Attachment G

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

Evaluation Plan 2015 to 2020

1. Introduction

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

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

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

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

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

- Preserving eligibility methods currently in use for children ages 12 through 23 months;
- Simplifying the definition of a parent or caretaker relative to include people caring for children under age 19

- Providing full MA benefits for pregnant women during the period of presumptive eligibility;
- Payments for graduate medical education costs through the MERC fund.

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

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

Caretaker Adults with 18-Year-Old
The PMAP+ waiver provides expenditure authority for Medicaid coverage for Caretaker Adults who live with and assume responsibility for a youngest or only child who is age 18 and is not enrolled full time in secondary school. PMAP+ waiver authority allows Minnesota to waive the requirement to track the full-time student status of children age 18 living with a caretaker Beginning in 2014, Minnesota covers both adults without children and caretaker adults to 133% of the FPL under the state plan. Adults without children and caretaker adults are eligible for the full MA benefit set. Without waiver authority, a caretaker adult with a youngest child or only child turning 18 would need to be re-determined under an "adult without children" basis of eligibility. This exercise is meaningless because Minnesota covers adults and parents to the same income level. Health care coverage and cost sharing are the same.

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

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

Pregnant Women
The Patient Protection and Affordable Care Act (ACA) established the hospital presumptive eligibility (PE) program effective January 2014 allowing qualified hospitals to make MA eligibility determinations for people who meet basic criteria. Under hospital PE, covered benefits for pregnant women during a presumptive eligibility period are limited to ambulatory prenatal care. Minnesota has secured PMAP+ waiver authority to allow pregnant women to receive

services during a presumptive eligibility period that are in addition to ambulatory prenatal care services. The benefit for pregnant women during a hospital presumptive eligibility period will be the full benefit set that is available to qualified pregnant women in accordance with section 1902(a)(10)(i)(III) of the Act. Implementation of presumptive eligibility began in July 2014.

5. Hypotheses, Research Questions and Evaluation Metrics

5.1 MA One-Year-Olds

Goal/Objective

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

Research Question

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

Hypothesis

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

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
1. Did the MA one-year-old child population experience comparable utilization of preventative and chronic disease services, when compared to national Medicaid averages?	Children 12-24 months who are enrolled in Medicaid in the United States.	a) Childhood immunization status (2 yr) b) Well-child visits (first 15 months) c) Child access to primary care practitioners (ages 12-24 mo.s)	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the MA one-year-old child population compared to other children enrolled in public health care programs. A comparison and stratification of the selected HEDIS 2016 and other performance measures will be made between the MA one-year-old population and the Medicaid national child (12-24

months) population to show the ongoing improvement in care for children enrolled in Medicaid in Minnesota.

5.2 Medicaid Caretaker Adults with 18 –Year- Old

Goal/Objective

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

Research Questions

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

Hypothesis

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

Research Question(s)	Comparison Population(s)	Measures	Measurement Years (MY)/ Reference Years (RY)	Data Source(s)
1. Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota?	a) MA parents b) MA adults without children	For both comparison populations, the following measures will be used: a) Annual dental visit b) Cervical cancer screening c) Comprehensive diabetes care d) Follow-up after hospitalization for mental illness e) Medication	MY 2016-2020 RY 2014-2015	MMIS claims data

		management for people with asthma f) Access preventative/ambulatory health services		
2. Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to national Medicaid averages (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?	a) Other adults enrolled in MA in the United States	a) Cervical cancer screening b) Comprehensive diabetes care c) Follow-up after hospitalization for mental illness d) Medication management for people with asthma e) Access preventative/ambulatory health services	MY 2016-2020 RY 2014-2015	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the MA caretaker adult waiver population compared to other adults enrolled in public health care programs. A comparison and stratification of the selected HEDIS 2016 and other performance measures will be made between the waiver population and two separate populations (i.e. other adults enrolled in MA in Minnesota and national averages for adults enrolled in Medicaid) to show the ongoing improvement in care for MA caretaker adults in Minnesota.

5.3 Medical Education and Research Costs (MERC) Trust Fund

Goal/Objective

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

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

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

Hypothesis A

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

Research Questions

1. Were the number of subsidized training slots for graduate medical education maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?
2. How did the MERC fund grantees use the payments?

Hypothesis A

Research Question(s)	Comparison Population(s)	Measures	Comparison Years[1]	Data Source(s)
1. Were the number of subsidized training slots maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?[2]	a. **Rural:** Number of subsidized training slots in rural areas of the state for Demonstration Year (DY) 19[3] and DY 20[4].	a. **Rural**: Compare the number of subsidized training slots in rural Minnesota for years 2016 through 2020 to the number of subsidized training slots in rural	MY 2016-2020 RY 2014- 2015	MERC Program data

[1] Comparison Years are based on State Fiscal Years.
[2] Urban areas of the state include the seven-county metro area which includes the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Washington and Scott. The rural areas of the state include the remaining 80 counties in Minnesota.
[3] PMAP demonstration year 19 covers the period of July 1, 2013 through June 30, 2014.

	b. **Urban:** Number of subsidized training slots in urban areas of the state for DY 19 and DY 20.	Minnesota for DY 19 and DY 20. b. **Urban**: Compare the number of subsidized training slots in urban areas of the state for the current waiver period to the number of subsidized training slots in urban areas of the state in DY 19 and DY 20.		
2. How did the MERC-funded grantees use the payments?	N/A	Of the total grant distribution for years 2016 through 2020, identify the percentage of funds that were used to support training in the following health professions: a. Medical training (physicians) b. Dental providers (including dental therapists) c. Psychologists d. Pharmacists e. Community Paramedics f. Other health professionals	MY 2016-2020	MERC Program Data

Hypothesis B

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

Research Question

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

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

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

Hypothesis B

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

Statistical Methods

The evaluation will use MERC program data to compare the annual number of subsidized training slots in rural and urban areas of the state across the two waiver periods. Grant fund distributions will be analyzed to determine utilization rates across health professions. The evaluation will use appropriate statistical analysis to compare differences in provider ratios between rural and urban areas. Additional analysis will evaluate provider to beneficiary ratios within geographical regions of the state to determine if MERC has impacted ratios between the two waiver periods.

5.4 Pregnant Women in a Presumptive Eligibility Period

Goal/Objective

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

Research Question

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

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

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the waiver population compared to national averages. A comparison and stratification of the selected HEDIS 2016 and other performance measures will be made between the waiver population and national Medicaid averages for pregnant women to show the ongoing improvement in care for pregnant women enrolled in MA in Minnesota. Minnesota Managed Care HEDIS Hybrid data will also be utilized to determine differences in administrative versus hybrid rates for this measure.

6. Qualifications of Staff Conducting Evaluation

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

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

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

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

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

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

7. Evaluation Implementation Strategy and Timeline

Waiver Populations under Sections 5.1, 5.2, and 5.4

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

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

Below is an overview of evaluation activities and timelines:

August 2020: DHS will calculate measurement rates for baseline goals.
September-October 2020: DHS will calculate and stratify HEDIS 2015-2019 performance measures.
October 2021: HEDIS results will be reviewed and evaluated.
November-December 2021: Draft final waiver report is written, reviewed and submitted to CMS.
March 2022: CMS submits feedback to DHS.
May 2022: DHS incorporates CMS feedback. Final report is submitted to CMS.

Waiver Authority under Sections 5.3

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