mental health block grant to states. The data collected are also used to report the client-level data to the federal government as part of the federal block grant requirement. The MHIS has been modified to allow reporting of

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[47] For more information about other mental health services, please visit: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_003497 and

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_176546.

[48] For more information about the manual, visit: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=mhis_home#.

the ICD-10 codes that are required for all diagnostic assessments as of October 1, 2015. The MHIS is also being modified to assist in reporting on mental health crisis service measures as part of the Olmstead Plan.

Adult Mental Health Services Survey

As part of a federal requirement, the Adult Mental Health Division (AMHD) conducts an annual survey of consumers receiving more intensive rehabilitative services, such as Adult Rehabilitative Mental Health Services (ARMHS)49 and Assertive Community Treatment (ACT)50. ARMHS is a combination of basic living, social skills and community intervention services to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent and community skills. ACT is an intensive comprehensive, non-residential rehabilitative mental health service team model.

The survey follows the format recommended by Substance Abuse and Mental Health Services Administration (SAMHSA) measuring satisfaction with access, appropriateness of service and well as perceived outcomes from receiving the service. A quality of life component has also been added to the survey. Providers of ARMHS and ACT are also required to do a consumer satisfaction survey as part of their quality assurance. The AMHD is working with ARMHS and ACT providers to conduct the annual survey to meet both the federal requirement as well as the state requirement for providers.

The goal of the survey to examine the service quality issues related to the State's delivery of state-funded mental health services. This includes studying clients' perception of ACT and ARMHS services. The survey data are used for federal reporting and to measure service performance.

The survey has been administered by mail to a random sample of clients from each ARMHS and ACT provider each year. In the current year a web-based (SNAP) version of the survey has been developed to give an alternative way for consumers to complete the survey online.

Incomplete Applications

Approximately forty percent of paper applications received when the state agency was processing applications at the implementation of Minnesota's health care exchange was incomplete. Consumers did not always understand the questions and often left questions unanswered. Also, some questions asked on the online application were not reflected in the paper application resulting in additional incomplete applications.

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[49] To learn more about ARMHS: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_004956.

[50] To learn more about ACT: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_027849.

Incomplete applications delay eligibility determinations for the public health care programs and consequently delay access to needed health care services. To address this issue, which adversely affects access, a project was initiated to change the wording on the applications to make it more user-friendly and add the missing questions to the paper application. The goal was to reduce the number of incomplete applications.

Two revisions were issued in 2014, May and November. Sample changes are excerpted below.

- Marital status added for each household member to assist workers in determining relationship statuses.
- A "Due Date" field for pregnant women to indicate when their newborn is due.
- The immigration "Document ID Number" field renamed "Alien ID Number" to match the wording on an immigrant applicant's immigration documentation.
- Additional questions to assist in assessing an applicant's disability status.
- Significant updates to the "Current Job and Income Information" section to identify seasonal employment from other employment, and clarify income adjustments by displaying a list of allowable adjustments.
- Additional fields to "Your Family's Health Coverage" section for applicants to provide detailed information about their household's current health insurance coverage.
- A new "Family Changes" section to assist in accurately determining MinnesotaCare and Advanced Premium Tax Credit (APTC) eligibility.
- Expanded MA liens and estate claims language.

A process was established to continue updates and improvements to the application questions. Suggestions are accepted from the Recipient Help Desk, department policy staff, the health care exchange's assistance resource center, navigators and others. The suggestions are collected centrally in the Health Care Eligibility and Access Division, where they are vetted and considered for inclusion in the next update of the application questions.

Subsequent to this project, paper application processing was transferred to local county human services offices. Data on the rate of incomplete applications is not available from the county offices at this time.