Minnesota Prepaid Medical Assistance Project Plus (PMAP+)
§1115 Waiver No. 11-W-0039/5

Demonstration Year 20
First Quarter Report
July 1, 2014 through September 30, 2014

Submitted to:

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

Submitted by:

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State of Minnesota
Department of Human Services

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Appendices

FORWARD

As required by the terms and conditions approving §1115(a) waiver No. 11 -W-00039/5, entitled "Minnesota Prepaid Medical Assistance Project Plus (PMAP+)," this document is submitted to the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services as the first quarter report for the period of July 1, 2014 through September 30, 2014. This document provides an update on the status of the implementation of the PMAP + Project.

1. Overview

The PMAP+ waiver was scheduled to expire on December 31, 2013. On December 20, 2013 CMS granted a one-year extension of Minnesota's PMAP+ waiver for the period January 1, 2014 through December 31, 2014. This extension ensured the continued provision of services to Minnesota residents with incomes at or below 200 percent FPL in order to not disrupt such coverage as the state prepares a request for a Basic Health Plan (BHP). Minnesota will continue to receive financial participation for the program at the state's regular federal medical assistance percentage (FMAP) during the extension period which will expire December 31, 2014.

The waiver extension reflects changes to MinnesotaCare that were necessary due to modifications to Minnesota's Medical Assistance program and changes to MinnesotaCare to align the program with the requirements for a BHP under the ACA. The temporary extension allows the PMAP+ waiver demonstration to serve as a bridge to a BHP in 2015 and to coordinate with the expanded Medicaid state plan and MNsure, Minnesota's new health insurance exchange, in accordance with the Affordable Care Act. The MinnesotaCare program will continue on as a BHP effective January 1, 2015.

1.1 Changes Effective January 1, 2014

With the expansion of Medicaid eligibility under the ACA, the following MinnesotaCare beneficiaries became eligible for Medical Assistance beginning January 1, 2014:

- Children under age 19 with incomes at or below 275 percent of the FPL
- Pregnant Women with incomes at or below 275 percent of the FPL
- MinnesotaCare Children age 19 and 20 with incomes below 133 percent of the FPL
- MinnesotaCare Caretaker Adults with incomes below 133 percent of the FPL
- MinnesotaCare Adults without Children with incomes below 133 percent of the FPL

Effective January 1, 2014 the MinnesotaCare program continues to cover the following:

- Children ages 19 and 20 with incomes above 133 and at or below 200 percent of the FPL
- Caretaker Adults with incomes above 133 and at or below 200 percent of the FPL
- Adults without Children with incomes above 133 and at or below 200 percent of the FPL

Effective January 1, 2014 the following MinnesotaCare beneficiaries will be enrolled in MNsure, Minnesota's health insurance exchange:

- 19- and 20-year olds with incomes above 200 percent of the FPL
- Caretaker Adults with incomes above 200 percent of the FPL

Effective January 1, 2014, eligible individuals no longer have the option of coverage under the MinnesotaCare program instead of enrolling in Medical Assistance. The demonstration will also provide expenditure authority for Caretaker Adults eligible for Medical Assistance who live with a child or children age 18 who are not full time secondary school students. The demonstration will also provide coverage to children and adults with incomes under 200 percent of FPL that are

eligible under the household composition rules under the exchange, but would not be eligible using Medicaid household composition rules.

Beginning January 1, 2014, programmatic changes were made to reduce monthly premiums and cost-sharing for inpatient hospital services for adults, apply a family deductible for adults equal to that authorized under the state plan, and eliminate waiting periods. Finally, the PMAP+ waiver demonstration continues to provide important authorities for Minnesota's Medicaid program such as streamlining benefit sets for pregnant women, authorization of medical education funding with amendments to the distribution methodology, preserving eligibility methods currently in use for children ages 12 through 23 months and allowing mandatory enrollment of certain populations in managed care.

MinnesotaCare Premiums. As of January 1, 2014, a new premium scale was applied. People age 21 and older pay per-person premiums, based on a sliding scale tied to the federal poverty guidelines. A covered household pays a percentage of household income based on a sliding scale and the number of persons covered, with no premiums charged to children in households with incomes that do not exceed 200 percent of FPL. Please refer to Appendix A for a copy of the MinnesotaCare Premium Estimator Table. The premium table is intended to help beneficiaries estimate their premium amount prior to receiving an actual bill.

2 PMAP+ Enrollment

Please refer to Appendix B for PMAP+ §1115 enrollment by demonstration eligibility group for the period July 2014 through September 2014.

3 Purchasing and Service Delivery

3.1 PMAP and MinnesotaCare Purchasing

Coverage for a large portion of MA enrollees and all MinnesotaCare enrollees is purchased on a prepaid capitated basis. Minnesota purchases services for MA and MinnesotaCare recipients in accordance with the state plan, this §1115 waiver, §1915(b) and §1915(c) waivers, and through the authority of §1915(a) of the Social Security Act, as follows:

- PMAP+ §1115 Waiver
- State Plan managed care under §1932(a)
- Mandatory managed care under a §1915(b) waiver for most people over age 65.
- Comprehensive, risk-based managed care, authorized under §1915(a) of the Social

Security Act, for dually eligible Medicare and Medicaid recipients who voluntarily enroll with a managed care organization (MCO) for Medicare and Medicaid coverage. This purchasing model includes both acute and certain long term care services.

- Consolidated Chemical Dependency Treatment Fund §1915(b) waiver.

- §1915(c) waivers for people at risk of requiring institutional care.

The remaining MA recipients receive services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities; the rest are excluded from managed care for other reasons. MCO contracts are in place covering all 87 Minnesota counties.

3.1.1 Mandatory Enrollment of Exempt Groups

The State may mandate enrollment of several MA eligible groups who are exempt from mandatory enrollment under the managed care regulations at 42 CFR §438.50(d), namely, individuals dually eligible for Medicare and Medicaid, American Indians who are members of federally recognized tribes; children in foster care or other out-of-home placements, children receiving Title IV-E adoption assistance, and children under age 19 receiving Title V services.

3.1.2 Purchasing for American Indian Recipients

Tribal Health Work Group. The quarterly Tribal Health Work Group was formed to address the need for a regular forum for formal consultation between tribes and state employees. The work group met in St. Paul on August 19, 2014. Agenda items included an update from DHS staff on the transition from Minnesota Care to a BHP in 2015. Staff from the Minnesota Department of Health presented a report on the Prevalence of Neonatal Abstinence Syndrome and Maternal Opioid Abuse During Pregnancy, a report on the Disproportionality Index of Children in Foster Care by Race and State for 2000-2011 and a report on the recommendations of the Stakeholder Input Process American Indian Community (SIPAIC) final meeting. Staff from the Minnesota Department of Health provided an update on the Pregnancy Risk Assessment Monitoring System (PRAMS). Health Directors were also provided updated information about all state plan amendments that are awaiting CMS approval or that are being developed and the status of the state's Medicaid waivers.

Exempting Indians from Premiums in MinnesotaCare. A provision in the American Recovery and Reinvestment Act (ARRA) requires that states not impose any premiums on Medicaid recipients who are American Indian/Alaska Natives. The state has developed processes for enrolling American Indians/Alaska Natives into the MinnesotaCare program without premiums. Under state policy, the exemption is applied to all MinnesotaCare-eligible members of an American Indian’s household.

PMAP+ Out-of-Network Model. The Minnesota Legislature enacted a number of provisions, subsequently authorized by CMS, to address issues related to tribal sovereignty that prevent Indian Health Service (IHS) facilities from entering into contracts with MCOs, and other provisions that have posed obstacles to enrolling American Indian MA recipients living on reservations into PMAP. The legislation permits MA and MinnesotaCare to cover services provided to American Indian MCO enrollees by IHS and certain tribal providers (commonly referred to as "638s") whether or not those providers are in the MCO's network.

Contracts with MCOs include provisions designed to facilitate access to health care providers for American Indian recipients, including direct access to IHS and 638 providers. IHS and 638 providers may refer recipients to MCO network specialists without requiring the recipient to first see a network primary care provider.

DHS has implemented the PMAP+ out-of-network purchasing model for American Indian recipients of MA who are not residents of reservations

Summary Data. Following is summary information showing the number of people identified as American Indians who were enrolled in MinnesotaCare and MA during calendar year 2013.

MinnesotaCare Program Enrollees who are American Indian Calendar Year 2013	Medical Assistance Enrollees who are American Indian Calendar Year 2013
3,373	48,094

3.2 Managed Care Contract Development and Management

The managed care contracts are structured into three model contracts: Families and Children, Minnesota Senior Health Options/ Minnesota Senior Care Plus (MSHO/MSC+), and Special Needs BasicCare (SNBC). The Families and Children contract covers persons eligible for MA under the age of 65 and all eligible persons in MinnesotaCare.

3.2.1 2014 Contracts

Negotiations for a 12-month contract (January 1, 2014 – December 31, 2014) for Families and Children began in September 2013 and resulted in agreements with eight MCOs: Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan d/b/a Hennepin Health, PrimeWest Health, South Country Health Alliance and UCare Minnesota. Final contracts, rate setting methodologies and actuarial certifications were submitted to the CMS Regional Office as required for CMS approval.

3.2.2 MCO Service Areas

A graphic representation of the location of MCO service areas and information about the number of plans under contract in each county for PMAP and MinnesotaCare, can be found at Health Plan Service Areas.

3.2.3 Contract Management

To assure continuation of effective and efficient contract monitoring while enhancing communications between DHS and the MCOs, designated employees are assigned to monitor individual MCOs for contract compliance, to initiate corrective action or breach of contract notices when necessary, and to act as primary contact persons for issues relating to the contract. Contract management employees also have responsibility for managing the integration of specific policy areas into managed care.

In addition, designated DHS employees focus their efforts on developing and expanding the managed care program. In collaboration with other employees, these development employees coordinate expansion efforts in the targeted counties.

Issues are identified through enrollee complaints and appeals, enrollee phone calls, providers, county employees, and state employees. Service delivery issues are addressed as part of the contract monitoring plan. Employees meet regularly to discuss, revise, and update managed care issues and policies.

3.2.4 MCO Meetings

DHS employees meet bi-monthly with the MCOs. These meetings are used to address contract issues and to keep MCOs informed about changes to federal or state laws and policies that will affect the plans' operations.

3.2.5 Managed Care Contract Managers Meeting

DHS contract managers meet weekly to discuss issues related to health plans and enrollees.

3.3 Service Implementation

3.3.1 Development and Maintenance

Contract managers are responsible for the development and implementation of the technical aspects of managed care. As part of managed care expansion, they participate in county and tribal development team meetings, develop education and enrollment processes, create education and enrollment materials, and define system requirements related to expansion initiatives. Employees coordinate internal and external education and enrollment functions to assure the smooth implementation of managed care programs.

In addition to activities associated with managed care development, employees also provide technical support and serve as policy resources to managed care counties and prepaid MCOs. DHS employees monitor MCO and county enrollment and education activity through the use of reports and adjustment operations; meet with counties to develop action plans; and respond to issues that are reported by counties, providers and clients. DHS employees conduct semiannual site visits at the counties to assure that education presentations are being conducted in an unbiased manner and to review quarterly activity data; conduct annual site visits to the MCOs to assure accurate and timely enrollment; and develop and maintain educational and enrollment materials for recipients.

3.3.2 PMAP and MinnesotaCare Education and MCO Enrollment Activities

The MNsure web site provides information on how to choose health coverage through Minnesota health care programs. The site is designed to assist health care enrollees and potential enrollees determine what health care program they qualify for. The site provides a description of the MNsure, Medical Assistance and MinnesotaCare coverage options, information about the application, enrollment and appeals processes for these coverage options, and where to find additional resources and assistance.

Applicants and enrollees who receive Medical Assistance through fee for service can call the DHS Member Help Desk for assistance with questions about eligibility, information on coverage options, status of claims, spenddowns, prior authorizations, reporting changes that may affect program eligibility, and other health care program information.

At this time MCO education and enrollment continue to be accomplished through a mail-in process. When MinnesotaCare applicants are determined eligible, they are enrolled in a default health plan and at the same time receive a system-generated MCO enrollment form along with MCO primary clinic information. The form: 1) lists the default plan; 2) lists other MCOs that are available to enrollees in their county of residence; and 3) offers the enrollee the opportunity to choose the MCO that is best for their household. Enrollees are provided with toll-free telephone numbers for the MCOs for further assistance.

MinnesotaCare enrollees also have the option of speaking directly with the Member Help Desk regarding questions about the MCO selection and enrollment process. County and State MinnesotaCare employees are active in providing opportunities for enrollees to choose an MCO, either in person or by phone, instead of being assigned to one. DHS ombudsmen and county advocates help enrollees change from one health plan to another.

3.4 Application for Health Care Coverage

On October 1, 2013, DHS converted to a common streamlined application for MA, MinnesotaCare and MNsure coverage. A copy of the application form is included as Appendix D. MA and MinnesotaCare applicants have the option of applying on-line through the MNsure web site or downloading a paper application and mailing it in.

3.5 Advocacy and Ombudsman Activities

The grievance system is available to managed care enrollees who have problems accessing medically necessary care, billing issues or quality of care issues. Enrollees may file a complaint (grievance) or an appeal with the MCO and may file a state fair hearing (SFH) through DHS. A county advocate or a state managed care ombudsman may assist managed care enrollees with grievances, appeals, and state fair hearings. The provider or health plan must respond directly to county advocates and the state ombudsman regarding service delivery and must be accountable to the state regarding contracts with Medical Assistance funds.

3.5.1 MCO Grievance and Appeal Procedures

A **grievance** is a complaint about any matter other than a MCO action. An action is defined below. Grievances include complaints regarding quality of care, rude or disrespectful behavior, lack of access to providers or complaints about any matter other than an action. The PMAP or MinnesotaCare enrollee or a provider acting on behalf of the enrollee with the enrollee's written consent may file a grievance regarding the enrollee's complaint. Complaints can be filed with the MCO either orally or in writing within 90 days of the complaint issue.

The MCO must give enrollees any reasonable assistance in completing forms and taking other procedural steps, including but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Oral grievances must be resolved by the MCO within 10 days of receipt and written grievances must be resolved within 30 days of receipt. Oral grievances may be resolved through oral communication, but the MCO must send the enrollee a written decision for written grievances.

The MCO may extend the timeframe for determinations of a grievance by an additional 14 days if the enrollee or the provider requests the extension, or if the MCO justifies that the extension is in the enrollee's interest (for example, due to a need for additional information). The MCO must provide written notice to the enrollee of the reason for the decision to extend the timeframe.

An **appeal** is an oral or written request from the enrollee, or the provider acting on behalf of the enrollee with the enrollee's written consent, to the MCO for review of an action. An **action** is a denial, termination or reduction of a service, denial in whole or part of a payment for a service, failure to provide services in a timely manner, or the denial of an enrollees' request to exercise his or her right to obtain services outside the network if they are a resident of a rural area with only one MCO.

The enrollee or the provider acting on behalf of the enrollee with the enrollee's written consent may file an appeal within ninety 90 days of the notice of action. In addition, attending health care professionals may appeal utilization review decisions at the MCO level without the written signed consent of the enrollee in accordance with Minnesota Statutes, § 62M.06. An appeal may be filed orally or in writing. The initial filing determines the timeframe for resolution. If the appeal is filed orally, the MCO must assist the enrollee, or provider filing on behalf of the

enrollee, in completing a written signed appeal. Once the oral appeal is reduced to a writing by the MCO, and pending the enrollee's signature, the MCO must resolve the appeal in favor of the enrollee, regardless of receipt of a signature, or if no signed appeal is received within thirty 30 days, the MCO may resolve the appeal as if a signed appeal were received.

The MCO must give enrollees any reasonable assistance required in completing forms and taking other procedural steps, including but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

If the MCO is deciding an appeal regarding denial of a service based on lack of medical necessity, the MCO must ensure that the individual making the decision is a health care professional with appropriate clinical expertise in treating the enrollee's condition or disease.

Resolution of Standard Appeals: The MCO must resolve each appeal as expeditiously as enrollee's health requires, not to exceed thirty (30) days after receipt of the appeal.

Resolution for Expedited Appeals: The MCO must resolve and provide written notice of resolution for both oral and written Appeals as expeditiously as the enrollee's health condition requires, but not to exceed 72 hours after receipt of the appeal. If the MCO denies a request for expedited appeal, the MCO shall transfer the denied request to the standard appeal process, preserving the first filing date of the expedited appeal. The MCO must notify the enrollee of that decision orally 24 hours of the request and follow up with a written notice within two days. When a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, the MCO must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. In such an appeal, the MCO must ensure reasonable access to the MCO's consulting physician.

*Extension of Resolution of Appeals***.** An extension of the timeframes of resolution of appeals of 14 days is available for appeals if the enrollee requests the extension, or the MCO justifies both the need for more information and that an extension is in the enrollee's interest. The MCO must provide written notice to the enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a determination no later than the date the extension expires.
If an enrollee's health plan is stopping or reducing an ongoing service, the enrollee can keep getting the service if they file a health plan appeal or request a state fair hearing within 10 days after the date of the health plan notice or before the service is stopped or reduced, whichever is later.

A **state fair hearing** is a review by a state fair hearing human services judge regarding a denial (full or partial) of a claim or service by the MCO, failure of an MCO to make an initial determination in 30 days or any other action by the MCO.

The enrollee, or the provider acting on behalf of the enrollee with the enrollee's written consent, may file a request for a state fair hearing within 30 days of the notice of action or MCO appeal

decision or within 90 days, if there is good cause for the delay pursuant to Minnesota Statutes, § 256.045.

Standard State Fair Hearing Decisions: The State must take final administrative action on any request for a state fair hearing within 90 days of the date of the request for a state fair hearing.

Expedited State Fair Hearing Decisions: The State must take final action within three working days of receipt of the file from the MCO on a request for an expedited state fair hearing, or for a request from the enrollee which meets the criteria of 42 CFR § 438.410(a).

The MCO must comply with the decision in the state fair hearing promptly and as expeditiously as enrollee's health condition requires.

In the course of a state fair hearing, an enrollee or the human services judge may request an expert medical opinion by an external review entity. This external review is paid for by the State. The MCO must participate in the external review process in accordance with this section and must comply with the decision as specified in Minnesota Statutes, § 62Q.73, subd. 6, (a).

If the enrollee disagrees with the determination of the State resulting from the State fair hearing, the enrollee may seek judicial review in district court. Please refer to Appendix E for a summary of state fair hearings closed in the third quarter of calendar year 2014.

3.5.2 Notifications and Continuation of Services

Enrollees receive an evidence of coverage (EOC) from their MCO including but not limited to information about covered services, enrollee rights, responsibilities, grievance, appeal and the state fair hearing process. The EOC includes phone numbers to file a grievance or appeal with the MCO and the telephone number for the Ombudsman Office for State Managed Health Care Programs. The Ombudsman Office can help enrollees file a grievance or appeal with their MCO and can help the enrollee request a state fair hearing.

Denial, Termination or Reduction of Service (DTR) Notifications:

If the MCO denies, reduces or terminates services or claims that are requested by an enrollee; 2) ordered by a participating provider; 3) ordered by an approved, non-participating provider; 4) ordered by a care manager; or 5) ordered by a court, the MCO must send a DTR notice to the enrollee.

An MCO DTR must include the following:

- The action that the MCO has taken or intends to take;
- The type of service or claim that is being denied, terminated, or reduced;
- A clear detailed description in plain language of the reasons for the action;
- The specific federal or state regulations that support or require the action;

- The date the DTR was issued;
- The effective date of the action if it results in a reduction or termination of ongoing or previously authorized services;
- The date the MCO received the request for service authorization if the action is for a denial, limited authorization, termination or reduction of a requested service;
- The first date of service, if the action is for denial, in whole or in part, of payment for a service;
- The State's language block with an MCO phone number that enrollees may call to receive help in translation of the notice;
- A phone number at the MCO that enrollees may call to obtain information about the DTR; and
- The "Your Appeal Rights" notice approved by the State.

The members appeal rights notice includes, but is not limited to, the enrollee's right (or provider on behalf of the enrollee with the enrollee's written consent) to file an appeal with the MCO. It also includes:

- The requirements and timelines for filing an MCO appeal;
- The enrollee's right to file a request for a state fair hearing without first exhausting MCO's appeal procedures, or file an appeal with the MCO;
- The process the enrollee must follow in order to exercise these rights;
- The circumstances under which expedited resolution is available and how to request it for an appeal or state fair hearing;
- The enrollee's right to continuation of benefits upon request within the time frame allowed, how to request that benefits be continued, and under what circumstances the enrollee may be billed for these services if the enrollee files an appeal with the MCO or requests a state fair hearing; and
- The right to seek an expert medical opinion from an external organization in cases of medical necessity, at the State's expense, for consideration at state fair hearings.

Notice to Provider: The MCO must notify the provider of the action. For a denial of payment, notice may be in the form of an Explanation of Benefits (EOB), explanation of payments, or remittance advice. The MCO must also notify the provider of the right to appeal a DTR.

Timing of the DTR Notice:

- For previously authorized services, the MCO must mail the notice to the enrollee and the attending health care provider at least 10 days before the date of the proposed Action.

- Denials of Payment. For denial of payment, the MCO must mail the DTR notice to the enrollee at the time of any action affecting the claim.

Standard Authorizations: For standard authorization decisions that deny or limit services, the MCO must provide the notice as expeditiously as the enrollee's health condition requires; To the attending health care professional and hospital by telephone or fax within one working day after

making the determination; and to the provider, enrollee and hospital, in writing, and which must include the process to initiate an appeal, within 10 business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period.
Expedited Authorizations: the MCO must provide the determination as expeditiously as the Enrollee's health condition requires, not to exceed 72 hours of receipt of the request for the service. Expedited service authorizations are for cases where the provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the Enrollee's life or health, or ability to attain, maintain or regain maximum function.

Extensions of Time: The MCO may extend the timeframe by an additional 14 days for resolution of a standard authorization if the enrollee or the provider requests the extension, or if the MCO justifies a need for additional information and how the extension is in the enrollee's interest. The MCO must provide written notice to the enrollee of the reason for the decision to extend the timeframe, and the Enrollee's right to file a grievance if he or she disagrees with the MCO's decision. The MCO must issue a determination no later than the date the extension expires.

Delay in Authorizations. For service authorizations not reached within the timeframe the MCO must provide a notice of denial on the date the timeframe expires.

Continuation of Benefits Pending Decision:

(A) If an enrollee files an appeal with the MCO before the date of the action proposed on a DTR and requests continuation of benefits within the time allowed, the MCO, may not reduce or terminate the service until 10 days after a written decision is issued in response to that appeal, unless the enrollee withdraws the appeal; or if the enrollee has requested a state fair hearing with a continuation of benefits, until the state fair hearing decision is reached.

(B) The continuation of benefits is not required if the provider who orders the service is not an MCO participating provider or authorized non-participating provider.

3.5.3 County Advocates

Under Minnesota law, county advocates are required to assist managed care enrollees in each county. The advocates assist enrollees to resolve PMAP MCO issues. When unable to resolve issues informally, the county advocates educate PMAP enrollees about their rights under the grievance system. County advocates provide assistance in filing grievances through both formal and informal processes, and are available to assist in the appeal or state fair hearing process. State ombudsmen and county advocate employees meet regularly to identify complaint and appeal issues and to cooperate in resolving problematic cases.

3.6 Managed Care Quality Improvement

3.6.1 Quality Improvement

To ensure that the level of care provided by each MCO meets acceptable standards, the state monitors the quality of care provided by each MCO through an ongoing review of each MCO's quality improvement (QI) system, grievance procedures, service delivery plan, and summary of health utilization information.

3.6.2 Quality Strategy

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

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

The quality strategy assesses the quality and appropriateness of care and service provided by MCOs for all managed care program enrollees. It incorporates elements of current DHS/MCO contract requirements, Minnesota HMO licensing requirements (Minnesota Statues, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 CFR 438). 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. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with 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).

The quality strategy will evolve over time as the External Quality Review activities continue. DHS intends to review the effectiveness of the quality strategy. Significant future modifications will be published in the State Register to obtain public comment, presented to the Medicaid Citizen's Advisory Committee and reported to CMS. The current version of the quality strategy can be accessed on the DHS website at: http://www.dhs.state.mn.us/dhs16_160043.

3.6.3 MCO Internal Quality Improvement System

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

The Minnesota Department of Health conducts triennial audits of the HMO licensing requirements.

3.6.4 External Review Process

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

1) Determination of compliance with federal and state requirements,

2) Validation of performance measures, and performance improvement projects, and

3) An assessment of the quality, access, and timeliness of health care services provided under managed care.

Where there is a finding that a requirement is not met, the MCO is expected to take corrective action to come into compliance with the requirement. The external quality review organization (EQRO) conducts an overall review of Minnesota's managed care system. The review organization's charge is to identify areas of strength and weakness and to make recommendations for change. Where the ATR describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's ATR. The technical report is published on the DHS website at: http://www.dhs.state.mn.us/dhs16_160043.

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The annual survey results report is published annually and is available on DHS' public web page at: http://www.dhs.state.mn.us/dhs16_160043.

3.6.5 Consumer Satisfaction

DHS sponsors an annual satisfaction survey of public program managed care enrollees using the Consumer Assessment of Health Plans Survey (CAHPS®) instrument and methodology to assess and compare the satisfaction of enrollees with services and care provided by MCOs. DHS contracts with a certified CAHPS vendor to administer and analyze the survey. Survey results are published on the DHS web page at: http://www.dhs.state.mn.us/dhs16_160043.

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Minnesota Department of **Human Services**

MinnesotaCare Premium Estimator Table

Effective January 1, 2014 – December 31, 2014

Federal Poverty Guidelines (FPG) %	Family Size								Monthly Premium Per Person
	1	2	3	4	5	6	7	8	
0%	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$4
55%	6,320	8,531	10,742	12,953	15,164	17,375	19,586	21,797	$4
80%	9,192	12,408	15,624	18,840	22,056	25,272	28,488	31,704	$6
90%	10,341	13,959	17,577	21,195	24,813	28,431	32,049	35,667	$8
100%	11,490	15,510	19,530	23,550	27,570	31,590	35,610	39,630	$10
110%	12,639	17,061	21,483	25,905	30,327	34,749	39,171	43,593	$12
120%	13,788	18,612	23,436	28,260	33,084	37,908	42,732	47,556	$15
130%	14,937	20,163	25,389	30,615	35,841	41,067	46,293	51,519	$18
140%	16,086	21,714	27,342	32,970	38,598	44,226	49,854	55,482	$21
150%	17,235	23,265	29,295	35,325	41,355	47,385	53,415	59,445	$25
160%	18,384	24,816	31,248	37,680	44,112	50,544	56,976	63,408	$29
170%	19,533	26,367	33,201	40,035	46,869	53,703	60,537	67,371	$33
180%	20,682	27,918	35,154	42,390	49,626	56,862	64,098	71,334	$38
190%	21,831	29,469	37,107	44,745	52,383	60,021	67,659	75,297	$43
200%	22,980	31,020	39,060	47,100	55,140	63,180	71,220	79,260	$50

You will receive a premium bill in the mail. To estimate your premium prior to receiving your bill, follow the steps below.

Step 1: Determine Per Person Monthly Premium

- Find the correct family size column in the table below.
- Move down the column until you find the first dollar amount that is more than your combined annual income of everyone in the family.
- Move across the row to the last column on the right to find the monthly per person premium amount.

Step 2: Determine Monthly Premium Amount for the Household

- Multiply the dollar amount from step 1 by the number of people in the household that owe a premium.
- The result is the total estimated monthly premium for the family.

The following people in MinnesotaCare pay a $0 premium:

- Individuals under age 21.
- American Indians and Alaska Natives and their family members.
- Military members who have completed a tour of active duty within 24 months of approval for MinnesotaCare and their family members (for up to 12 months).

This chart is here to help you estimate your premium amount prior to receiving your actual bill. The premium calculation performed by the system and listed on your bill is the official calculation and the amount you must pay. Coverage does not begin until your premium has been paid.

Step 2: Determine the monthly premium for your family.

- Multiply the dollar amount from step 1 by the number of people in the household that owe a premium.
- The result is the total estimated monthly premium for your family.

The following people in MinnesotaCare pay a $0 premium:

- People in a household that has a combined annual income below 35 percent of the federal poverty guideline (see table)
- People under the age of 21
- American Indians and Alaska Natives and their family members
- Military members who have completed a tour of active duty within 24 months of approval for MinnesotaCare and their family members (for up to 12 months)

This table is here to help you estimate your premium before you receive your bill. The premium calculated by the system and listed on your bill is the official calculation and the amount you must pay.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

ចំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកការងារសង្គមរបស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LBR-0001 (2-13)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2670, toll-free 800-675-3739, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Appendix B

PMAP+ §1115 Waiver Demonstration Year 20
Enrollment Data by Eligibility Group

July 2014 through September 2014

	MinnesotaCare Children ages 19 and 20 Above 133% and at or below 200%	MinnesotaCare Caretaker Adults Above 133% and at or below 200%	MinnesotaCare Adults without Children Above 133% and at or below 200%	MA One Year Olds
July 2014	3,176	45,655	50,147	4,665
August 2014	3,176	46,904	51,584	4,775
September 2014	3,176	48,201	53,045	4,614

MinnesotaCare Pregnant Women

SFY	Member Mo	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
1996	9,286	532.85	242.86	4,948,045	2,255,164	0	2,255,164	2,692,881	
1997	13,190	550.96	336.20	7,267,162	4,434,527	0	4,434,527	2,832,636	38.44%
1998	14,466	780.63	441.18	11,292,594	6,382,066	0	6,382,066	4,910,528	31.22%
1999	12,673	808.73	749.11	10,249,035	9,493,489	0	9,493,489	755,546	69.80%
2000	14,808	855.64	805.78	12,670,263	11,932,002	0	11,932,002	738,261	7.56%
2001	16,148	905.26	645.22	14,618,191	10,419,027	0	10,419,027	4,199,164	-19.93%
2002	17,769	957.77	499.39	17,018,589	8,873,703	0	8,873,703	8,144,885	-22.60%
2003	21,539	455.17	455.17	9,803,907	9,803,946	0	9,803,946	-39	-8.85%
2004	24,132	491.58	495.34	11,863,059	11,953,746	0	11,953,746	-90,686	8.83%
2005	19,320	530.91	550.77	10,257,187	10,558,806	82,151	10,640,957	-383,770	11.19%
2006	18,757	573.38	583.60	10,754,947	10,339,207	607,367	10,946,574	-191,627	5.96%
2007	17,125	619.25	591.18	10,604,721	9,532,274	591,739	10,124,013	480,707	1.30%
2008	13,775	668.79	608.91	9,212,638	7,877,371	510,300	8,387,671	824,967	3.00%
2009	12,509	715.28	659.57	8,947,378	7,800,594	449,911	8,250,505	696,873	8.32%
2010	12,189	764.99	694.68	9,324,425	8,032,682	434,755	8,467,437	856,988	5.32%
2011	14,724	818.15	602.28	12,046,418	8,429,347	438,634	8,867,981	3,178,437	-13.30%
2012	15,395	861.51	548.79	13,262,952	7,978,761	469,910	8,448,671	4,814,281	-8.88%
2013	13,196	907.17	714.12	11,971,020	8,852,603	570,865	9,423,468	2,547,552	30.12%
2014	9,926	955.25	635.57	9,482,243	5,702,044	606,923	6,308,967	3,173,276	-11.00%
2015	0	1005.88	0.00	0	0	576,070	576,070	-576,070	-100.00%
2016						0	0	0	

MinnesotaCare Children

SFY	Member Mo	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
1996	598,163	77.28	61.81	46,226,037	36,975,285	0	36,975,285	9,250,752	
1997	626,322	84.84	68.55	53,137,158	42,935,448	0	42,935,448	10,201,710	10.90%
1998	647,966	93.34	63.16	60,481,146	40,923,510	0	40,923,510	19,557,636	-7.87%
1999	663,575	98.57	83.48	65,408,588	55,397,445	0	55,397,445	10,011,142	32.18%
2000	684,169	105.82	100.08	72,402,015	68,468,394	0	68,468,394	3,933,620	19.87%
2001	743,321	113.61	110.02	84,451,266	81,779,245	0	81,779,245	2,672,021	9.94%
2002	817,362	121.98	141.24	99,698,060	115,443,524	0	115,443,524	-15,745,463	28.38%
2003	845,901	152.97	152.97	129,397,476	129,399,234	0	129,399,234	-1,758	8.31%
2004	871,613	164.23	161.76	143,143,803	140,988,649	0	140,988,649	2,155,155	5.74%
2005	700,204	176.32	171.94	123,457,040	118,715,216	1,676,114	120,391,330	3,065,710	6.29%
2006	700,153	189.29	179.33	132,533,824	119,376,959	6,184,667	125,561,626	6,972,198	4.30%
2007	597,980	203.22	189.58	121,524,246	106,992,026	6,374,137	113,366,163	8,158,083	5.71%
2008	516,430	218.18	218.57	112,675,695	106,515,703	6,362,419	112,878,122	-202,428	15.29%
2009	486,582	233.35	270.57	113,541,757	124,830,755	6,825,130	131,655,885	-18,114,128	23.79%
2010	476,338	249.56	287.15	118,876,384	128,311,163	8,471,078	136,782,241	-17,905,857	6.13%
2011	556,156	266.92	254.73	148,447,896	133,560,474	8,109,906	141,670,380	6,777,516	-11.29%
2012	576,281	280.00	254.18	161,356,776	139,444,933	7,032,337	146,477,270	14,879,506	-0.22%
2013	535,929	293.72	279.00	157,411,208	138,040,769	11,484,999	149,525,768	7,885,440	9.77%
2014	452,318	308.11	235.00	139,363,114	96,238,827	10,055,930	106,294,757	33,068,357	-15.77%
2015	22,824	323.21	663.89	7,376,978	3,637,507	11,515,426	15,152,933	-7,775,955	182.51%
2016						562,051	562,051	-562,051	

MinnesotaCare Caretaker Adults

SFY	Member Mo**	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
1996									
1997									
1998									
1999	161,697	135.46	158.45	21,903,476	25,620,274	0	25,620,274	-3,716,799	
2000	323,174	143.32	181.55	46,316,225	58,670,873	0	58,670,873	-12,354,648	14.58%
2001	409,506	151.63	197.33	62,093,005	80,807,937	0	80,807,937	-18,714,932	8.69%
2002	221,611	160.42	286.82	35,551,619	63,562,150	0	63,562,150	-28,010,530	45.35%
2003	236,029	294.62	294.63	69,538,864	69,540,849	0	69,540,849	-1,985	2.72%
2004	246,048	318.19	322.47	78,289,835	79,342,154	0	79,342,154	-1,052,319	9.45%
2005	203,869	343.64	342.26	70,058,515	69,134,246	641,139	69,775,385	283,130	6.14%
2006	203,320	371.14	353.03	75,459,443	67,853,429	3,924,546	71,777,975	3,681,467	3.15%
2007	207,730	400.83	364.70	83,263,846	72,009,983	3,749,864	75,759,847	7,503,999	3.31%
2008	144,883	432.89	401.55	62,718,900	53,505,487	4,671,560	58,177,047	4,541,853	10.10%
2009	203,903	462.98	447.20	94,402,915	86,724,587	4,461,799	91,186,386	3,216,530	11.37%
2010	349,867	495.16	468.84	173,238,957	158,984,682	5,047,152	164,031,834	9,207,123	4.84%
2011	431,505	529.57	430.77	228,512,100	177,078,865	8,798,806	185,877,671	42,634,429	-8.12%
2012	445,254	557.64	423.17	248,290,195	179,331,694	9,085,272	188,416,966	59,873,229	-1.76%
2013	391,222	587.19	506.79	229,722,419	183,871,905	14,395,217	198,267,122	31,455,297	19.76%
2014	402,751	618.31	518.63	249,026,450	195,225,833	13,652,774	208,878,607	40,147,843	2.34%
2015	334,462	651.08	394.87	217,762,486	116,398,864	15,669,702	132,068,566	85,693,920	-23.86%
2016						15,703,841	15,703,841	-15,703,841	

MinnesotaCare Adults without Children (>= 75% FPG)

SFY	Member Mo**	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
2008	186,323		397.72		70,530,235	3,573,832	74,104,067		
2009	219,400		418.15		88,168,476	3,573,130	91,741,606		5.14%
2010	283,219	499.06	499.06	141,342,735	137,808,553	3,534,181	141,342,734	1	19.35%
2011	408,016	530.00	507.75	216,248,357	201,320,084	5,850,136	207,170,220	9,078,137	1.74%
2012	442,481	562.86	500.68	249,054,826	212,203,567	9,337,541	221,541,108	27,513,718	-1.39%
2013	370,696	597.76	588.21	221,586,121	203,451,740	14,594,477	218,046,217	3,539,904	17.48%
2014	421,664	634.82	691.22	267,680,094	277,247,519	14,214,969	291,462,488	-23,782,395	17.51%
2015	386,593	674.18	498.43	260,632,196	175,799,964	16,889,767	192,689,731	67,942,465	-27.89%
2016						24,117,771	24,117,771	-24,117,771	

MA One-Year-Olds

SFY	Member Mo	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
1996	7,210	480.34	180.98	3,463,251	1,304,893	0	1,304,893	2,158,358	
1997	7,133	516.24	228.78	3,682,340	1,631,891	0	1,631,891	2,050,449	26.41%
1998	5,904	534.46	276.51	3,155,452	1,632,486	0	1,632,486	1,522,966	20.86%
1999	6,498	198.10	186.67	1,287,254	1,212,991	0	1,212,991	74,263	-32.49%
2000	8,877	212.68	149.89	1,887,960	1,330,612	0	1,330,612	557,348	-19.70%
2001	10,673	228.33	149.29	2,436,966	1,593,395	0	1,593,395	843,571	-0.40%
2002	10,173	245.14	186.58	2,493,809	1,898,065	0	1,898,065	595,744	24.98%
2003	10,030	177.25	177.25	1,777,818	1,777,805	0	1,777,805	12	-5.00%
2004	27,798	190.30	160.09	5,289,901	4,450,252	0	4,450,252	839,648	-9.68%
2005	37,956	204.30	174.99	7,754,462	6,585,261	56,543	6,641,804	1,112,658	9.30%
2006	41,817	219.34	219.22	9,172,054	8,860,603	306,371	9,166,974	5,080	25.28%
2007	43,796	235.48	238.35	10,313,135	10,095,710	342,898	10,438,608	-125,473	8.73%
2008	45,569	252.81	263.50	11,520,419	11,625,515	381,705	12,007,220	-486,802	10.55%
2009	50,617	270.38	272.12	13,685,981	13,235,184	538,950	13,774,134	-88,152	3.27%
2010	55,023	289.17	272.47	15,911,261	14,322,815	669,373	14,992,188	919,073	0.13%
2011	56,530	309.27	257.68	17,482,885	13,795,088	771,701	14,566,789	2,916,096	-5.43%
2012	57,729	324.42	278.14	18,728,527	15,309,617	747,198	16,056,815	2,671,712	7.94%
2013	54,916	340.32	231.22	18,688,910	11,923,641	774,211	12,697,852	5,991,058	-16.87%
2014	58,113	356.99	243.70	20,745,909	13,185,437	976,604	14,162,041	6,583,868	5.40%
2015	64,772	356.99	258.04	23,123,082	15,661,613	1,052,228	16,713,841	6,409,242	5.89%
2016	65,945	356.99	290.02	23,541,827	17,998,054	1,127,294	19,125,348	4,416,478	12.39%
2017	67,490	356.99	289.57	24,093,644	18,379,515	1,163,958	19,543,473	4,550,171	-0.15%
2018	34,536	356.99	309.38	12,329,198	9,499,216	1,185,465	10,684,680	1,644,517	6.84%

MA Parents With Youngest Child 18 Years Old

SFY	Member Mo**	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
2009	6,439		503.09		2,994,428	244,996	3,239,425		
2010	8,578		502.11		4,051,903	255,203	4,307,107		-0.20%
2011	9,375		483.36		4,225,464	306,022	4,531,486		-3.73%
2012	9,061	476.54	476.54	4,317,884	3,957,623	360,261	4,317,884	0	-1.41%
2013	8,945	476.54	447.89	4,262,606	3,650,671	355,691	4,006,362	256,244	-6.01%
2014	12,394	476.54	489.82	5,906,022	5,739,932	330,723	6,070,656	-164,634	9.36%
2015	15,909	476.54	467.93	7,581,398	7,040,389	404,163	7,444,552	136,846	-4.47%
2016	16,144	476.54	540.07	7,693,146	8,161,586	557,241	8,718,827	-1,025,680	15.42%
2017	16,076	476.54	548.08	7,660,640	8,150,215	660,634	8,810,850	-1,150,209	1.48%
2018	8,038	476.54	596.67	3,830,320	4,086,698	709,211	4,795,909	-965,589	8.86%

Annual ceiling less expenditures, all waiver groups

	MinnesotaCare Pregnant Women	MinnesotaCare Children	MinnesotaCare Caretaker Adults	MinnesotaCare Adults w/o Kids	MA 1-Year-Olds	MA Parents with Youngest Child 18-Years-Old	Total	Cumulative
1996	2,692,881	9,250,752			2,158,358		14,101,991	14,101,991
1997	2,832,636	10,201,710			2,050,449		15,084,795	29,186,786
1998	4,910,528	19,557,636			1,522,966		25,991,130	55,177,916
1999	755,546	10,011,142	-3,716,799		74,263		7,124,152	62,302,068
2000	738,261	3,933,620	-12,354,648		557,348		-7,125,419	55,176,649
2001	4,199,164	2,672,021	-18,714,932		843,571		-11,000,176	44,176,473
2002	8,144,885	-15,745,463	-28,010,530		595,744		-35,015,364	9,161,109
2003	-39	-1,758	-1,985		12		-3,770	9,157,339
2004	-90,686	2,155,155	-1,052,319		839,648		1,851,798	11,009,137
2005	-383,770	3,065,710	283,130		1,112,658		4,077,729	15,086,865
2006	-191,627	6,972,198	3,681,467		5,080		10,467,118	25,553,984
2007	480,707	8,158,083	7,503,999		-125,473		16,017,316	41,571,300
2008	824,967	-202,428	4,541,853		-486,802		4,677,590	46,248,890
2009	696,873	-18,114,128	3,216,530		-88,152		-14,288,879	31,960,012
2010	856,988	-17,905,857	9,207,123		919,073		-6,922,673	25,037,339
2011	3,178,437	6,777,516	42,634,429		2,916,096		55,506,477	80,543,816
2012	4,814,281	14,879,506	59,873,229	27,513,718	2,671,712		109,752,447	190,296,264
2013	2,547,552	7,885,440	31,455,297	3,539,904	5,991,058		51,419,252	241,715,515
2014	3,173,276	33,068,357	40,147,843	-23,782,395	6,583,868	-164,634	59,026,316	300,741,831
2015	-576,070	-7,775,955	85,693,920	67,942,465	6,409,242	136,846	151,830,449	452,572,279
2016	0	-562,051	-15,703,841	-24,117,771	4,416,478	-1,025,680	-36,992,865	415,579,414
2017					4,550,171	-1,150,209	3,399,962	418,979,376
2018					1,644,517	-965,589	678,928	**419,658,305**
Sum	39,604,788	78,281,206	208,683,767	51,095,922	45,161,887	-3,169,266	419,658,305	

Trend scenario

PW/Parents	Kids
5.30%	**4.90%**

Trend scenario

MA	MA Parents With Young Child = 18
One-Year-Olds	
0.00%	**0.00%**

<= Bottom line cost neutrality

Total waiver expenditures, all waiver groups

	MinnesotaCare Pregnant Women	MinnesotaCare Children	MinnesotaCare Caretaker Adults	MinnesotaCare Adults w/o Kids	MA 1-Year-Olds	MA Parents with Youngest Child 18-Years-Old	Total	Federal Share
1996	2,255,164	36,975,285			1,304,893		40,535,342	21,897,192
1997	4,434,527	42,935,448			1,631,891		49,001,866	26,304,201
1998	6,382,066	40,923,510			1,632,486		48,938,062	25,697,376
1999	9,493,489	55,397,445	25,620,274		1,212,991		91,724,200	47,384,722
2000	11,932,002	68,468,394	58,670,873		1,330,612		140,401,882	72,292,929
2001	10,419,027	81,779,245	80,807,937		1,593,395		174,599,604	89,394,997
2002	8,873,703	115,443,524	63,562,150		1,898,065		189,777,441	95,420,098
2003	9,803,946	129,399,234	69,540,849		1,777,805		210,521,835	105,260,917
2004	11,953,746	140,988,649	79,342,154		4,450,252		236,734,800	118,367,400
2005	10,640,957	120,391,330	69,775,385		6,641,804		207,449,475	103,724,738
2006	10,946,574	125,561,626	71,777,975		9,166,974		217,453,150	108,726,575
2007	10,124,013	113,366,163	75,759,847		10,438,608		209,688,632	104,844,316
2008	8,387,671	112,878,122	58,177,047		12,007,220		191,450,061	95,725,030
2009	8,250,505	131,655,885	91,186,386		13,774,134		244,866,910	122,433,455
2010	8,467,437	136,782,241	164,031,834		14,992,188		324,273,701	162,136,850
2011	8,867,981	141,670,380	185,877,671		14,566,789		350,982,821	175,491,411
2012	8,448,671	146,477,270	188,416,966	221,541,108	16,056,815		580,940,830	290,470,415
2013	9,423,468	149,525,768	198,267,122	218,046,217	12,697,852		587,960,428	293,980,214
2014	6,308,967	106,294,757	208,878,607	291,462,488	14,162,041	6,070,656	633,177,516	316,588,758
2015	576,070	15,152,933	132,068,566	192,689,731	16,713,841	7,444,552	364,645,692	182,322,846
2016	0	562,051	15,703,841	24,117,771	19,125,348	8,718,827	68,227,838	34,113,919
2017					19,543,473	8,810,850	28,354,322	14,177,161
2018					10,684,680	4,795,909	15,480,589	7,740,295
Sum	165,989,985	2,012,629,261	1,837,465,484	947,857,315	207,404,157	35,840,792	5,207,186,996	2,614,495,815

NOTES

1. Payments through December 2013 are actual data.
2. MA one-year olds--enrollment is actual through December 2013.
3. The Fiscal Year 2004 expenditures include thirteen payments and FY 2005 expenditures include 11 payments.
4. Fiscal Year 2007 caretaker adult member months include 2 months of Medicaid waiver eligibility for the SCHIP parent group. Fiscal Year 2008 includes no months of waiver eligibility for the SCHIP parent group.
5. The SCHIP waiver for MinnesotaCare parents is terminated effective with the service month of February 2009. As a result, Fiscal Year 2009 includes 5 months of waiver eligibility for the SCHIP parent group. Further, caretaker adult member months in Fiscal Years 2010 through 2014 include all 12 months of Medicaid waiver eligibility for the former SCHIP parent group.
6. FY 2013 expenditures include 11 payments and FY2014 expenditures include 8 payments (payments for May and June 2013 are delayed to July 2013).
7. Beginning January 2014, eligible member months are limited to parents, 19-20 year olds, and adults without children with income between 138%-200% FPG.
8. FY2015 average monthly payments for children are skewed because the calculation includes the State's obligation to pay back the HMO withhold collected during CY2013, a time period which included a larger eligible children population. Eligible children in FY2015 include only 19-20 year olds with income between 138%-200% FPG while eligible children in CY2013 include 0-20 year olds with income under 275% FPG.
9. FY2018 reflects a six month waiver period: July-December 2017.
10. FY2018 expenditures reflect the State's obligation to pay back the HMO withhold collected during CY2017.

May 16, 2014

Appendix E

State Fair Hearings Closed in Quarter 3 of 2014 by Metro and Non-Metro Areas

	Number of SFHs
Area	
Eleven County Metro Area	189
Non-Metro Area	66
Total	**255**

State Fair Hearings Closed in Quarter 3 of 2014 by Type, Service Category and Outcome Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	State affirmed	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category						
Health Plan Change	.	.	.	3	2	**5**
Restricted Recipient	5	2	5	.	.	**12**
Total	**5**	**2**	**5**	**3**	**2**	**17**

Billing Type by Service Category and Outcome

Outcome	Dismissed	Resolved before hearing	Total
	Number of SFHs	Number of SFHs	Number of SFHs
Service Category			
Chiropractic	.	2	**2**
DME-Medical Supplies	.	2	**2**
Dental	2	7	**9**
Emergency Room	.	2	**2**
Hospital	1	2	**3**
Interpreter Services	.	1	**1**
Mental Health	1	.	**1**
Professional Medical Services	3	3	**6**
Vision Services	.	1	**1**
Total	**7**	**20**	**27**

Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category							
Chemical Dependency	.	1	.	.	.	1	**2**

Note: The basis of the State Fair Hearing report has changed January 1, 2009 from the ‘date received’ to the ‘date of outcome’.

Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category							
DME-Medical Supplies	2	.	.	7	.	1	**10**
Dental	1	3	.	12	18	2	**36**
EW Services	.	1	.	1	1	.	**3**
Home Care	23	22	8	42	19	5	**119**
Mental Health	.	.	.	2	.	1	**3**
Pharmacy	2	1	.	2	3	.	**8**
Professional Medical Services	.	.	.	11	8	1	**20**
Therapies/Rehabilitation	1	1	.	1	1	1	**5**
Transportation	1	.	.	2	.	.	**3**
Urgent Care	.	.	.	.	1	.	**1**
Vision Services	.	.	.	.	.	1	**1**
Total	**30**	**29**	**8**	**80**	**51**	**13**	**211**

Access Type by Service Category and Outcome

No values were returned for this table.

Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	State affirmed	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category								
Chemical Dependency	.	1	.	.	.	.	1	**2**
Chiropractic	.	.	.	.	2	.	.	**2**
DME-Medical Supplies	2	.	.	7	2	.	1	**12**
Dental	3	3	.	12	25	.	2	**45**
EW Services	.	1	.	1	1	.	.	**3**
Emergency Room	.	.	.	.	2	.	.	**2**
Health Plan Change	.	.	.	.	3	2	.	**5**
Home Care	23	22	8	42	19	.	5	**119**
Hospital	1	.	.	.	2	.	.	**3**
Interpreter Services	.	.	.	.	1	.	.	**1**
Mental Health	1	.	.	2	.	.	1	**4**
Pharmacy	2	1	.	2	3	.	.	**8**
Professional Medical Services	3	.	.	11	11	.	1	**26**
Restricted Recipient	5	2	.	5	.	.	.	**12**
Therapies/Rehabilitation	1	1	.	1	1	.	1	**5**
Transportation	1	.	.	2	.	.	.	**3**
Urgent Care	.	.	.	.	1	.	.	**1**
Vision Services	.	.	.	.	1	.	1	**2**
Total	**42**	**31**	**8**	**85**	**74**	**2**	**13**	**255**

Note: The basis of the State Fair Hearing report has changed January 1, 2009 from the ‘date received’ to the ‘date of outcome’.

Summary of SFHs Closed in Quarter 3 of 2014 by Outcome

	Number of SFHs
Outcome	
Dismissed	42
Enrollee prevailed	31
HP Partially Upheld/Member Partially Denied	8
Health Plan prevailed	85
Resolved before hearing	74
State affirmed	2
Withdrawn	13
Total	**255**

Note: The basis of the State Fair Hearing report has changed January 1, 2009 from the ‘date received’ to the ‘date of outcome’.