Minnesota PMAP+ Section 1115 Waiver Renewal Request

Project No. 11-W-00039/5

Submitted to:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

Submitted by:

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Section I – Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

For over 20 years, the MinnesotaCare program has provided affordable health care coverage to low-income working families. The longstanding goal of the demonstration has been to provide MinnesotaCare enrollees with comparable access to high- quality preventive and chronic disease care. Waiver evaluation reports have consistently shown a high level of access to quality preventive and chronic disease care at rates similar to Minnesota Medicaid experience and in most instances exceeding national Medicaid benchmarks.

Beginning in 2014, the Affordable Care Act will make federal tax credits and cost sharing subsidies available to families to help purchase private insurance through MNSure, which is Minnesota's health insurance exchange. For lower-income families, however, that financial assistance may not be enough to purchase coverage comparable to what is available today through MinnesotaCare. Therefore, Minnesota proposes to continue MinnesotaCare under the PMAP+ demonstration to ensure the stability of health coverage for low-income working families and adults.

The Affordable Care Act authorizes and the federal Centers for Medicare & Medicaid Services (CMS) plans to implement a basic health plan (BHP) option in 2015. Minnesota will continue to provide affordable and comprehensive health insurance for working families and preserve the legacy of MinnesotaCare through BHP. This minimizes out-of-pocket expenses for health care for people with incomes just above Medicaid levels, and provides comprehensive benefits to meet people's needs. Minnesota expects to continue MinnesotaCare under the BHP in 2015 when that option is available to states.

During 2014, however, the proposed PMAP demonstration will allow Minnesota to continue to support health care for low-income working families and individuals, while implementing as many of the features of BHP as possible to ensure a smooth transition to the BHP in 2015. Minnesota proposes to make coverage available to adults with children, 19- and 20-year olds, and adults without children at incomes between 133% and 200% of the federal poverty level, providing a more generous benefit set and lower cost sharing than people at these income levels are likely to be able to purchase with federal tax credits through MNSure. In addition, the PMAP demonstration will allow Minnesota to provide coverage to two additional groups during the interim year that Congress included in the BHP: children who are barred from Medicaid due to household composition and income methodologies; and lawfully present noncitizens who do not yet qualify for Medicaid.

Finally, the PMAP+ demonstration will continue to provide important authorities for Minnesota's Medicaid program such as streamlining benefit sets for pregnant women, authorization of medical education funding, preserving eligibility methods currently in use for children ages 12 to 23 months, simplifying the definition of a parent or caretaker relative to

include people living with child(ren) under age 19, and allowing coverage of certain populations in managed care.

2) Include the rationale for the Demonstration.

The purpose of the extension of this waiver is to demonstrate positive health outcomes and cost savings by providing an accessible, preventive approach to comprehensive health care for adults with incomes above Medicaid levels but below 200% FPL as an alternative to Minnesota's health insurance exchange, MNSure. By providing a platinum-level benefit coverage with low premiums and cost sharing reductions as compared to what is expected to be available through MNSure for comparable coverage, Minnesota seeks to ensure that people enrolled in the program will have better access to care and better health outcomes.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

Under the demonstration Minnesota seeks to reduce the proportion of uninsured and provide better coverage and better value for those who are participating in the program.

The hypotheses that will be tested during the demonstration renewal period, the program objectives, and associated indicators for measurement of progress toward those objectives, are summarized below:

Goal1: Reduce Proportion of Uninsured

Increase the proportion of Minnesotans at MinnesotaCare income levels who become insured, than otherwise would be under Minnesota's health insurance exchange, MNSure.

- **Objective**: Increase the proportion of Minnesotans over 18 at 133-200% FPL with health insurance as compared with Minnesotans at 200-250% FPL.
- **Measurement:** Compare the waiver group, as a proportion of all Minnesotans at their income level (133-200% FPL), to MNSure participants at a similar income level (200-250% FPL), as a proportion of all Minnesotans at that income level.
- **Hypothesis**: The proportion of the waiver group (Minnesotans over 18 at 133-200% FPL) is of all Minnesotans at that income level will be greater than the proportion than MNSure enrollees at 200-250% FPL are of all Minnesotans at that income level.
- **Data Sources**: MNSure eligibility data; Census Data.

Goal 2: Provide Better Coverage for Insured

Provide better health insurance coverage to Minnesotans at MinnesotaCare income levels than they might otherwise select through MNSure.

- **Objective:** Increase the proportion of Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance as compared with the Minnesotans at 200-250% FPL on MNSure.
- **Measurement**:
    - Categorize MinnesotaCare waiver benefits, cost-sharing and premiums, and that of plans available through MNSure, to determine comparative levels of coverage comprehensiveness.
    - Determine the proportions of people receiving coverage through MNSure with incomes 200-250% FPL who are enrolled in bronze, silver, gold and platinum level plans.
    - Determine the proportion of people at incomes of 200-250% FPL enrolled through MNSure who have benefit sets just as or more comprehensive than the benefit set of the waiver group.

- **Hypothesis**: Minnesotans in the waiver group will have more comprehensive coverage and lower cost-sharing than they would likely have otherwise chosen through Minnesota's health insurance exchange, MNSure, assuming their choices would be similar to those Minnesotans purchasing coverage through MNSure with incomes between 200 and 250% FPL.
- **Data Source:** MNSure eligibility data.

Goal 3: Value

Provide greater health insurance coverage for Minnesotans at MinnesotaCare income levels for no more than would otherwise be spent covering the same group through MNSure.

- **Objective:** Provide Minnesotans over 18 at 133-200% FPL with comprehensive health insurance in a cost effective manner.
- **Measurement**:
    - Compare MinnesotaCare benefits, cost-sharing and premiums to plans available through MNSure.
    - Calculate premiums, cost-sharing and tax credit expenditures for purchase of MinnesotaCare-level coverage via MNSure for people at incomes of 200-250% FPL, by level of coverage (bronze, silver, gold and platinum).

Hypothesis: Combined federal and state per capita spending on the waiver group will be equal to or less than federal per capita spending on Minnesotans at the 200-250 % FPL income level enrolled through MNSure were they to choose benefit coverage similar to what the waiver group will receive.

- **Data Source:** MNSure eligibility data; state and federal expenditure data on waiver group; CMS data on cost-sharing settle-ups.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions; within the State.

The demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration.

Minnesota seeks to renew the PMAP+ waiver under Section 1115 of the Social Security Act for the period beginning January 1, 2014 through December 31, 2017. Some portions of the demonstration, such as authority to cover the MinnesotaCare expansion populations, are expected to transition to basic health plan authority as of January 1, 2015. Other components of the demonstration such as graduate medical education and authorities relating to state plan eligible populations affected by the demonstration, will continue through 2017.

In the alternative, Minnesota is also interested in exploring a one-year extension with amendments at this time and revisiting the question of a full three-year waiver renewal at a later date.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The demonstration includes eligibility, benefits and cost-sharing for demonstration expansion populations described below. In addition, the demonstration will impact eligibility for certain populations eligible under the state plan and will continue expenditure authorities relating to graduate medical education.[1]

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration.

[1] With respect to graduate medical education, Minnesota seeks to continue existing expenditure authorities and amend the language relating to the distribution formula to reflect legislative changes. See Attachment A.

Eligibility Chart
Demonstration Expansion populations

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
MinnesotaCare Children ages 19 through 20		133-200% FPL APTC MAGI
MinnesotaCare Children under age 19 who have incomes at or below 200% FPL under APTC MAGI but are barred from Medicaid solely because of special Medicaid household composition and income counting rules	42 CFR § 435.603(f)	0-200% FPL APTC MAGI
MinnesotaCare Adults with Children		133-200% FPL APTC MAGI
MinnesotaCare Adults		133-200% FPL APTC MAGI
Lawfully present noncitizen adults who are not qualified under Medicaid	ACA § 1331(e)(1)(A-D)	0-200% FPL APTC MAGI

Definitions: Demonstration Expansion Populations

- **MAGI or Modified Adjusted Gross Income**. Eligibility standards and income calculation methodologies required under the Medicaid state plan by the Affordable Care Act.

- **APTC or Advanced Premium Tax Credits MAGI.** Eligibility standards and income calculation methodologies required by the Affordable Care Act for people not covered by Medicaid.

- **MinnesotaCare Adults.** Individuals and families with no children under age 21 with incomes above 133 percent and equal to or less than 200 percent of the FPLFPL for the applicable family size.

- **MinnesotaCare Adults with Children.** Individuals and families with incomes above 133 percent and equal to or less than 200 percent of the FPL for the applicable family

size. A MinnesotaCare adult with children is means a person age 21 or older who is living with a child under the age of 21.

- **Family.** Family has the meaning given for family and family size as defined in 26 CFR § 1.36B-1. A taxpayer's family includes individuals whom a taxpayer indicates he or she expects to claim as a tax dependent. The term includes children who are temporarily absent from the household in settings such as schools, camps or parenting time with noncustodial parents.

- **Tax Filing Status.** Eligibility for MinnesotaCare may be granted for individuals and families who are taxpayers and their dependents. To qualify for MinnesotaCare, the tax filer must attest that he or she plans to file a tax return for the benefit year, and if married, that he or she plans to file a joint tax return. For members of a family, the tax filer must indicate that he or she plans to claim each individual as a tax dependent. Individuals and families who are denied MinnesotaCare eligibility solely because they did not indicate the intention to file taxes, to file jointly, or to be claimed as tax dependents, can revisit and change their attestation with regard to tax filing status without having to submit a new application.

- **Citizenship Requirements.** Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as described below. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171 and the Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

- **Lawfully present noncitizens.** Eligible persons include individuals who are lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12 and ineligible for medical assistance by reason of immigration status, who have family income equal to or less than 200 percent of FPL for the applicable family size. Undocumented noncitizens are ineligible for MinnesotaCare. An undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

- **MinnesotaCare Children under age 19 who have incomes at or below 200% FPL under APTC MAGI but are barred from Medicaid solely because of special Medicaid household composition and income counting rules.** Children under age 19 with family income at or below 200 percent of the federal poverty guidelines and who are ineligible for medical assistance by sole reason of the application of federal household composition rules for medical assistance. This population will include children who expect to be claimed by one parent as a tax dependent and reside with both parents, and children who expect to be claimed as a tax dependent by a noncustodial parent.

Eligibility Chart
Affected Medicaid State Plan Eligibility Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Medically needy MA recipients with only unvarying, unearned income *12 month eligibility period*		Medically needy families, kids and pregnant women at or below 133% FPL MAGI standard; aged, blind disabled at/below 75% FPL standard
MA Caretaker Relatives *Caretaker if living with children under age 19*		133% FPL
MA One Year Olds (12-23 months) *Apply methods for MA infants*		converted standard

Definitions: State Plan Eligibility Groups

- **Caretaker Relative.** Caretaker relative means a person age 21 or older that is a relative, by blood, adoption, or marriage, of a child under age 19 with whom the child is living and who assumes primary responsibility for the child's care.

2) **Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.**

Eligibility Standards, Methodologies and Procedures for Demonstration Expansion Populations

- **Financial Eligibility.** To qualify for MinnesotaCare, an applicant must have income within the income bands specified above, utilizing the family size and MAGI methodology as defined at 26 CFR § 1.36B-1. There is no asset test for MinnesotaCare. Individuals who have been determined eligible for Medical Assistance may not enroll in MinnesotaCare.

- **Eligibility Verification Activities.** Income verification will follow the rules set out in the approved Medicaid verification plan for MAGI groups. Citizenship and immigration status are verified at application, following the reasonable opportunity policies under medical assistance.

- **Minimum Essential Coverage.** To be eligible, a family or individual must not have access to minimum essential coverage, or subsidized health coverage that is affordable

and provides minimum value as defined in 26 § CFR 1.36B-2. This requirement does not apply to a family or individual who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit. An individual, who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under Title XVIII of the Social Security Act, 42 U.S.C. sections 1395c to 1395w-152, is considered to have minimum essential health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

- **Effective Date of Coverage.** MinnesotaCare coverage begins the first day of the calendar month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added. The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month. For American Indians and certain members of the military and their families who meet the criteria for premium-free MinnesotaCare, the effective date of coverage is the first day of the month following the month in which eligibility is verified.

- **Retroactive coverage for people transitioning from Medical Assistance to MinnesotaCare.** Retroactive coverage is effective the first day of the month following termination from Medical Assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. Retroactive coverage is repealed once eligibility determination for MinnesotaCare is conducted by MNSure.

- **Disenrollment from MinnesotaCare.** Nonpayment of the premium will result in disenrollment from benefits effective for the calendar month for which the premium was due. Benefits will be reinstated retroactively under fee-for-service for persons who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment. In addition, individuals whose income increases above program limits will be disenrolled effective the last day of the calendar month following the month in which it is determined that the income exceeds program income limits.

Eligibility Standards, Methodologies and Procedures for State Plan Populations Affected by the Demonstration

- **MA One Year Olds.** DHS will apply income methodology for MA infants to children age 12 to 23 months with family incomes at or below 275 percent of the federal poverty level.

- **Medically needy MA recipients with only unvarying, unearned income.** DHS will perform annual income reviews for certain medically needy recipients who have only unvarying unearned income or whose sole income is from a source excluded by law, whereas other medically needy recipients are subject to 6-month income reviews.

- **Caretaker Relative.** Caretaker relative means a person that is a relative, by blood, adoption, or marriage, of a child under age 19 with whom the child is living and who assumes primary responsibility for the child's care.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

No enrollment limits apply.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Please see the budget neutrality worksheets at Attachment B for the projected eligible member months for each expansion population under the demonstration. Eligible member months may be divided by twelve to approximate the number of unique individuals who will be eligible under the demonstration.

The projected eligible member months for MinnesotaCare Adults with Children, Adults without Children, and MinnesotaCare 19 and 20 year olds are based on current MinnesotaCare program data for the people in those groups, trended forward using the rate derived from composite historical data for all MinnesotaCare adults, MinnesotaCare children ages 19 and 20, and noncitizens enrolled in state-funded programs. The projected eligible member months for MinnesotaCare Nonqualified Noncitizen Adults is based on current data for state-funded programs serving this group, trended forward using the rate derived from composite historical data for all MinnesotaCare adults, MinnesotaCare children ages 19 and 20, and noncitizens enrolled in state-funded programs.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under

42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

N/A

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

Please see responses to item 2 above.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

Please see responses to item 2 above.

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

_x__ Yes __ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

_x_ Yes ___ No (if no, please skip questions 8 - 11)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration.

Benefit packages for demonstration expansion populations are set out in the table below. Benefits for state plan eligible populations are not affected by the demonstration.

Benefits for demonstration expansion populations

Eligibility Group	Benefit Package
MinnesotaCare Children age 19-20 133-200% FPL APTC MAGI	Full state plan
MinnesotaCare Children under age 19 who are barred from Medicaid solely because of special income rules 0-200% FPL APTC MAGI	Full state plan
MinnesotaCare Adults with Children 133-200% FPL APTC MAGI	MinnesotaCare Benefit Package
MinnesotaCare Adults 133-200% FPL APTC MAGI	MinnesotaCare Benefit Package
Lawfully present non-citizen adults who are not qualified 0-200% FPL APTC MAGI	MinnesotaCare Benefit Package

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

N/A

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
___ Secretary Approved

5) Demonstration Benefits for Expansion Populations

The MinnesotaCare benefits for certain demonstration expansion populations include those benefits offered to categorically eligible individuals under Minnesota's Medicaid state plan, with certain exclusions outlined below.

MinnesotaCare Benefit Exclusions

Benefit	Description of Amount, Duration and Scope	Reference
Services included in an individual's education plan	Excluded	
Private duty nursing	Excluded	Optional 1905(a)(8)
Orthodontic services	Excluded	
Non-emergency medical transportation services	Excluded	Optional 2110(a)(26) Optional 1905(a)(29) 42 CFR 440.170 Required as an admin function 42 CFR 431.53
Personal Care Services	Excluded	In beneficiary's home: Optional 1905(a)(24) 42 CFR 440.170
Targeted case management services (except Mental Health Targeted case management)	Excluded	Optional 1905(a)(19) 1915(g)
Nursing facility services	Excluded	Mandatory 1905(a)(4) Optional 1905(a)(29), 42 CFR 440.170(d)
Intermediate care facility services	Excluded	Optional 1905(a)(15)

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below) _X_ No (if no, please skip this question)

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

The following section discusses premiums for demonstration expansion populations. Premiums are not charged to state plan populations.

Monthly premium amounts for demonstration expansion populations are established on a sliding scale based on income and family size. Children who are 20 years of age and younger and enrolled in MinnesotaCare pay no premiums. The following premium scale will apply to each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline		**Individual Premium**
Greater than or Equal to	**Less than**	**Amount**
0%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$15
120%	130%	$18
130%	140%	$21
140%	150%	$25
150%	160%	$29
160%	170%	$33
170%	180%	$38
180%	190%	$43
190%		$50

Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the state. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

American Indians enrolled in MinnesotaCare and their families shall have their premiums waived in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan.

The following section discusses cost-sharing for certain demonstration expansion populations. Cost-sharing for state plan eligibility populations is set out in the state plan. Cost-sharing for MinnesotaCare enrollees is the same as cost sharing requirements for categorically eligible individuals under Minnesota’s Medicaid state plan, with certain exceptions for adults in the expansion populations.

Cost Sharing Under this demonstration the MinnesotaCare benefit plan shall include the following cost-sharing requirements for adults in the expansion populations:

a) $3 per prescription for adult enrollees;

b) $25 for eyeglasses for adult enrollees;

c) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

d) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

e) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

The cost-sharing provision in item (a) through (e) above do not apply to children under the age of 21. Paragraph (c) does not apply to mental health services. The table below summarizes the MinnesotaCare cost sharing provisions.

Exceptions from state plan cost-sharing amounts for expansion populations

Population	Premiums	Deductibles	Copayments
MinnesotaCare Children ages 19 through 20 133-200% FPL APTC MAGI	N/A	N/A	Same as State Plan
MinnesotaCare Children under age 19 who are barred from Medicaid solely because of special household composition rules and income counting rules	N/A	N/A	Same as State Plan
MinnesotaCare Adults with Children 133-200% FPL APTC MAGI	Monthly premium based on a sliding scale based on income and family size.	Maximum family deductible under 42 CFR 447.54	$3 for prescription drugs $25 for eyeglasses $3 per visit for non-preventive visit (excludes mental health services) $6 per visit for non-emergency use of the emergency room
MinnesotaCare Adults 133-200% FPL APTC MAGI	Monthly premium based on a sliding scale based on income and family size.	Maximum family deductible under 42 CFR 447.54	$3 for prescription drugs $25 for eyeglasses $3 per visit for non-preventive visit (excludes mental health services) $6 per visit for non-emergency use of the emergency room
Lawfully present noncitizen adults who are not qualified 0-200% FPL APTC MAGI	Monthly premium based on a sliding scale based on income and family size.	Maximum family deductible under 42 CFR 447.54	$3 for prescription drugs $25 for eyeglasses $3 per visit for non-preventive visit (excludes mental health services) $6 per visit for non-emergency use of the emergency room

10) Indicate if there are any exemptions from the proposed cost sharing.

As noted above, state plan cost-sharing provisions apply to demonstration expansion enrollees under age 21. In addition, items or services furnished to an Indian directly by the Indian Health Service, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services are exempt from copayments, coinsurance, deductibles, or similar charge.

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

___ Yes

_X_ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

Minnesota currently utilizes both fee-for-service and managed care delivery systems under the Medicaid State plan. Demonstration expansion populations will be enrolled in managed care. State plan eligible affected by the demonstration will receive services from enrolled providers who are paid both on a managed care and on a fee-for-service basis.

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

By retaining MinnesotaCare for people who would otherwise be eligible to purchase coverage through MNSure, Minnesota is providing platinum-level benefits and cost-sharing and reduced premiums. This is expected to support better access to needed health care services thereby enhancing healthcare outcomes for demonstration participants. For American Indian participants, the demonstration makes platinum level benefits available for no premium. If purchasing coverage via MNSure, this group could access a silver level benefit without a premium.

MinnesotaCare will continue to operate statewide.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

___ Managed care
_X_ Managed Care Organization (MCO)
___ Prepaid Inpatient Health Plans (PIHP)

___ Prepaid Ambulatory Health Plans (PAHP)
__ Fee-for-service (including Integrated Care Models)
___ Primary Care Case Management (PCCM)
___ Health Homes
___ Other (please describe)

The following information is provided in response to the extension application requirements under 42 CFR 431.412 (c)(2)(iv):

Quality Strategy
In accordance with 42 CFR § 438.202(a) of the 1997 Balanced Budget Act (BBA) DHS has developed a written strategy (Quality Strategy) for assessing and improving the quality of health care services offered by MCOs. A copy of the 2013 Quality Strategy can be found at http://edocs.dhs.state.mn.us/lfserver/Public/DHS-4538A-ENG. The Quality Strategy has been developed to assess the quality and appropriateness of care and service provided under the Minnesota Health Care Program's publicly-funded managed care contracts. Reporting on the Quality Strategy's implementation, effectiveness and compliance with federal and state standards is addressed in the Annual Technical Report (ATR) produced by the External Quality Review Organization (EQRO).

Annual Technical Report;
In keeping with federal External Quality Review (EQR) requirements, as set forth in the Balanced Budget Act of 1997 (BBA), the Michigan Peer Review Organization (MPRO) conducted a comprehensive review of Minnesota's eight publicly funded MCOs to evaluate each organization's performance relative to the quality of health care, timeliness of services, and accessibility to care for enrollees. Through the evaluation of objective information from Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) satisfaction surveys, MPRO determined each MCOs' strengths and weaknesses. Statewide MCO performance was strong with 20 of the 27 measures evaluated meeting an acceptable range of performance or above the 90th percentile. Overall, individual MCO performance was high in measures reflecting access and fluctuated in areas evaluating quality. Consistent with 2010 findings, timeliness indicators remained the lowest. MPRO also provided comments on other quality information such as Triennial Compliance Assessment (TCA) Audits, Performance Improvement Projects, and voluntary disenrollment, but did not consider these results in relation to the evaluation of strengths and weaknesses.

A copy of the 2011 Annual Technical Report (ATR) can be found at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6738-ENG.

Interim Evaluation Report

The goal of the PMAP+ demonstration is to provide comparable access and quality of prevention and chronic disease care to child and adult waiver populations as compared to Minnesota's other managed care public program enrollees. The PMAP+ waiver evaluation utilizes a subset of HEDIS performance measures to compare, contrast and draw out differences between PMAP

and MinnesotaCare populations compared to the National Medicaid rates. On April 1, 2011 DHS submitted a report on the findings of the evaluation conducted for calendar years 2008 and 2009. This document may be found at Attachment D. A supplemental report of evaluation activities and findings has been completed for calendar years 2010 and 2011 and is included at Attachment E. The HEDIS performance measures examined in the supplemental report compare the utilization of preventive and chronic disease care services, physical and mental health, and satisfaction of adults with contracted managed care health care services.

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment will be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

Demonstration expansion populations are required to utilize a managed care delivery system to access health care benefits under the demonstration.

The demonstration also allows Minnesota to require managed care enrollment for certain Medicaid State Plan groups that would otherwise be exempt from mandatory managed care, including the following:

- Medicare and Medicaid dual eligibles under 65 years who are not using a disabled basis of eligibility;
- American Indians, as defined in 25 U.S.C. 1603(c), who would not otherwise be mandatorily enrolled in managed care;
- Disabled children under age 19 who are eligible for SSI under Title XVI and who have not elected to be made eligible on the basis of disability;
- Children under age 19 who are in State-subsidized foster care or other out-of-home placement;
- Children under age 19 who are receiving foster care under Title IV-E;
- Children under age 19 who are receiving adoption assistance under Title IV-E;
- Children under 19 with special health care needs who are receiving services through family-centered, community-based coordinated care system that receives grants funds under Section 501(a)(l)(D) of Title V who are not using a disabled basis of eligibility.

American Indians

In consultation with tribal governments, DHS has developed an approach to Medicaid purchasing for American Indian recipients that is different from the remainder of the Medicaid program. These approaches address issues related to tribal sovereignty, the application of Federal provisions that prevent Indian Health Services (IHS) facilities from entering into contract with managed care organizations (MCOs), and other issues that have posed obstacles to enrolling

American Indian/Alaska Native Medicaid recipients into PMAP. Minnesota will continue to abide by the terms of these agreements, as stipulated below.

American Indian Medicaid recipients, whether residing on or off a reservation, will have direct access to out-of-network services at IHS, 93-638 (IHS/638) facilities, or Urban Indian Organizations. DHS will reimburse IHS and 93-638 out-of-network services at the State plan rate. Physicians at IHS and 93-638 facilities will be able to refer recipients to specialists within the MCO network. Enrollees may not be required to see their MCO primary care provider prior to accessing the referral specialist.

The State will consult with tribal governments before approving marketing materials that target American Indians recipients. Certificates of Coverage (COC) will include a description of how American Indian enrollees may direct access IHS/638 providers and how they may obtain referral services. The State will consult with tribal government prior to approving the COC. MCOs will provide trainings and orientation material s to tribal governments upon request, and will make training and orientation available to interested tribal governments. Tribal governments may assist the State in presenting or developing materials describing various MCO options to their members. If a tribal government revises any MCO materials, the MCO may review them. No MCO materials will be distributed until there is agreement between the MCO and Tribal government on any revisions.

MCOs may not require any prior approval or impose any condition for an American Indian to access services at IHS/638 facilities. A physician in an IHS/638 facility may refer an American Indian recipient to an MCO participating provider for services covered by Medicaid and the MCO may not require the recipient to see a primary care provider within the MCO's network prior to referral. The participating provider may determine that services are not medically necessary.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

Managed care will be statewide.

c) Indicate whether there will be a phased-in rollout of managed care.

For over 15 years DHS has administered the PMAP+ 1115 waiver on a statewide basis, allowing for the purchase of coverage for a large portion of MA enrollees and all MinnesotaCare enrollees from managed care organizations on a prepaid capitated basis. Minnesota intends to continue to operate managed care purchasing and service delivery for MinnesotaCare enrollees on a statewide basis.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

The following description applies to new MinnesotaCare applicants. Minnesota is currently in discussion with CMS regarding the procedures that will be in place during the conversion of existing MinnesotaCare enrollees for coverage effective January 1, 2014.

All Medical Assistance and MinnesotaCare recipients that are potential enrollees in an MCO are notified about the requirements and options to enroll in a MCO, and provided a deadline date for enrollment. The deadline date is no less than 30 days from the date the recipient is mailed educational materials. To ensure consistency across the State, all counties are required to use a standard set of educational materials developed by the Department of Human Services.

The Department of Human Services or county staff provides information to Medical Assistance and MinnesotaCare recipients about their MCO options, including if enrollment in an MCO is required or voluntary.

All recipients eligible to enroll in an MCO are encouraged to choose an MCO. If the recipient does not make a choice, the Department of Human Services systematically assigns them to an MCO when the MinnesotaCare enrollee makes a premium payment.

When a Medical Assistance or MinnesotaCare recipient has either chosen or been assigned to an MCO, the recipient is mailed an enrollment notice. This notice informs the client of the effective date that coverage begins and the name of the MCO.

After a Medical Assistance or MinnesotaCare recipient is enrolled in an MCO, there are opportunities and options for changing enrollment between MCOs. The following is a list of options for switching MCOs:

- First year change - Enrollees may change to a new MCO at any time during the first 12 months after initial enrollment in an MCO. The first day of enrollment is defined as the initial effective date of MCO enrollment.

- Open enrollment - Enrollees may change MCOs during the annual 30-day open enrollment period, which starts in the fall with the mailing of the open enrollment notices. Enrollment in the new plan is effective January 1 of the following year.

- The first 90 days after MCO enrollment. This change option is available within 90 days with each enrollment in a new MCO.

- Termination of MCO contract - A MCO must notify the State 150 days prior to terminating its contract. Enrollees will be notified of the need to choose a new MCO.

- Following a break in eligibility of more than 2 full calendar months. The recipient must request the change in MCOs within 60 days of being re-enrolled.

- If the recipient was not eligible at the time of open enrollment.

- If the enrollee permanently relocated to another county and requests a change within 60 days from the date of the relocation.

- If there is a change in health care programs (e.g., a recipient moves from Medical Assistance to MinnesotaCare) and the enrollee requests a change.

- Inaccessibility to the enrollee's primary care provider. Inaccessibility in the metro area is defined as the travel time to an enrollee's primary care provider, which exceeds 30 minutes or 30 miles from the enrollee's residence. In the non-metro area inaccessibility is when travel time is considered excessive by community standards. A written appeal request must be submitted to the Managed Care Ombudsman for approval.

- Agency error - Upon an enrollee's request, the county shall change an enrollee's MCO or primary care physician/dentist without a hearing when the enrollee's MCO or primary care physician/dentist choice was incorrectly designated due to local agency error.

- Good cause and continuity of care - In addition to the specific instances above, enrollees may change MCOs at any time for "good cause". This is a highly subjective exception and decisions are determined on a case-by-case basis. Issues involved could be, but are not limited to, poor quality of care, lack of access to providers experienced in dealing with the enrollee's health care needs, continuity of care, or other reasons satisfactory to the Department of Human Services. The request to change MCOs based on "good cause" must be made to the Managed Care Ombudsman within the Department of Human Services.

e) Describe how the managed care providers will be selected/procured.

Every year the Department of Human Services issues a procurement for managed care services in a geographic area of the state. Minnesota law places a five-year limitation on the procurement of grant contracts, including managed care contracts. Therefore, DHS has a rolling cycle of procurements that result in one-year contracts that can be renewed for up to five years. For MinnesotaCare procurement, the state is divided into five regions and each region is procured once every five years. Procurement for 2014 is currently underway for 28 of Minnesota's 87 counties.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Non-emergency transportation is not included in the managed care capitation rate because it is coordinated at the local level.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.

N/A

___ Yes ___ No

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Fee-for-service provider payment rates will not deviate from those set forth in Minnesota's approved state plan.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

General Rate Setting Methodology
In general, managed care capitation rates are set on an aggregate basis, meaning that the Department of Human Services develops capitation rates on a statewide basis (not plan-specific) using data from all of the plans. The Department of Human Services does not negotiate rates on an individual plan basis. However, MCO capitation rates vary based on the demographic mix of enrollees enrolled in a plan. The demographic factors that cause the capitation rate to vary across plans are: Age, gender, type of eligibility, health-risk status, and geographic location. While the Department of Human Services does not negotiate rates on an individual plan basis, it does make certain plan-specific adjustments to the capitation rates based on hospital utilization, medical education and legislatively mandated enhanced hospital payments.

The base capitation rates are developed from the MCOs' actual aggregate medical claims experience and costs. The capitation rates paid are a projection of anticipated MCO costs per member per month based on past cost and service utilization.. The base period for the 2013 rates was 2011, adjusted for the impact of competitive bidding in 2012. For 2014, the base will be 2012 expenditures, adjusted for changes in benefits and pricing, and the impact of the competitive procurement in greater Minnesota. The capitation rates also incorporate cost-based adjustments such as utilization changes, underlying medical inflation, fee-for-service payment changes and ratable reductions, legislative changes in eligibility and benefits, administrative adjustments, and an allowance for contributions to reserves.

Risk Adjustment
Risk adjustment of MCO capitation rates uses previous enrollees' claims history to more accurately target money to managed care plans with a greater proportion of higher-cost individuals than the traditional demographic, age and gender rates. Risk adjustment uses the diagnosis history of an MCO's previous enrollees to assign relative cost weights

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

The MCO contracts include supplemental payment incentives designed to promote access, efficiency and quality. The supplemental payments for contract year 2013 are described in Section 7.10 of the 2013 Families and Children model contract at http://www.dhs.state.mn.us/main/dhs16_139710

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Minnesota proposes implementation on 1/1/2014.

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Many changes will occur on January 1, 2014, including an expansion of Medicaid state plan benefits to children and adults at higher income levels, a new "bright line" policy separating MinnesotaCare from Medical Assistance, and the availability of tax credits for purchasing private insurance coverage on MNSure. Many individuals who are currently enrolled in the MinnesotaCare demonstration will be transitioning to coverage under Medical Assistance or MNSure.

Minnesota will use the same streamlined application for MA, MinnesotaCare and MNSure coverage. People who are eligible for Medical Assistance using the MAGI-based methodology must enroll in Medical Assistance. Applicants determined eligible for MinnesotaCare at application will be permitted to enroll in MinnesotaCare. However, if the application indicates the person requested a full Medical Assistance determination or may be eligible for Medical Assistance as an individual who is age 65 or older, a person with a disability, medically needy, resides in a long-term care facility, or needs home and community-based waiver services, additional information will be collected and referred to the county social service agency for an evaluation of Medical Assistance eligibility under a non-MAGI basis of eligibility.

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

The 2011-2013 PMAP+ demonstration includes MinnesotaCare Adults with incomes at or below 200% FPL and MinnesotaCare Adult Caretakers with incomes at or below 275% FPL. After January 1, 2014, the MinnesotaCare demonstration will include adult caretakers and adults with incomes above 133% and equal to or less than 200% FPL. Adults and Adult Caretakers with incomes at or below 133% FPL will be converted to Medical Assistance for coverage effective January 1, 2014. Adult Caretakers with incomes above 200% FPL will be notified of the opportunity to seek coverage via MNSure. MinnesotaCare Adults and Adults with Children with

incomes above 133% and equal to or less than 200% FPL will remain on MinnesotaCare. The increased benefits and reduced cost-sharing outlined here will take effect on January 1, 2014 as outlined in the transition plan currently under discussion with CMS.

The 2011-2013 PMAP+ demonstration includes MinnesotaCare Children with incomes at or below 275% FPL. After January 1, 2014, the MinnesotaCare demonstration will include MinnesotaCare Children ages 19-20 with incomes above 133% and equal to or less than 200% FPL. Children ages 18 and under with incomes at or below 275% FPL will be converted to Medical Assistance for coverage effective January 1, 2014, as will children ages 19 and 20 with incomes at or below 133% FPL. Children ages 19 and 20 with incomes over 200% FPL will be notified of the opportunity to seek coverage via MNSure. MinnesotaCare Children ages 19and 20 with incomes above 133% and equal to or less than 200% FPL will remain on MinnesotaCare, with state plan benefits and cost-sharing.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

DHS procures managed care services for Medical Assistance and MinnesotaCare enrollees in a portion of the state every year. Minnesota law places a five-year limitation on the procurement of grant contracts, including managed care contracts. DHS has adopted a rolling cycle of procurements that result in one-year contracts that can be renewed for up to five years. For MinnesotaCare procurement, the state is divided into five regions. Each region is procured at least once every five years. Procurement for 2014 is currently underway for 28 of Minnesota's 87 counties.

Section VI – Demonstration Financing and Budget Neutrality

1) Budget Neutrality

The Budget Neutrality Worksheets are provided at Attachment C. Historical data is provided at Attachment B.

In order to control for the relatively small numbers of enrollees at higher income levels and several program changes over the last five years affecting adults without children and noncitizens, a composite approach was utilized to derive the proposed trend rates for the demonstration. The trend rates for enrollment and per member per month expenditures at Attachment C are a composite trend based on actual historical expenditures and enrollment experience during calendar years 2008-2012 from the MMIS system for the following populations:

- MinnesotaCare Adults without Children, all income levels (federally-funded)
- MinnesotaCare Adults without Children, all income levels (state-funded)
- MinnesotaCare Parents, all income levels
- MinnesotaCare 19 and 20 year olds, all income levels
- MinnesotaCare Noncitizen Adults without children (state-funded group)
- Medical Assistance Noncitizens (state-funded group)

2) Standard Funding Questions

1. **The following questions are being asked and should be answered in relation to all payments made to all providers under the section 1115 demonstration under review. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan.**

    a. **Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the federal and non-federal share (NFS) or is any portion of any payment returned to the state, local governmental entity, or any other intermediary organization?**

    b. **If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.).**

Response: Please see combined response to questions 1 to 3 below.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.**

    a. **Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.**

    b. **Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer (IGT) agreements, certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide the NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please also indicate if any managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans participate in IGT or CPE arrangements.**

    c. **Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.**

d. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

e. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds is in accordance with 42 CFR 433.51(b).

f. For any payment funded by CPEs or IGTs, please provide the following:

- **(i) a complete list of the names of entities transferring or certifying funds;**
- **(ii) the operational nature of the entity (state, county, city, other);**
- **(iii) the total amounts transferred or certified by each entity;**
- **(iv) clarify whether the certifying or transferring entity has general taxing authority; and**
- **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Please see combined response to questions 1 to 3 below.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved state Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response to Questions 1 to 3: For the sake of efficiency, we are responding to questions 1 to 3 together.

We have elected not to discuss here the supplemental payments and any related source of non-federal share that exist only in fee-for-service via the state plan because those supplemental payments are thoroughly described to CMS through each state plan amendment.

Because we do not require managed care organizations to account for every dollar that they may have paid to various forms of government, we do not assert that MCOs "retain" their funding. However, to the best of our knowledge, MCOs do not return Medicaid payments. The following paragraphs include descriptions of various types of payments by health care providers to the state. We do not consider any of them to "return" Medicaid payments, but we list them because the CMS questions do not define the term "return."

Provider Taxes

Minnesota has a 2% tax on hospitals, surgical centers, wholesale drug distributors, and other health care providers and a 1% tax on MCO premiums, including Medicaid participating MCOs. The 2% tax on health care providers is set out at Minnesota Statutes, § 295.52, and is a gross receipts tax on all revenue except Medicare revenue. The 1% tax on managed care organization premiums is at Minnesota Statutes, § 297I.05, sub. 5.

Minnesota Statutes, § 295.58 requires the receipts from both the provider tax and the premium tax to be deposited into the Health Care Access Fund. The Health Care Access Fund is the primary source of revenue that makes up the nonfederal share of capitation payments for the MinnesotaCare program. We believe the tax to be broad-based and uniform.

Minnesota also has separate taxes (known as surcharges) on hospitals, nursing homes, HMOs, and intermediate care facilities, the revenue from which is deposited in the General Fund. The General Fund is the primary source of funding for the nonfederal share of capitation payments in the medical assistance program. We consider these surcharges to be broad-based and uniform.

Supplemental Payments

The remainder of this section discusses certain supplemental payments that already exist in the Medical Assistance Program, related to managed care service delivery, that are related to funding sources other than state appropriation.

Minnesota Statutes, §256B.196, sub. 2, paragraph (c) provides for a monthly intergovernmental transfer from Hennepin and Ramsey Counties in amounts not to exceed $1 million monthly for Hennepin County and $500,000 monthly from Ramsey County. Those transfers are associated with the non-federal share of an enhanced hospital payment included in the capitation payment for the Families and Children contract with the managed care organizations (MCOs) that have admissions at Hennepin County Medical Center (HCMC) and Regions Hospital. The MCOs are required by section 4.1.12 of the Families & Children contract to make monthly enhanced hospital payments to HCMC and Regions Hospitals equal to the per member per month value of the rate add-on labeled "Enhanced Hospital Payment" in Appendix II-A of the contract, less the 1% premium tax paid by the MCO, multiplied by the MCO's monthly enrollment for each rate cell. This payment was approved by CMS for the 2011 MCO contracts.

Under Minnesota's PMAP+ Section 1115 waiver, CMS has approved payments related to medical education that are included in the MCO capitation rates for purposes of actuarial soundness, but are carved out and paid to Medicaid-enrolled providers that provide clinical training. The carved-out funds are transferred to the Minnesota Department of Health, paid to the sponsoring institutions, and paid by the sponsoring institutions to the participating providers. The source of the carved-out funds is the Medical Assistance Account, which is funded by appropriation from the General Fund.

Section 4.1.9 of the Families & Children managed care contracts provides for an increase in the capitation rates for MCOs that have a contract that includes enrollees residing in Hennepin County to make a monthly payment to Hennepin County Medical Center. The value of that payment is the "GME Add-on" listed in Appendix II-A of the Families & Children contract for MCOs in Hennepin County, minus the MCO cost of the 1% premium tax, and multiplied by the MCO's monthly enrollment for each rate cell. Pursuant to Minnesota Statutes, section 256B.19, sub. 1(d), Hennepin County, which owns and operates the hospital, is responsible for a monthly intergovernmental transfer to the state in the amount of $566,000 as part of Hennepin County's portion of the nonfederal share of Medical Assistance costs.

Section VII – List of Proposed Waivers and Expenditure Authorities

Statewideness/Uniformity — **Section 1902(a)(l) as implemented by 42 CFR § 431.50**

To the extent necessary to enable the State to provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas of the State.

Freedom of Choice — **Section 1902(a)(23)(A) as implemented by 42 CFR § 431.51**

To the extent necessary to enable the State to restrict the freedom of choice of providers for demonstration participants who are made eligible through the State plan in order to enroll the participants into managed care. Specifically this waiver enables the mandatory enrollment of the exempt groups into managed care.

Amount, Duration, and Scope — **Section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b) and CFR § 431.51**

To the extent necessary to enable the State to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or in the absence of managed care arrangements, and to enable the State to provide a different benefit package to persons who participate in MinnesotaCare than is being offered to the traditional Medicaid population.

Coverage /Benefits for Pregnant Women — **Section 1902(a)(10)(A)(i)(IV) in the matter after 1902(a)(10)(G)(VH)**

To the extent necessary to exempt the State from the requirement that it limit medical assistance to certain pregnant women for services related to pregnancy and conditions that may complicate pregnancy.

Comparability of Eligibility Standards — **Section 1902(a)(17)**

To the extent necessary to permit the State to apply different eligibility standards across populations. Specifically, this waiver enables the State to perform annual income reviews for certain medically needy recipients who have only unvarying unearned income or whose sole income is from a source excluded by law, whereas other medically needy recipients are subject to 6-month income reviews. In addition, this waiver enables the State to utilize the definition of “family, “family size” and “household income” as defined in 26 CFR 1.36B-1 so that

the MinnesotaCare eligibility determination will be consistent with and easily transitioned to Basic Health Plan rules when that program is implemented.

Retroactive Coverage **Section 1902(a)(34)**

To the extent necessary to enable the State to not provide medical assistance to the demonstration population for any time prior to when an initial application for the demonstration is made.

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) will be regarded as expenditures under the State's title XIX plan for the period of this extension.

The following expenditure authorities shall enable Minnesota to operate its section 1115 demonstration.

1. Expenditures for Medicaid coverage to children age 12 to 23 months with family incomes at or below 275 percent of the Federal poverty level (FPL) who would not be otherwise eligible for Medicaid.

2. Expenditures for Medicaid coverage for pregnant women described in section 1902(a)(10)(A)(i)(IV) of the Act, to the extent that services are provided that are in addition to services related to pregnancy and conditions which may complicate pregnancy.

3. Expenditures for Medicaid coverage for pregnant women during a presumptive eligibility period described in section 1920(d), as implemented by 42 CFR 435.1110, to the extent that services are provided that are in addition to ambulatory prenatal care

4. Expenditures for MinnesotaCare coverage for children ages 19-20 with incomes above 133 percent and at or below 200 percent of the FPL who (a) would not be otherwise eligible for Medicaid under the State Plan, and (b) are not entitled to Medicare.

5. Expenditures for MinnesotaCare coverage for adults with children with incomes above 133 percent and at or below 200 percent of the FPL who (a) would not be otherwise eligible for Medicaid under the State Plan, and (b) are not entitled to Medicare.

6. Expenditures for Medicaid coverage for medically needy individuals who have unvarying unearned income or whose sole income is from a source excluded from consideration by law, to the extent that they would be ineligible under the State plan using a 6-month budget period instead of a 12-month budget period.

7. Expenditures for MinnesotaCare coverage for adults age 21 to 64 years old, without children, with incomes above 133 percent and at or below 200 percent of the FPL, and who (a) would not be otherwise eligible for Medicaid under the State Plan, and (b) are not entitled to Medicare.

8. Expenditures for payments made directly to medical education institutions or medical providers and restricted for use to fund graduate medical education (GME) of the recipient institution or entity through the Medical Education and Research Costs (MERC) Trust Fund. In each Demonstration Year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009. Except as specifically authorized in of the STCs, the State may not include GME as a component of capitation rates or as the basis for other direct payment under the State plan. This expenditure authority will be subject to changes in Federal law or regulation that may restrict the availability of Federal financial participation for GME expenditures.

9. Expenditures for MinnesotaCare enrollees residing in a correctional or detention facility while awaiting disposition of charges, consistent with 42 USC 18032(f)(1)(B).

Requirements Not Applicable to the Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the list below, shall apply to the expenditure authorities beginning July 1, 2011 through December 31, 2013. The list below is applicable to demonstration participants receiving MinnesotaCare coverage who would not otherwise be eligible for Medicaid or who would be eligible under the State plan but who have elected not to apply under the State plan. This list does not pertain to MA One Year Olds.

Cost Sharing — **Sections 1902(a)(14) insofar as it incorporates 1916**

To enable the State to impose premiums and cost sharing that are above the limits in current Medicaid statutes.

Financial Responsibility/Deeming — **Section 1902(a)(17)(D)**

To exempt the State from the limits on whose income and resources may be used in determining the eligibility of family members. This waiver enables the State to utilize the definition of "family," family size," and "household size" as defined in 26 CFR 1.36B-1 so that the MinnesotaCare eligibility determination will be consistent with and easily transitioned to Basic Health Plan rules when that program is implemented.

Methods of Administration: Transportation — **Section 1902(a)(4), insofar as it incorporates 42 CFR § 431.53**

To the extent necessary to enable the State to not assure transportation to and from providers for non-pregnant adults ages 21-64.

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to allow the State not to provide coverage until the first day of the month following an individual's first premium payment.

Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to allow the State to not provide coverage for any time prior to the first of the month following an individual's first premium payment.

Managed Care Payment **Section 1903(m)(2)(A)(ii)**
Section 1902(a)(4)

To the extent necessary to allow the State to make payments directly to providers, outside of the capitation rate, for graduate medical education through the Medical Education and Research Costs (MERC) Trust Fund.

Income Disregard **Section 1902(r)(2)**

To the extent necessary to allow the State to apply an income disregard to MinnesotaCare adults without children applicants who have incomes above 133 percent and at or below 200 percent of the FPL.

Section VIII – Public Notice

Please include the following elements as provided for in 42 CFR § 431.408 when developing this section:

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

A notice requesting public comment on the proposed PMAP+ §1115 waiver extension request was published in the Minnesota State Register on June 24, 2013. This notice announced a 30-day comment period from June 24, 2013 to July 24, 2013 on the PMAP+ waiver extension request. The notice informed the public on how to access an electronic copy or request a hard copy of the waiver request. Instructions on how to submit written comments were provided. In addition, the notice included information about two public hearings scheduled to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The time and location for the two public hearings, along with information about how to arrange to speak at either of the hearings, was provided. Finally, the notice provided a link to the PMAP+ Waiver web page for complete information on the PMAP+ waiver request including the public notice process, the public input process, planned hearings and a copy of waiver application. A copy of the Minnesota State Register Notice published on June 24, 2013 is provided as Attachment F.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

The DHS public web site provides the public with information about the PMAP+ waiver extension request. The web site is updated on a regular basis and includes information about the public notice process, opportunities for public input, planned hearings and a copy of the waiver application. The main page of the DHS public website includes a "Public Participation" link to help people quickly identify what comment periods are open. This page contains a link to the PMAP+ waiver web page. During the state comment period, it will instruct how to submit comments on the PMAP+ waiver extension request to DHS. After the comment period, it will be updated to alert web visitors of the upcoming federal comment period on the PMAP+ extension request and to provide the link to the federal website when it is available. A copy of the final draft of the waiver request that includes modifications following the public input process will also be posted on the website.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

The State convened at least two public hearings, of which one hearing included teleconferencing and/or web capability. Two public hearings were held to provide stakeholders and other interested parties the opportunity to comment on the waiver request. Teleconferencing was available at each hearing to allow interested stakeholders the option to participate in the hearing remotely. The first public hearing was held at the DHS Elmer Andersen building on July 8, 2013. Public testimony was not given at this hearing. There were four members of the public in attendance. The second public hearing was held at the DHS Lafayette location on July 15, 2013. Public testimony was not given at this hearing. There were seven members of the public in attendance. DHS staff provided an overview of the changes requested under the waiver, along with the objective of the change and desired outcomes at each of the two hearings. A copy of the written summary providing an overview of changes requested under the waiver is also available at Attachment K.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public.

The State used an electronic mailing list or similar mechanism to notify the public. On June 24, 2013 an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the State's intent to submit the PMAP+ waiver extension request and directing them to the Minnesota State Register notice published on June 24, 2013. A second email was sent to provide notice that the final submitted version of the waiver was on the web site and to alert stakeholders that a federal comment period on the PMAP+ renewal request is expected soon. Please refer to the stakeholder e-mail list at Attachment G.

5) Comments received by the state during the 30-day public notice period.

DHS received written comments from one stakeholder regarding the proposed PMAP+ Waiver extension request during the comment period from June 24, 2013 to July 24, 2013. A copy of the written comment is included at Attachment L. Comments that include private medical or public assistance information regarding the commenter will be redacted to remove individually identifying information.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

The written comment received by DHS was in support of the PMAP+ waiver extension and the proposed changes aligning the MinnesotaCare program with the requirements for a Basic Health Plan under the Affordable Care Act.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

In Minnesota, there are seven Anishinaabe (Chippewa or Ojibwe) reservations and four Dakota (Sioux) communities. The seven Anishinaabe reservations include Grand Portage located in the northeast corner of the state, Bois Forte located in extreme northern Minnesota, Red Lake located in extreme northern Minnesota west of Bois Forte, White Earth located in northwestern Minnesota; Leech Lake located in the north central portion of the state; Fond du Lac located in northeastern Minnesota west of the city of Duluth; and Mille Lacs located in the central part of the state, south of Brainerd. The four Dakota Communities include: Shakopee Mdewakanton Sioux located south of the Twin Cities near Prior Lake; Prairie Island located near Red Wing; Lower Sioux located near Redwood Falls; and Upper Sioux whose lands are near the city of Granite Falls. While these 11 tribal groups frequently collaborate on issues of mutual benefit, each operates independently as a separate and sovereign entity – a state within a state or nation within a nation. Recognizing American Indian tribes as sovereign nations, each with distinct and independent governing structures, is critical to the work of DHS. DHS has a designated staff person in the Medicaid Director's office who acts as a liaison to the Tribes. Attachment H is Minnesota's tribal consultation policy.

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

On October 29, 2012 a letter was sent to all Tribal Chairs and Tribal Health Directors informing them of the State's intent to submit a request to extend the PMAP+ waiver. The letter also informed Tribes of the public input process and the initial Minnesota State Register notice to be published on December 3, 2012. Please refer to Attachment I for a copy of the October 29, 2012 letter.

The State's intent to submit a request to extend the PMAP+ waiver was included in a summary of federal waiver activity provided to Tribal Chairs and Tribal Health Directors at the May 15, 2013 Tribal Health Work Group meeting.

On April 22, 2013 a second letter was sent to all Tribal Chairs and Tribal Health Directors requesting their comment on DHS' intent to submit a second, more detailed request to extend the PMAP+ waiver. The letter informed Tribes that additional information regarding the proposed extension and the public input process would be posted in the Minnesota State Register and that a copy of the waiver request would be available on the DHS web site. Please refer to Attachment J for a copy of the April 22, 2013 letter.

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).

N/A

Section IX – Demonstration Administration

Contact

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Attachment A: MEDICAL EDUCATION AND RESEARCH COSTS (MERC)

Below are proposed amendments to the existing PMAP+ special terms and conditions relating to MERC.

38. **Medical Education and Research Costs (MERC) Trust Fund.** Through expenditure authority granted under this Demonstration, total computable payments that are paid directly to medical education institutions (or to medical care providers) through the MERC Trust Fund are eligible for FFP to the extent consistent with the following limitations:

(a) Each Demonstration Year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009. This aggregate limit applies to all MERC payments authorized under this Demonstration.

(b) The State may not include GME as a component of capitation rates or as a direct payment under the State plan for managed care enrollees while this expenditure authority exist, with the exception of GME paid outside of MERC based on hospital services furnished to managed care enrollees through managed care products for which no carve-out existed in calendar year 2008, which includes the MinnesotaCare Program, the Minnesota Disability Health Options Program, and those capitation payments for dual eligibles enrolled in the Minnesota Senior Health Options Program. The State may also continue to make a GME adjustment to capitation rates paid to a health plan or demonstration provider serving MA and MinnesotaCare enrollees residing in Hennepin County~~Metropolitan Health Plan~~ in order to recognize higher than average GME costs associated with enrollees utilizing Hennepin County Medical Center, not to exceed $6,800,000 in annual total computable payments. The GME authorized to be paid outside of MERC and the adjustment to the health plan or demonstration provider~~Metropolitan Health Plan rate~~s is in addition to the MERC adjustment and is not subject to the MERC limit. Nothing in this provision exempts Minnesota from any of the requirements of 42 CFR 438.6(c) with respect to Medicaid managed care rate setting and actuarial soundness.

(c) The amounts described in (a) may be distributed as follows:

i. Up to $2,157,000 may be paid to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians in rural areas, and efforts to increase the number of medical school graduates choosing careers in primary care;

ii. Up to $1,035,360 may be paid to Hennepin County Medical Center for graduate clinical medical education;

iii. Up to $1,121,640 may be used to fund payments to teaching institutions and clinical training sites for projects that increase dental access for under-served populations and promote innovative clinical training of dental professionals;

iv. Up to $17,400,000 may be paid to the University of Minnesota Academic Health Center for purposes of clinical GME;

v. Amounts in excess of those distributed under (i) through (iv) above, up to the prescribed limit, may be paid to eligible training sites, based on public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; ~~a formula that incorporates a two-part public program factor described in (vi) below.~~

~~vi. The two part public program factor is calculated as follows: (1) public program revenue for each training site eligible for the carve-out funding; and (2) a supplemental public program factor, which is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The distribution to training sites whose public program revenues accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental public program factor.~~

vi~~i~~. Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. Training sites whose training site level grant is less than $5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph. The distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training sites grant. ~~Training sites that received no public program revenues are ineligible for payments from the PMAP funding transferred to the trust fund.~~

(d) FFP is available for total computable amounts paid from the MERC Trust Fund to recipient entities, within the limits described in this paragraph and the expenditure authorities. The Minnesota Department of Health, which operates the MERC Trust Fund, must certify the total computable payments made from the MERC Trust fund to eligible entities in order for the State to receive FFP.

(e) The State shall provide information to CMS regarding any modifications to the existing source of non-Federal share for any GME expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

(f) As part of the Annual Report required under paragraph 41the State must include a report on GME activities in the most recently completed DY, that must include (at a minimum):

Attachment D

Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) §1115 Waiver Evaluation

For Demonstration Extension Period of July 1, 2008 through June 30, 2011

Final Report
April 1, 2011

Table of Contents

Section One Information About the Demonstration

1.1 Demonstration Name and Effective Dates

This evaluation report relates to the renewal period July 1, 2008 through June 30, 2011, for the Prepaid Medical Assistance Plus (PMAP+) §1115 Demonstration.

1.2 Brief Description and History of the Demonstration

Enrollees began receiving services from health plans under the first Prepaid Medical Assistance (PMAP) Section 1115 demonstration in July of 1985, more than twenty-five years ago. This waiver allowed Minnesota's Medicaid Program (Medical Assistance or MA) to purchase coverage from health plans on a prepaid capitated basis. The project required that nondisabled MA recipients be enrolled with a health plan, and remain enrolled with that plan for a 12-month period. PMAP was originally limited to a few Minnesota counties.

In April 1995, HCFA approved a statewide health reform amendment to the PMAP waiver. Generally, this amendment, known as Phase 1, allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the FPG into the Medicaid Program. An amendment approved in February 1999 expanded the program to include parents enrolled in MinnesotaCare.

In March 1997, the State proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that HCFA authorize a second phase of provisions that had been enacted by the Minnesota Legislature. On August 22, 2000, HCFA approved most aspects of Minnesota's Phase 2 amendment request, known as the PMAP+ waiver. Some important components of this waiver amendment allowed for administrative simplification and mandatory enrollment of certain MA populations in managed care.

With promulgation of the BBA Managed Care regulations in 2002, states were able to implement through their State Plans many of the provisions that were previously only permitted under a §1115 waiver. Minnesota has taken advantage of this option, and now provides prepaid managed care coverage to infants, children, pregnant women and parents via the state plan. Minnesota has also obtained a separate §1915(b) waiver for coverage of its senior population, which was previously covered under the PMAP+ waiver. Nevertheless, the PMAP+ §1115 waiver remains necessary to implement several important components of Minnesota’s publicly funded health care programs, including providing Medicaid services with federal financial participation to expansion populations

under the MinnesotaCare program and mandatory managed care for certain MA populations, such as Native Americans and children with special needs.

As the scope of the demonstration authority has evolved over time, so has the evaluation design. Similarly, as mandatory managed care has been implemented statewide for almost all of Minnesota's recipients without disabilities, Minnesota has little access to useful fee for service data for comparison.

1.3 Overview of Current PMAP+ Waiver Authorities

MinnesotaCare Authorities
The waiver provides Minnesota the flexibility to implement the MinnesotaCare managed care program with components that differ from traditional Medicaid, including:
- higher premiums and copays than would be allowed under traditional Medicaid
- prospective enrollment
- enrollees must not have access to health insurance for four months prior to enrollment
- a less rich benefit set for adult caretaker enrollees;
- a simplified income methodology
- a broader definition of family
- mandatory enrollment of all children in a family

Medical Assistance Authorities
The waiver also allows Minnesota to deviate from standard Medicaid rules in the state Medical Assistance program, including:
- streamlined MA eligibility and benefit set for pregnant women up to 275% FPG
- elimination of 6 month income reviews for medically needy MA recipients with unvarying, unearned income
- payment of graduate medical education via a carve-out from the managed care rates
- mandatory managed care enrollment for exempt groups not covered by the state plan (i.e. American Indians, duals under 65 who are not using a disabled basis of eligibility, and children receiving title V, adoption assistance or foster care)

In December 2007, Minnesota submitted a request to CMS for an extension of the PMAP+ waiver for the period July 1, 2008 through June 30, 2011. CMS approved most components in October 2008.

1.4 Population Groups Impacted by the Demonstration

The PMAP+ demonstration allows Minnesota to receive federal financial participation to provide coverage to the following eligibility groups

i. MA One Year Olds. This group includes infants age 12 through 23 months of age, with family incomes at or below 275% of the FPL. State plan income methodologies and eligibility rules apply.

ii. MinnesotaCare Children. This group includes children under 21 years of age with family incomes at or below 275% of the FPL. MinnesotaCare income methodologies and eligibility rules apply.

iii. MinnesotaCare Pregnant Women. This group includes pregnant women with family incomes at or below 275% of the FPL. MinnesotaCare income methodologies and eligibility rules apply.

iv. MinnesotaCare Caretaker Adults. This group includes parents and other caretaker relatives with family incomes at or below 275% of the FPL. MinnesotaCare income methodologies and eligibility rules apply.

The benefit offered to MinnesotaCare Children, MinnesotaCare Pregnant Women, and MA One Year Olds is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid state plan, including all services that meet the definition of early and periodic screening, diagnostic, and treatment (EPSDT) found in section 1905(r) of the Act. The benefit offered to MinnesotaCare Caretaker Adults is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (a) through (h) below are excluded, and inpatient hospital services are limited for certain participants as described in (i).

a) Services included in an individual's education plan;
b) Private duty nursing;
c) Orthodontic services;
d) Non- emergency medical transportation services;
e) Personal Care Services;
f) Targeted case management services (except mental health targeted case management);
g) Nursing facility services; and
h) ICF/MR services.
i) Inpatient Hospital Limit. MinnesotaCare Caretaker Adults (except pregnant women) with income above 215 percent of the FPL are subject to a $10,000 annual limit on inpatient hospitalization.

1.5 Purposes, Aims, Objectives, and Goals of the Demonstration

The goal of the demonstration is to provide comparable access and quality of prevention and chronic disease care to child and adult waiver populations as compared to Minnesota's other managed care public program enrollees. The waiver hypothesis is that providing health care coverage to child and adult waiver populations who would otherwise be uninsured will result in the following outcomes:

1. Improved utilization of preventative and chronic disease care services for children (childhood immunizations, child access to PCP, annual dental visits, and well-child visits)
2. Improved health and utilization of preventative and chronic disease care services for adults (diabetes screenings, adult preventive visits, cervical cancer screening)
3. Improved utilization of postpartum care services for pregnant women (postpartum care services)
4. Enrollee satisfaction with the delivery and quality of services for all populations (satisfaction survey results)

The quantifiable target goal for the first three outcomes will be to provide comparable access and quality of prevention and chronic disease care to child and adult waiver populations as compared to Minnesota's other managed care public program enrollees. This will be demonstrated by the waiver evaluation set of HEDIS performance measures calculated from MCO submitted encounter data. The quantifiable target goal for the fourth outcome will be to demonstrate continued satisfaction of waiver and non-waiver populations. Satisfaction survey results will be calculated from responses to the annual satisfaction (CAHPS) survey. See section 2.4 for a description of the analysis plan.

1.6 Lessons Learned – Observations from the Previous Waiver Period

The evaluation conducted for the waiver period July 1, 2005 through June 30, 2008 showed a gradual increase in access to preventive health services by adults and children in both MinnesotaCare and PMAP. The findings also suggested that managed care providers have increased their use of preventive health services for all MinnesotaCare and PMAP enrollees. Expected disparities in access to care due to enrollee family income level did not influence how managed care populations access or use prevention services. Some positive impact was noted in access to care for children whose parents were enrolled in MinnesotaCare, although it was not statistically significant.

1.7 Summary of the Evaluation Requirements in the Demonstration Special Terms and Conditions

Paragraph 55 of the Special Terms and Conditions includes the following requirements regarding the evaluation design for the demonstration:

1. A discussion of the demonstration goals and objectives, as well as the specific hypotheses that are being tested.
2. A discussion of the outcome measures that will be used to evaluate the impact of the demonstration during this extension period,

3. A discussion of the data sources and sampling methodology for assessing the outcomes.
4. A detailed analysis plan that describes how the effects of the demonstration will be isolated from other initiatives occurring in the State.

Section Two Evaluation Design

2.1 Management and Coordination of the Evaluation

The Minnesota Department of Human Services (DHS), Performance Measurement and Quality Improvement Division conducted the PMAP+ §1115 Waiver evaluation. Below is an overview of the evaluation and activities and timeline:

- March 2010 - DHS provides HEDIS measure results for the comparison population's three baseline years (2005 through 2007) in the PMAP+ waiver quarterly progress report to CMS. As CMS is aware, HEDIS based measures are annually calculated each June and more frequent reporting is inefficient utilization of State resources.
- June through August 2010 - Calendar years 2005 through 2009 HEDIS rates are calculated and performance measure validation process completed
- September through December 2010, an analysis of the rates is conducted
- November 2010 - DHS provides HEDIS measure results for measurement years (2008 and 2009) in the PMAP+ waiver annual progress report to CMS.
- January through March 2011 - The draft and final waiver report is written, reviewed and approved
- April 2011 - Final report is submitted to CMS.

A subset of HEDIS 2010 performance measures are expected to demonstrate the continuation of the ongoing quality of care and services provided by the contracted managed care organizations as seen in previous waiver periods.

As the state Medicaid agency, DHS will conduct the evaluation. This is preferable to contracting with an outside vendor because the complex design of the evaluation, the utilization of encounter data, the five to six months necessary to complete the competitive procurement required by the state to contract with a qualified organization, and the time needed to educate the new vendor makes outsourcing of this project impractical.

2.2 Performance Measures

The selected HEDIS 2010 performance measures will evaluate the childhood prevention, adult chronic disease care management and care provided to pregnant women for the waiver population compared to all PMAP and MinnesotaCare enrollees.[1] Performance measure data will be extracted from DHS' managed care encounter data base during June 2010 to allow for a sufficient encounter run-out period.

[1] For the Childhood immunization performance measure a statewide immunization registry will be used to augment DHS managed care encounters.

Evaluation populations will consist of three subgroups:

- Children age 0 to 19 years in MinnesotaCare with income at or below 275% FPG.
- Parents (caretakers) with income at or below 275% FPG with children enrolled in MinnesotaCare or Medical Assistance.
- Pregnant women enrolled in MinnesotaCare with income at or below 275% FPG.

The table below provides a list of the annual HEDIS 2010 performance measures that will be analyzed in the evaluation.

Childhood Prevention (0-19 yrs.)
Childhood immunizations (2 yrs)
Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs)
Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs)
Well –child visits first 15 months
Well-child visits 3 to 6 yrs.
Adolescent well-care visits (12-19 yrs)
Adult Chronic Care Management (Parents of children)
Diabetes A1c screening
Diabetes LDL screening
Adult access preventive/ambulatory health services
Cervical CA screening
Pregnant Women Care
Postpartum Care

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

The waiver hypothesis subcomponents will be evaluated for evidence of historical and measurement period changes:

- Utilization of preventative and chronic disease care services for children - Analysis of trends/comparisons over the baseline/measurement period performance of the child waiver population and non-waiver child population. Measures of this hypothesis component will be the childhood immunizations, child access to PCP, annual dental visits, and well-child visits.
- Improved health and utilization of preventative and chronic disease care services for adults - Analysis of trends/comparisons over the baseline measurement period performance of the adult caretaker waiver population and non-waiver adult caretaker population. Measures of this hypothesis component will be the diabetes screening, adult preventive visits, and cervical cancer screening.

[2] The final evaluation report will include an attachment of MetaStar's validation report.

- Improved utilization of postpartum care services for pregnant women - Analysis of trends/comparisons over the baseline measurement period performance of the pregnant women waiver population and pregnant women non-waiver population. The measure of this hypothesis component will be the postpartum care.
- Satisfaction - analysis and comparison of satisfaction and disenrollment surveys reflecting the enrollee's perspective on agreement with the delivery and quality of health care services. Measures of this hypothesis component will be the results of the annual CAHPS satisfaction survey and the monthly disenrollment surveys.

The overall goal of the CAHPS project is to conduct an annual consumer satisfaction survey of access and quality of care provided by MCOs to Minnesota's publicly funded health care program enrollees. The CAHPS® 4.0 Adult Medicaid Core Questionnaire Module plus optional CAHPS® questions and supplemental DHS questions are incorporated with the core module to create the survey instrument. The survey is conducted using a four-wave mail plus telephone data collection method. The CAHPS vendor works toward the goal of collecting 300 completed questionnaires/interviews in each of 28 cells defined by DHS, for a total of 8,400 completed interviews. Data collection will be completed between January 2010 and April 2010.

For the past nine years, DHS has been conducting monthly surveys of enrollees who voluntarily change from one MCO to another. The one-page survey with a brief explanation of the purpose and the survey questions is mailed to the head of each household. The initial mailing is made early in the month that the change became effective. Three weeks later, a second survey is mailed to non-respondent households. The survey instrument is in English, with interpreter services available by telephone. The survey is composed of a set of questions that form four composites: I changed my health plan because; I was dissatisfied with my health plan because; I was dissatisfied with my health plan's medical provider because; and I was dissatisfied with my health plan's dental provider because. Each composite includes specific statements relating to the topic. It is expected the survey results will be integrated with other MCO quality information to guide improvement of care and services. DHS uses this information and other quality indicators to monitor the performance of MCOs, ensure the health of enrollee and that purchased services meet the needs of public program enrollees. DHS' expectation is that statewide change rates will vary over time, but remain below a 5% threshold.

2.3 Integration of the Quality Improvement Strategy

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

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

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

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

2.4 Plan for Analysis

A simple and straightforward comparison of the selected HEDIS 2010 performance measures will be made between the waiver populations and other public program managed care enrollees demonstrating the ongoing improvement in care for all publicly funded program enrollees. Performance measurement rates for the baseline period (CYs 2005 through 2007) will be calculated for the targeted populations and compared to the first two calendar years (CYs 2008 and 2009) of the waiver period. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass data to compare performance of Minnesota's waiver and the entire public programs populations (PMAP and MinnesotaCare population's) performance measurement rates.

To demonstrate continued satisfaction with program level care and services a review of historical and evaluation period satisfaction information will be undertaken with two surveys. 1) CAHPS program level composite responses will be used to assess the

domains of enrollee experiences. 2) The DHS conducted "Voluntary Changes in MCO Enrollment Survey" or disenrollment survey will be reviewed and assessed as an indicator of ongoing enrollee satisfaction.

Performance measurement rates will be presented in a series of tables to analyze and compare performance similar to the table below:

Childhood Prevention	**Waiver Population**	**PMAP**	**MinnesotaCare**	**National Medicaid**
Child Immunizations				
CY 2005				
CY 2006				
CY 2007				
CY 2008				
CY 2009				

2.5 Limitations and Opportunities

The following limitations may impact the results of this evaluation:

- Unexpected consequences due to changes in state law regarding public programs.
- Future changes to HEDIS Technical Specifications influence future coding or data reporting that would bias this type of longitudinal analysis. If these types of changes occur the biases and potential consequences will be reported in the final report limitation section.
- Measures with high rates may show only small changes or remain stable over time.
- The HEDIS Technical Specification criteria of continuous enrollment, while reducing the population included in the measure offers a simple methodological adjustment that allows a straightforward comparison. The HEDIS methodology is critical for the evaluation's longitudinal design, providing the opportunity to retrospectively identify factors that may seem insignificant, but became important with the passage of time. These types of relationships will be considered during the analysis to provide a deeper understanding of the motivational forces behind the complex relationships of how enrollees utilize and value prevention and chronic health care services.

2.6 Conclusion, Best Practices, and Recommendations

The final evaluation report will discuss the principle conclusions and lessons learned based upon the findings of the evaluation and current program and policy issues. The discussion will also include a review of any changes in enrollee satisfaction as measured by the annual CAHPS and Disenrollment surveys conducted before and during the waiver period. A discussion of recommendations for potential action to be taken by DHS to

improve health care services in terms of quality, access and timeliness will be provided for CMS and other states with similar demonstration waivers.

Section Three Evaluation Findings

3.1 Evaluation Analysis

As indicated in the Waiver Evaluation Plan, DHS has completed the data collection, calculated and reviewed 20 HEDIS based performance measurement rates for calendar years 2005 through 2009. The purpose in using the HEDIS performance measures is to compare, contrast and draw out differences between; 1) PMAP and MinnesotaCare children populations compared to national Medicaid rates, 2) adult waiver population, PMAP and MinnesotaCare adults, and 3) MinnesotaCare pregnant women. These comparisons and differences support the waiver hypothesis that providing health care coverage for parents and caretaker adults who would otherwise be uninsured will lead to three outcomes: 1) improved utilization of preventive and chronic disease care services, 2) improved physical and mental health; and 3) satisfaction of adults and their children.

Table A below lists the HEDIS 2010 performance measures extracted from DHS' managed care encounter database to evaluate childhood preventive care, adult chronic disease care management and care provided to pregnant women[3]

Table A: HEDIS Performance Measures[4]

Childhood Prevention (0-19 yrs.)
Childhood immunizations (2 yrs)
Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs)
Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs)
Well –child visits first 15months
Well-child visits 3 to 6 yrs
Adolescent well-care visits (12-19 yrs)
Adult Chronic Care Management (Parents of children)
Diabetes A1c screening
Diabetes LDL screening
Adult access preventive/ambulatory health services
Cervical Cancer screening
Pregnant Women Care
Postpartum Care

For the purpose of the waiver evaluation three public program population subgroups have been specified:

[3] The Childhood Immunization measures include data from a statewide immunization registry to augment DHS managed care encounters.
[4] All HEDIS measures are consistent with HEDIS 2010 Technical Specifications and annually audited by an independent certified HEDIS Auditor.

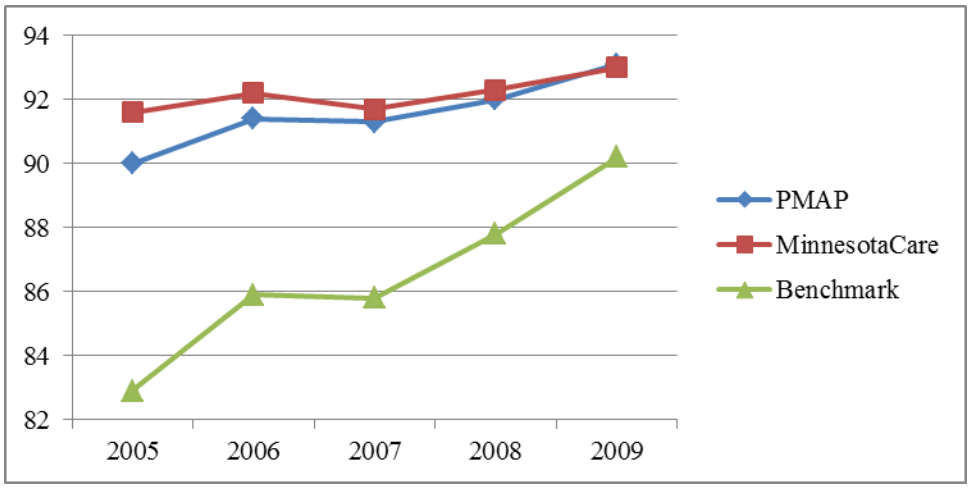
- Children age 0 to 19 years in MinnesotaCare with income at or below 275% FPG. Fourteen performance measures have been calculated and reviewed to identify improvements in care and services that have occurred since calendar year 2005.
- Parents (caretakers) with income at or below 275% FPG with children enrolled in MinnesotaCare or Medical Assistance. Five chronic care management performance measures have been calculated to assess care provided for the adult waiver population.
- Pregnant women enrolled in MinnesotaCare with income at or below 275% FPG. One performance measure has been calculated to evaluate care.

Appendix A: Tables 1-20 present HEDIS rates for the evaluation subgroups to demonstrate the ongoing improvement in the quality of care and support of the waiver hypothesis.

MinnesotaCare Children

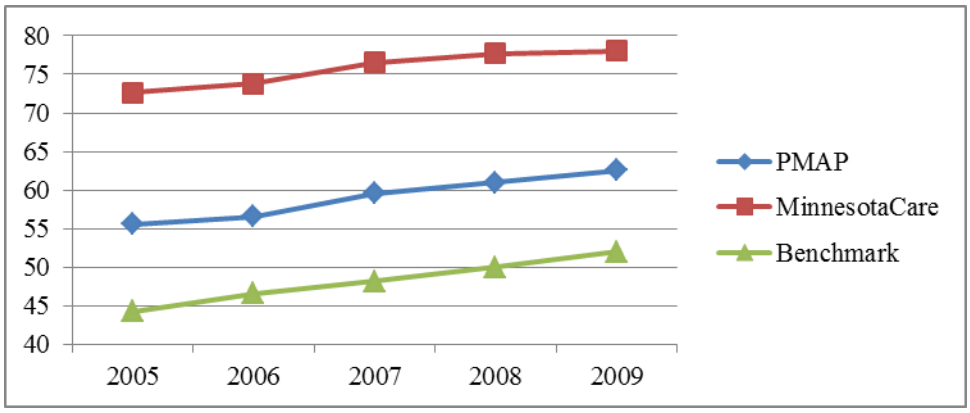
As demonstrated in Attachment A's Childhood Prevention Tables (1-14), the majority (9 out of 14) of PMAP and MinnesotaCare rates from calendar years 2005 through 2009 are above the national Medicaid average. These nine measures (child access and dental visits) confirm PMAP and MinnesotaCare children have significantly greater access to primary and dental care than the national benchmark. Graph 1 shows children in Minnesota's managed care public programs access primary care providers much more frequently than the national Medicaid average, with rates consistently above 90 percent.

Graph 1: Child Access to PCP 7-11 yrs.



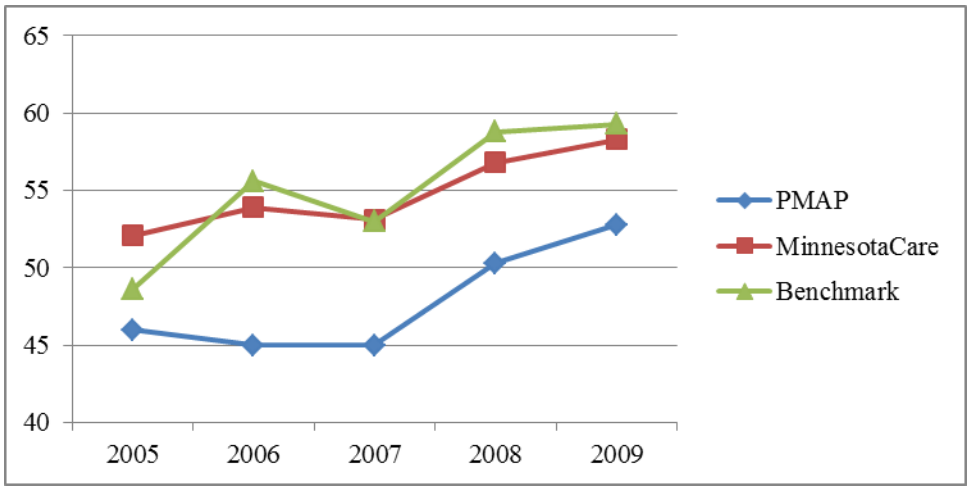
Graph 2 demonstrates that one of the strengths of Minnesota's managed care public programs is ensuring low-income children have greater access to dental care than other state Medicaid programs.

Graph 2: Annual Dental Visit 11-14 yrs.



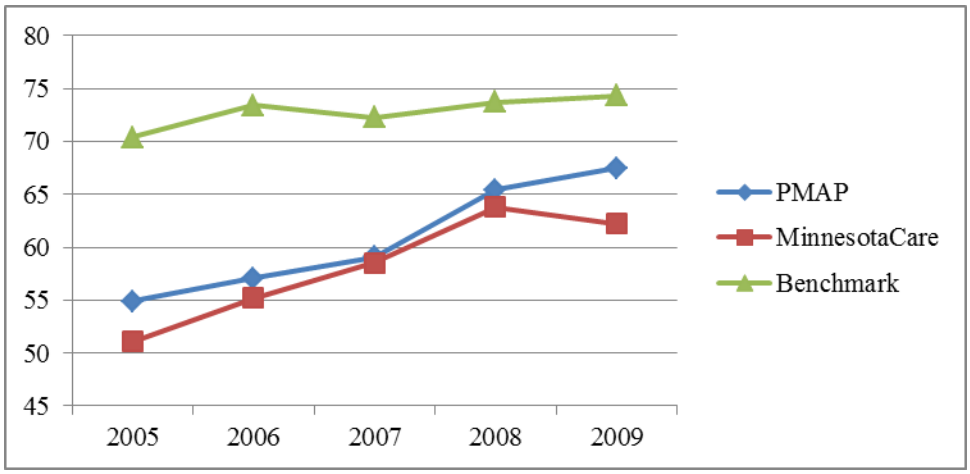
In addition, Graphs 2 and 3 point out the long standing recognition that PMAP and MinnesotaCare enrollees utilize services somewhat differently when measured by certain performance measures as seen in these two graphs.

Graph 3: Well-Child Visits First 15 Months (six or more visits)



All of the childhood measures confirm PMAP and MinnesotaCare rates have been increasing since 2005. Although children's rates have trended up over the past few years, as seen in Graph 4, there is a significant opportunity to improve immunization rates reducing the gap between these populations and the national Medicaid benchmark rates.

Graph 4: Childhood Immunizations (combo #2)



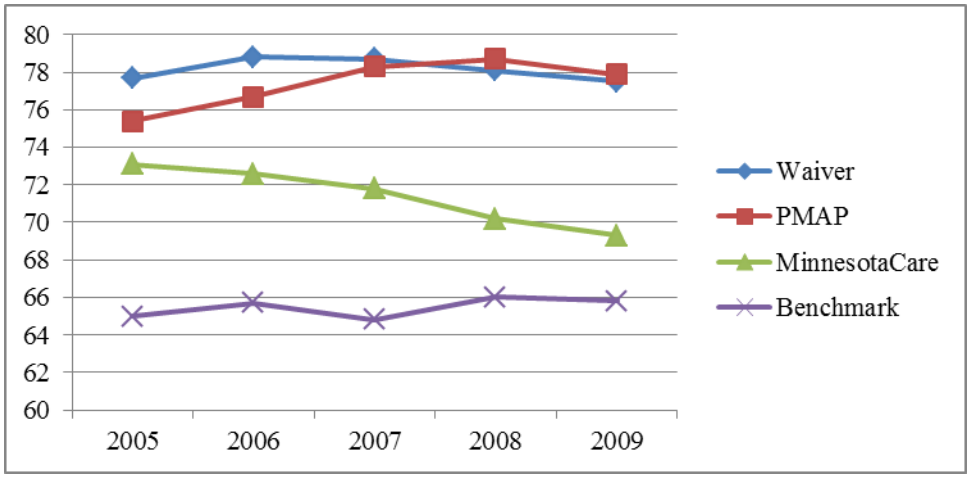
A very straightforward review of Appendix A: Tables 1-14 reveals the majority (9 of 14 measures) of the primary and dental care children's PMAP and MinnesotaCare rates have remained, across all age groups, higher than the national Medicaid average rates.[5] The remaining 5 measures (Immunizations and Well-child visits) provide confounding information in light of the high access to primary care providers.

Parents of MinnesotaCare Children (Waiver Population)

Minnesota's waiver evaluation hypothesis is that providing health care coverage for parents and caretaker adults who would otherwise be uninsured) will encourage appropriate access and utilization of health care services for themselves and their children resulting in improved health status. The Adult Chronic Care Management measurement results in Appendix A: Tables 15-19 demonstrate that for all five measures the waiver, PMAP and MinnesotaCare populations utilize services at a considerably higher rate than the national Medicaid benchmark rate.[6] Cervical Cancer Screening rates illustrated in Graph 5 below reveal that Minnesota's public program adult female population access these critical health status screenings at a higher frequency than the national Medicaid benchmark rate.

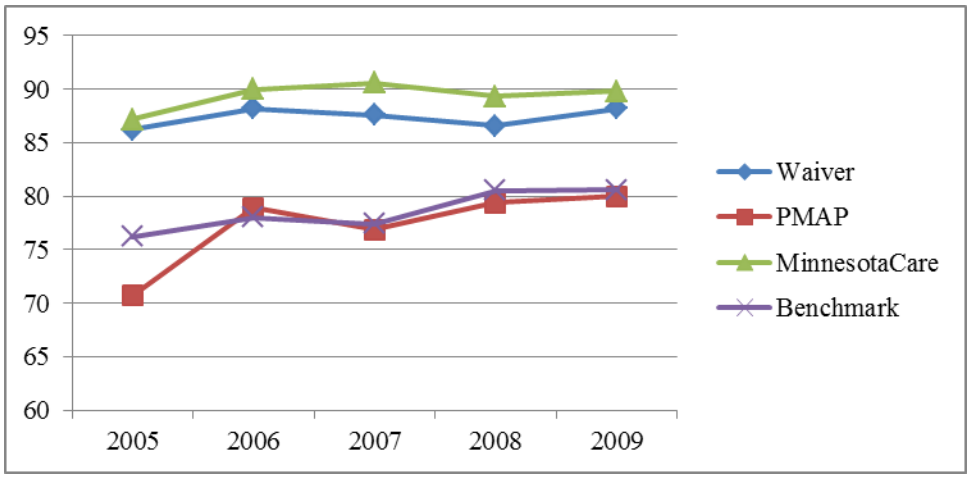
[5] Child access (12-24 mos.; 25mos.-6yrs; 7-11yrs; 12-19 yrs), Annual dental visit (2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14yrs; 15-18yrs)
[6] PMAP Diabetes LDL screening rates are the only exceptions with rates much lower than the benchmark.

Graph 5: Cervical Cancer Screening



An additional positive finding (Graph 6) is the fact the waiver diabetic population is accessing appropriate A1c and LDL screening tests that are essential in care management.

Graph 6: Diabetes A1c Screening

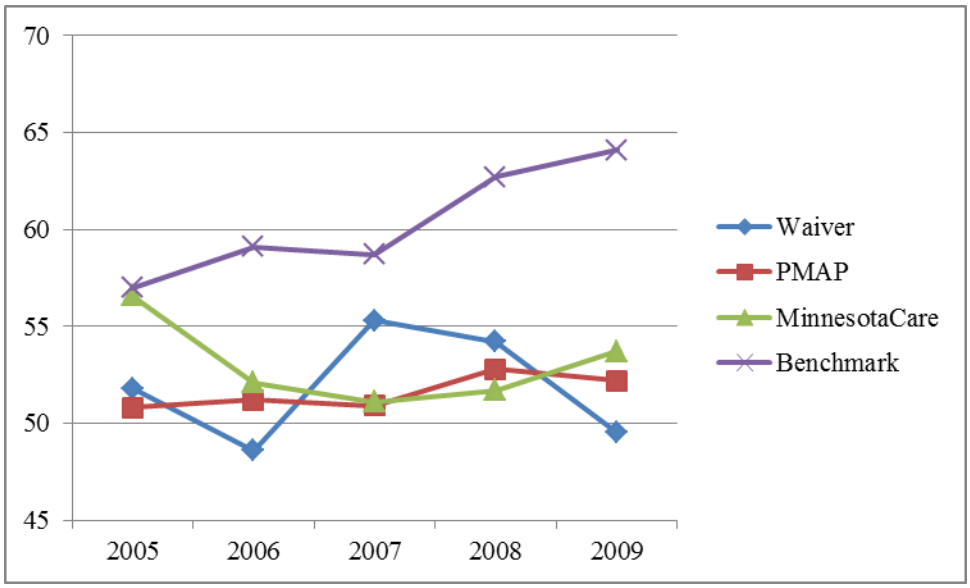


The five measures analyzed demonstrate waiver adults are accessing and receiving services consistent with the entire MinnesotaCare population and often at rates greater then all PMAP enrollees. When waiver adult rates are compared to the national Medicaid benchmark rates they are noticeably higher.

Pregnant Women Care

The Postpartum Care measure shows there has been no real change in the rates for MinnesotaCare pregnant women since calendar year 2005, although national Medicaid benchmark rates have improved.

Graph 7: Postpartum Care



3.2 Evaluation Analysis Summary

CAHPS survey results[7] illustrate over the waiver period that PMAP and MinnesotaCare enrollees have remained satisfied with "getting needed care" and "getting care quickly" at or above national Medicaid benchmark rates. Overall satisfaction information can also be gathered from DHS Disenrollment Survey of Voluntary Changes. DHS conducts monthly surveys of enrollees who voluntarily change from one MCO to another to identify reasons why enrollees switch between MCOs. Appendix A: Table #22 indicates the rate of voluntary changes have remained stable and well below the established five percent threshold.

All of the waiver adult HEDIS measures confirm the waiver has been effective. The waiver population is receiving appropriate adult health care services that they would otherwise not obtain.

[7] See Appendix A: Table 21.

Attachment E

Minnesota's PMAP+ 1115 Waiver Evaluation
Performance Measurement

Update

June 17, 2013

Evaluation Analysis Update – June 13, 2013

The PMAP and MinnesotaCare program rates for calendar years 2010 and 2011 have been calculated and are discussed in this update. One additional HEDIS measure, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) access/availability of care measure has been added to be more inclusive of the addition of the MA Expansion population.

As stated in previous Waiver Reports the purpose in using the HEDIS performance measures is to compare, contrast and draw out differences between PMAP and MinnesotaCare populations compared to National Medicaid rates. The following set of HEDIS performance measure data Tables (1-24) demonstrate the results of managed care ongoing quality improvement efforts in:

- The utilization of preventative and chronic disease care services,
- Physical and mental health, and
- Satisfaction of adults with contracted managed care health care services.

Summary of Comparison Population Results- Calendar Years 2010 through 2011

1. **PMAP and MinnesotaCare vs. National Medicaid Averages.** The first comparison is of how well Minnesota's public program enrollees are doing when compared to the National Medicaid average.
   a) As seen in the Childhood Prevention Tables (1-14), the majority (10 out of 14 measures) PMAP and MinnesotaCare measurement rates for calendar years 2010 and 2011 are above the National Medicaid averages.
   b) Likewise, 4 of the 6 Adult and Postpartum measures (Tables 15-20) were above the Medicaid average. However one, the PMAP and MinnesotaCare postpartum measures are lower than the National Medicaid averages.
   c) PMAP and MinnesotaCare satisfaction rates have remained unchanged but below the national rates for calendar years 2010 and 2011.

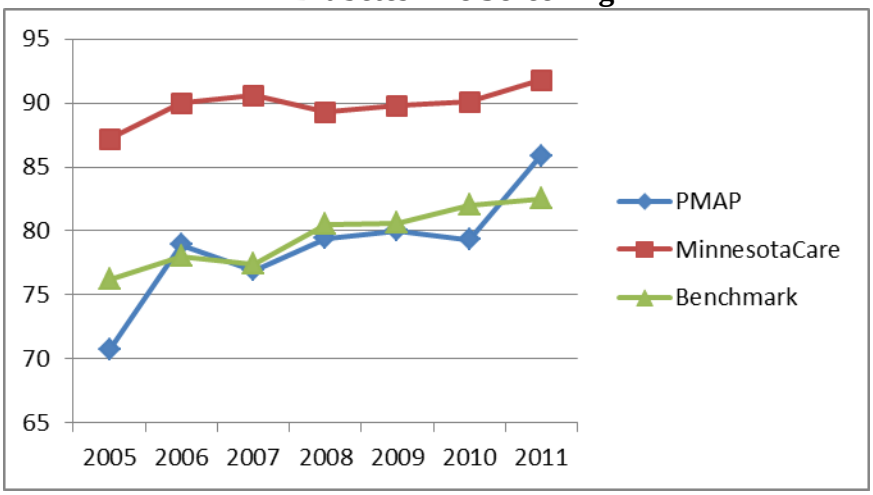
2. **PMAP vs. MinnesotaCare.** It has been a general understanding, PMAP and MinnesotaCare enrollees utilize services somewhat differently when measured by certain performance measures. It is important to recognize these differences and acknowledge these two sub-populations may utilize certain services differently.

   a) Of the 14 Childhood Prevention measures, nine of the average individual measurement rates were approximately the same for both sub-populations. The other nine MinnesotaCare rates were higher than the PMAP rates. It is interesting to note, that in four of the five dental visit

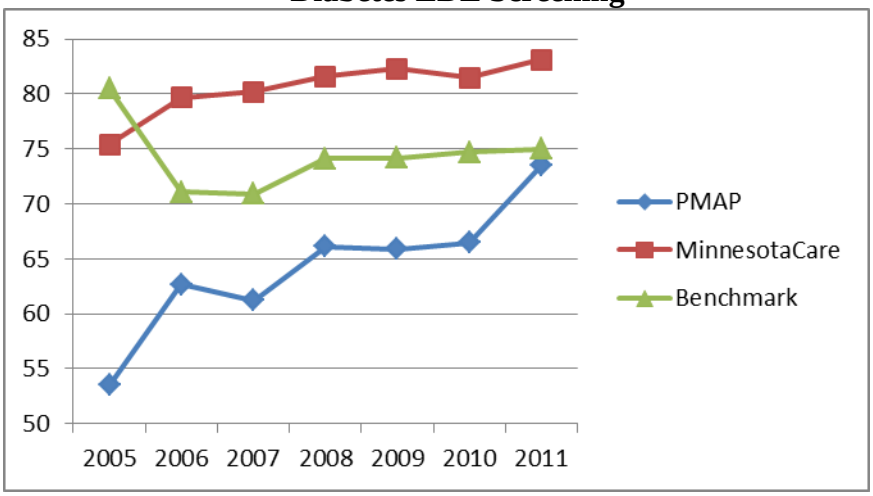
measures and the Well-child 15 months MinnesotaCare measures were higher than so for the PMAP populations.

b) The Adult measures demonstrated fewer differences between PMAP and MinnesotaCare rates then seen in the children's measures. But, MinnesotaCare Diabetes screening rates (A1c and LDLs) were appreciably higher than the rates achieved for the PMAP populations over a longer time period (since 2005) as seen the graphs. Pointing out that if these two public program populations difference are not considered, combining these sub-populations could lead to erroneous utilization conclusions.

Diabetes A1c Screening



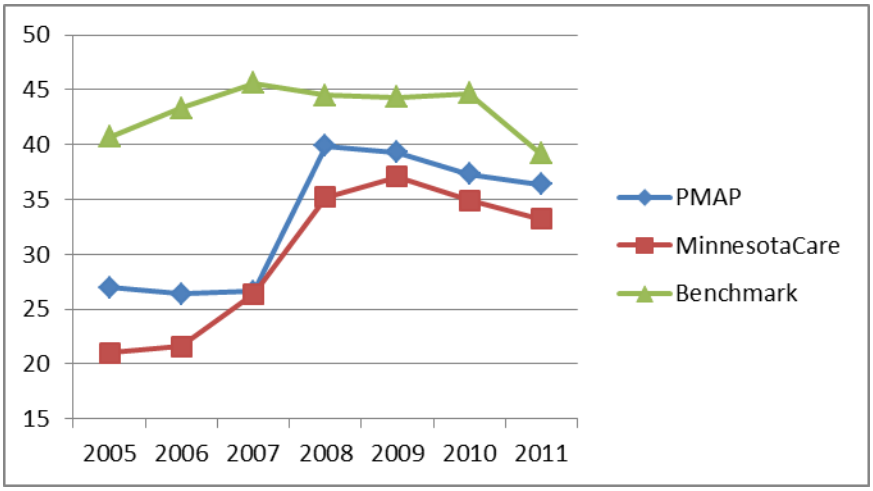
Diabetes LDL Screening



c) PMAP and MinnesotaCare satisfaction rates have not changed much, but there is a slight indication that MinnesotaCare may be somewhat more satisfied with managed care services. The higher MinnesotaCare disenrollment rates reflect the structural auto-assignment process in the MinnesotaCare program.

4. **IET HEDIS Measure**. Alcohol and drug dependence is a health care issue that important to publicly funded managed care enrollees. PMAP and MinnesotaCare initiation rates are below the national Medicaid average, but for engagement of treatment is approximately the same as the national average. As indicated in both measures, PMAP and MinnesotaCare rate have been steadily increasing since calendar year 2005 as seen in the graphs below.

IET Initiation



IET Engagement

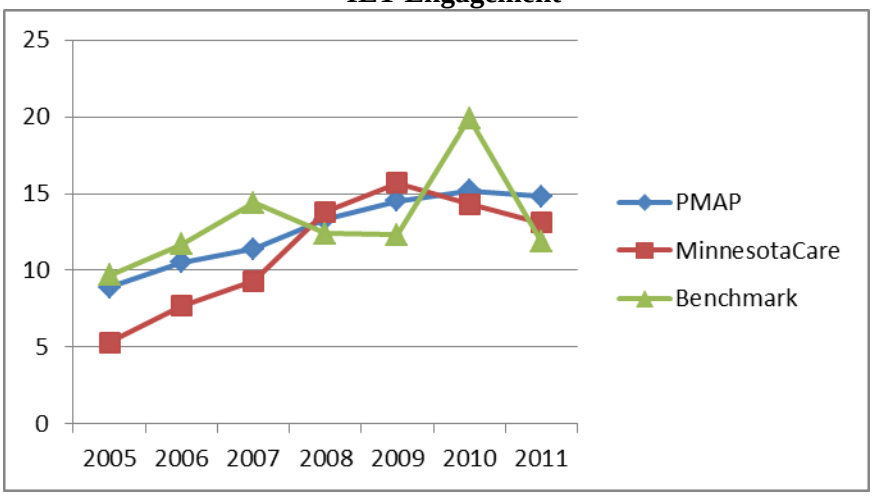


Table # 1

Childhood Immunizations (2 yrs) Combo 2	PMAP	MinnesotaCare	National Medicaid
CY 2010	63.8	62.8	74.1
CY 2011	71.5	61.9	74.5

Table # 2

Childhood Immunizations (2 yrs) Combo 3	PMAP	MinnesotaCare	National Medicaid
CY 2010	61.2	61.1	69.7
CY 2011	68.1	58.8	70.6

Table # 3

Child Access to PCP (12-24 mos)	PMAP	MinnesotaCare	National Medicaid
CY 2010	98.7	98.7	96.1
CY 2011	98.8	98.0	96.1

Table # 4

Child Access to PCP (25 mos-6 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	92.7	92.7	88.3
CY 2011	92.6	93.0	88.2

Table # 5

Child Access to PCP (7-11 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	93.4	93.4	90.2
CY 2011	92.9	93.7	89.5

Table # 6

Child Access to PCP (12-19 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	93.4	94.3	88.1
CY 2011	93.1	94.3	87.9

Table # 7

Annual Dental Visit (2-3 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	33.6	34.5	30.9
CY 2011	33.7	35.4	31.3

Table # 8

Annual Dental Visit (4-6 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	65.4	72.6	54.4
CY 2011	64.6	71.8	53.3

Table # 9

Annual Dental Visit (7-10 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	67.7	81.5	58.5
CY 2011	66.4	80.0	57.3

Table # 10

Annual Dental Visit (11-14 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	62.6	77.9	53.3
CY 2011	61.4	76.1	51.8

Table # 11

Annual Dental Visit (15-18 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	56.3	68.9	44.9
CY 2011	53.5	66.7	44.0

Table # 12

Well-Child Visit (first 15 months) six or more visits	PMAP	MinnesotaCare	National Medicaid
CY 2010	59.4	64.2	60.2
CY 2011	63.2	69.0	61.8

Table # 13

Well-Child Visit (3-6 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	66.1	66.0	71.9
CY 2011	64.9	65.9	72.0

Table # 14

Adolescent Well-Care Visits (12-19 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2010	36.2	33.5	48.1
CY 2011	34.5	32.7	49.7

Table # 15

Diabetes A1c Screening	PMAP	MinnesotaCare	National Medicaid
CY 2010	79.3	90.1	82.0
CY 2011	85.9	91.8	82.5

Table # 16

Diabetes LDL Screening	PMAP	MinnesotaCare	National Medicaid
CY 2010	66.5	81.5	74.7
CY 2011	73.5	83.1	75.0

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Table # 17

Adult Access Preventive/ Ambulatory Health Services (20-44)	PMAP	MinnesotaCare	National Medicaid
CY 2010	91.4	87.1	81.2
CY 2011	89.9	88.0	80.0

Table # 18

Adult Access Preventive/ Ambulatory Health Service (45-64)	PMAP	MinnesotaCare	National Medicaid
CY 2010	91.4	90.2	86.0
CY 2011	90.3	91.0	86.1

Table # 19

Cervical CA Screening	PMAP	MinnesotaCare	National Medicaid
CY 2010	78.2	67.9	67.2
CY 2011	74.4	68.1	66.7

Table # 20

Postpartum Care	PMAP	MinnesotaCare	National Medicaid
CY 2010	52.3	52.4	64.4
CY 2011	48.0	36.9	64.1

Table # 21

CAHPS Survey Composites (always)	PMAP	MinnesotaCare	National Medicaid
CY 2010 Getting Needed Care	50.6	59.9	74.9
Getting Care Quickly	52.5	59.8	79.4
CY 2011 Getting Needed Care	54.1	62.7	76.0
Getting Care Quickly	55.6	58.9	80.6

Table # 22

Disenrollment Survey Voluntary Change Rate	PMAP	MinnesotaCare
CY 2010	0.8	3.2
CY 2011	0.9	2.9

Table # 23

Initiation of Alcohol and other Drug Dependence Treatment (13-64 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2005	27.0	21.0	40.7
CY 2006	26.4	21.6	43.3
CY 2007	26.6	26.4	45.6
CY 2008	39.9	35.2	44.5
CY 2009	39.3	37.1	44.3
CY 2010	37.3	34.9	44.7
CY 2011	36.4	33.2	39.2

Table # 24

Engagement of Alcohol and other Drug Dependence Treatment (13-64 yrs)	PMAP	MinnesotaCare	National Medicaid
CY 2005	8.9	5.3	9.7
CY 2006	10.5	7.7	11.7
CY 2007	11.4	9.3	14.4
CY 2008	13.3	13.8	12.4
CY 2009	14.5	15.7	12.3
CY 2010	15.2	14.3	19.9
CY 2011	14.8	13.1	11.9

Department of Human Services

Health Care Administration

Request for Comments on the Prepaid Medical Assistance Project Plus Section 1115 Medicaid Waiver Renewal Request

DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request. Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver provides federal matching funds for Medical Assistance and MinnesotaCare. This allows the state to provide federally-funded health coverage to people who would not otherwise have been eligible. The current waiver ends December 31, 2013.

In December of 2012, DHS submitted a letter to the federal government requesting a renewal of the PMAP+ waiver. DHS now intends to submit a second, more detailed request to extend the PMAP+ waiver. This request reflects changes enacted by the 2013 Minnesota Legislature. The PMAP+ waiver extension request includes an expansion of Medical Assistance and changes to MinnesotaCare to align the program with the requirements for a Basic Health Plan under the Affordable Care Act.

A copy of the waiver renewal request can be found at http://www.dhs.state.mn.us/dhs16_171635. To request a paper copy of the waiver request, please contact Quitina Cook at (651) 431-2191.

Written comments may be submitted to the following email mailbox: Section1115WaiverComments@state.mn.us or by mail to the address below. DHS would like to provide copies of comments received in a format that is accessible for people with disabilities. Therefore, we request that comments be submitted in Microsoft Word format or incorporated

within the email text. If you would also like to provide a signed copy of the comment letter, you may submit a second copy in Adobe PDF format or mail it to the address below. Comments must be received by July 24, 2013.

Carol Backstrom
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

In addition to the opportunity to submit written comments during the 30-day public comment period, public hearings will be held to provide stakeholders and other interested persons the opportunity to comment on the waiver request. You may attend either hearing by phone or in person. If you would like to attend by phone, please send an email request to Section1115WaiverComments@state.mn.us to obtain the call-in information. If you would like to attend a hearing in person, the time and location for the two public hearings are provided below. If you plan to testify by phone or in person, please send an email to Section1115WaiverComments@state.mn.us indicating that you will testify.

Public Hearing #1
Date: Monday, July 8, 2012
Time: 9:00 a.m. – 12:00 p.m.
Location: DHS, Elmer L. Andersen Human Services Building, Room 2370, 540 Cedar St. St. Paul, MN 55164

Public Hearing #2
Date: Monday, July 15, 2012
Time: 9:00 a.m. – 12:00 p.m.
Location: Metropolitan Mosquito Control, Room 205, 2099 University Avenue, St. Paul, MN 55104

PMAP+ Waiver Extension
Stakeholder Email List

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gbork@co.carver.mn.us
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dheywood@co.carver.mn.us
reno.wells@co.cass.mn.us
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srynda@co.le-sueur.mn.us
chris.kujava@co.marshall.mn.us
gary.sprynczynatyk@co.mcleod.mn.us
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robert.cornelius@co.mille-lacs.mn.us
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Attachment H

Medicaid Tribal Consultation Process

May 2010

DHS will designate a staff person in the Medicaid 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.

- Tribal staff will keep the liaison updated 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 60 days prior to the anticipated submission date. When a 60-day notice is not possible, the longest practicable 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.

- Liaison will forward all comments received from Tribes to appropriate State policy staff for their response.

- Liaison will be responsible for insuring that all comments receive 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.

- 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.

Minnesota Department of **Human Services**

Attachment I

October 29, 2012

Re: Upcoming Medicaid Waiver Submissions

Dear Tribal Leader:

As you know, Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver provides federal matching funds for Medical Assistance (MA) and MinnesotaCare services to people who would not otherwise have been eligible. Minnesota has a second Section 1115 Medicaid waiver that authorizes the Minnesota Family Planning Program (MFPP). MFPP is about to enter its seventh year of operation. It provides a family planning benefit to people with incomes up to 200 percent of the federal poverty level.

Both waivers are currently approved until December 31, 2013. Generally, a request for extension must be submitted at least a year in advance. This letter is to notify you that the Minnesota Department of Human Services intends to submit requests to extend the PMAP+ and Family Planning waivers by December 31, 2012 to meet the federal deadline. Notice will be posted in the *Minnesota State Register* and will provide additional information regarding the proposed extension and the public input process. The waiver extension requests will reflect current state law. The Minnesota Department of Human Services may amend the waiver extension requests at the end of the upcoming legislative session, which is expected to focus on health care reform this session.

If you have any questions about these waiver amendments, you may contact Jan Kooistra (651-431-2188 or jan.kooistra@state.mn.us) or Kathleen Vanderwall (651-282-3720 or kathleen.vanderwall@state.mn.us), who are members of my staff.

Sincerely,

/s/

Kathleen Vanderwall
Medicaid Tribal Liaison

Minnesota Department of **Human Services**

Attachment J

April 22, 2013

Re: Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver Extension Request

Dear Tribal Leader:

As you know, Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver provides federal matching funds for Medical Assistance (MA) and MinnesotaCare. This allows the state to provide federally-funded health coverage to people who would not otherwise have been eligible. The current waiver ends December 31, 2013.

In December of 2012, DHS submitted a letter to the federal government requesting a renewal of the PMAP+ waiver. This letter is to notify you that DHS now intends to submit a second, more detailed request to extend the PMAP+ waiver. This request will reflect final legislation that has not yet been enacted. The PMAP+ waiver renewal request is expected to reflect an expansion of Medical Assistance and changes to MinnesotaCare to align the program with the requirements for a Basic Health Plan under the Affordable Care Act. Following is a summary of various bills currently under review. Program details are anticipated to change through the legislative process.

Medical Assistance

In February, state law was changed to expand Medical Assistance income standards to 133% of the federal poverty guidelines for adults and children ages 19-20, effective January 1, 2014. Additional proposals are pending to increase MA income standards for children under age 19 to 275% of the poverty level. Most children now covered under MinnesotaCare may be covered under Medical Assistance.

MinnesotaCare

The PMAP+ waiver renewal request is expected to seek more generous coverage than is currently provided to MinnesotaCare enrollees. Groups covered under the waiver will likely include adults with incomes above the Medical Assistance income standard. People with incomes above MinnesotaCare income limits may apply for advance premium tax credits and cost-sharing reductions through the Health Insurance Exchange.

DHS plans to submit the formal request to renew the PMAP+ waiver to the federal Centers for Medicare & Medicaid Services (CMS) by the end of June 2013. In the next few weeks, additional information regarding the proposed extension and the public input process will be posted in the *Minnesota State Register* and on the DHS web site. We invite you to comment on the proposed waiver renewal.

If you have any questions about the waiver renewal, please contact Gretchen Ulbee at (651) 431-2192 or Gretchen.Ulbee@state.mn.us). Thank you.

Sincerely,

Kathleen Vanderwall
Medicaid Tribal Liaison

Attachment K

Narrative Summary of Changes Requested

A number of changes have been made to the PMAP+ waiver proposal to reflect legislative changes in Minnesota's publicly funded health care programs. Below is a list of changes, the reasons for the changes, and page references to the main waiver document.

- **A "bright line" between MinnesotaCare and Medical Assistance or MA.** People who are eligible for MA must enroll in MA rather than MinnesotaCare. This ensures that people who are eligible for MA receive the most generous coverage they are entitled to receive. **Pages 7, 28**
- **Different MinnesotaCare eligibility groups.** With more generous eligibility standards for Medical Assistance in 2014, MinnesotaCare coverage is no longer needed for certain groups, so groups have changed to align with MA. **Pages 4-8, 28**
    - MinnesotaCare will no longer cover adults, parents and 19-20 year olds with incomes below 133% of the FPL because these groups will enroll in MA. Today adults, parents and 19-20 year olds may be eligible for MA if they have family incomes at or below 100% of the Federal Poverty Level or FPL. In 2014, this will expand to 133% of the FPL.
    - Pregnant women and children under age 19 with family incomes at or below 275% of the FPL will be enrolled in MA going forward. Certain children under age 19 may enroll in MinnesotaCare if they are ineligible for MA but they have family incomes at or below 200% FPL using Basic Health Plan household composition rules.
- **Coverage up to 200% FPL for adults and 19-20 year olds.** MinnesotaCare will cover parents, adults and 19-20 year olds with family incomes up to 200% FPL instead of 250% or 275% FPL to align eligibility standards with requirements in the Affordable Care Act for Basic Health Plans. This change will make it easier for people to transition to a Basic Health Plan in 2015. Healthy Minnesota Contribution is repealed. **Pages 4-8, 28**
- **More generous benefits for adults in MinnesotaCare.** MinnesotaCare benefits are increased to conform to benefits requirements in the Affordable Care Act. This change will make it easier for Minnesota to transition to a Basic Health Plan in 2015. (As before, enrollees under age 21 receive the full MA benefit set and pay only MA copays).
    - Benefits: For adults without children, the $10,000 cap on inpatient hospital services is eliminated. **Page 11**
    - Cost-sharing: For adults without children, the 10% co-pay on inpatient hospital services is eliminated. **Pages 13-14**
- **Reduced premiums.** Adults in MinnesotaCare will pay premiums that range from $4-$50 per individual. Enrollees under age 21 pay no premium. **Page 12**

- **Modified eligibility standards and processes.** MinnesotaCare eligibility rules are changed to align with requirements in the Affordable Care Act for Basic Health Plans and tax credit rules. This change will make it easier for MinnesotaCare enrollees to transition to coverage under the Basic Health Plan in 2015.
    - MinnesotaCare will no longer have an asset test. **Pages 7, 28**
    - MinnesotaCare will use the Affordable Care Act income calculation methods to determine eligibility**. Pages 4-8, 29**
    - The 4-month and 18-month eligibility waiting periods are eliminated. **Pages 7-8**
    - MinnesotaCare coverage may begin while an individual is hospitalized. **Page 8**
    - Incarcerated individuals are not eligible for MinnesotaCare unless they are awaiting disposition of charges. **Pages 4-8, 29**
    - Individuals who are eligible for minimum essential coverage as defined by the Affordable Care Act are not eligible for MinnesotaCare. **Page 7**
    - Eligibility for certain special populations (volunteer firefighters, former foster care children) is eliminated. (Former foster care children are covered under MA). **Pages 4-8, 12, 28**
    - Sponsor deeming requirements are eliminated. **Pages 7, 29**
    - Applications may be submitted by phone, mail, in person, and electronically. **Pages 4-8**

- **New MinnesotaCare eligibility.** MinnesotaCare eligibility is expanded to include groups that will be covered by Basic Health Plan in 2015. This change will make it easier for MinnesotaCare enrollees to transition to coverage under the Basic Health Plan in 2015.
    - MinnesotaCare will expand to provide coverage for children under 19 who are not eligible for MA under MA household composition rules but who have family incomes at or below 200% FPL using Basic Health Plan household composition rules. **Pages 4-7, 29**
    - Minnesota seeks federal matching funds for lawfully present noncitizen adults who are ineligible for MA because of immigration status with family incomes at or below 200% FPL. Children in this group are covered under MA. **Pages 5-6, 29**

- **Definition of Caretaker Relative for MA.** New authority is requested to define a caretaker relative in MA as a person assuming responsibility for and living with a related child under 19. This allows the caretaker relative to be considered a family member as long as the child is under age 19 instead of 18. The desired outcome is to make the definition of caretaker more consistent with federal regulations defining eligible children and stabilize eligibility of families for an additional year. **Page 7**

Attachment L

July 19, 2013

Ms. Carol Backstrom
Medicaid Director
Minnesota Department of Human Services
P. O. Box 64998
St. Paul, MN 55164

Re: Request for Comments on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid Waiver Renewal Request

Dear Ms. Backstrom:

Key to UCare's mission is improving the health of our members through innovative services, and we focus on what best supports individuals who need health care and other home and community-based services. As a managed organization dedicated to ensuring Minnesotans receive necessary Medicaid and MinnesotaCare services, UCare supports an extension of the Department's PMAP+ §1115 waiver renewal request.

The waiver renewal incorporates Medicaid and MinnesotaCare changes required by the 2013 Minnesota Legislature, including Medicaid expansion and more generous MinnesotaCare benefits for adults, and appropriately paves the way for MinnesotaCare to become a Basic Health Program in the future. We believe renewal of the PMAP+ waiver will provide children, adults, and families comprehensive coverage and the benefits of coordinated care now and into the future.

Thank you for this opportunity to comment on the waiver renewal. We look forward to continuing to serve Minnesota's Medicaid and MinnesotaCare beneficiaries.

Sincerely,

Ghita Worcester
Senior VP, Public Affairs and Marketing
UCare