STATE OF MINNESOTA

Office of Governor Mark Dayton

116 Veterans Service Building ♦ 20 West 12th Street ♦ Saint Paul, MN 55155

June 30, 2015

Ms. Sylvia Mathews Burwell,
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Renewal of Minnesota's Prepaid Medical Assistance Project Plus

Dear Secretary Burwell:

This is a request to renew Minnesota's PMAP+ Section 1115 waiver, which expires on December 31, 2015. The PMAP+ waiver has been in place for over 20 years, primarily as the federal authority for the MinnesotaCare program. The MinnesotaCare program provided comprehensive health care through Medicaid funding for people with income in excess of the standards in the Medical Assistance program. On January 1, 2015, the MinnesotaCare program converted to a Basic Health Plan.

Even though the PMAP+ waiver is no longer necessary to continue the MinnesotaCare program, the PMAP+ waiver is necessary to continue operating some aspects of Minnesota's current Medical Assistance program. The proposed waiver extension seeks to renew longstanding authorities for Minnesota's Medicaid program, including authorization of medical education funding; preserving eligibility methods currently in use for children ages 12 to 23 months; and simplifying the definition of a parent or caretaker relative to include people caring for children under age 19. The extension also seeks to continue federal authority to provide full medical assistance benefits for pregnant women during the period of presumptive eligibility.

I look forward to working with you toward approval of this renewal.

[redacted]

Mark Dayton
Governor

cc: Vikki Wachino, Deputy Administrator and Director, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services
Ruth Hughes, Associate Regional Administrator, Region V, Centers for Medicare and Medicaid Services, Division of Medicaid and Children's Health Operations

Minnesota PMAP+ Section 1115 Waiver Renewal Request

Project No. 11-W-00039/5

June 30, 2015

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Attachments

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).

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. On January 1, 2015, the MinnesotaCare Program converted to a Basic Health Plan (BHP), which is funded through payments related to the federal tax credit subsidies, and therefore the program no longer receives Medicaid funding.

However, the waiver continues to be necessary in order to continue certain elements of the Medical Assistance Program, such as the authorization of medical education funding, preserving eligibility methods currently in use for children between ages one and two, simplifying the definition for a parent or caretaker adult to include people living with an 18-year-old who is not a full-time secondary school student, and allowing coverage of certain populations in managed care. This is an application to renew those waiver authorities for the time period beginning January 1, 2016, and ending December 31, 2018.

2) Include the rationale for the Demonstration.

The purpose of the renewal of this waiver is to continue longstanding authorities for Minnesota's Medicaid program including the authorization of medical education funding, preserving eligibility methods currently in use for children ages 12 to 23 months and simplifying the definition of a parent or caretaker adult to include people living with an 18-year-old child who is not a full-time secondary school student. This waiver request also seeks to continue federal authority to provide full Medical Assistance benefits for pregnant women during the period of presumptive eligibility.

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.

Please refer to Attachment G for the PMAP+ Waiver Evaluation Plan for calendar years 2015 to 2018.

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 January 1, 2016 through December 31, 2018.

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 no longer includes eligibility, benefits and cost-sharing for demonstration expansion populations because the MinnesotaCare program has transitioned to a Basic Health Plan, as described above. The waiver affects eligibility for certain populations eligible under the state plan and will continue expenditure authorities relating to graduate medical education.

Section II – Demonstration Eligibility

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

Eligibility Chart
Affected Medicaid State Plan Eligibility Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
MA Parents and Caretaker Adults Living with child(ren) age 18 who are not full-time secondary school students		At or below 133% FPL
MA One-Year-Olds (12-23 months) *Apply methods for MA infants*		Above 275% and at or below 283% FPL

Definitions: State Plan Eligibility Groups

- **MA Parents and Caretaker Adults.** MA parent and caretaker adult means a person age 21 or older that is a parent or a relative, by blood, adoption, or marriage, of a child age 18 with whom the child is living and who assumes primary responsibility for the child's care. This group is limited to adults whose only or youngest child is age 18 and not yet age 19.

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.**

- **MA One-Year-Olds.** Minnesota will apply the income methodology used for MA infants under 12 months old to children age 12 to 23 months.

- **MA Parents and Caretaker Adults.** An adult who is a parent, or relative by blood, adoption, or marriage, of a child age 18 with whom the child is living and who assumes primary responsibility for the child's care will retain coverage under the caretaker relative basis of eligibility, whether or not the child is a full-time student. This group is limited to adults whose only or youngest child is age 18 and not yet age 19.

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.

It is expected that all groups affected under the demonstration would otherwise be eligible for Medical Assistance. Under Minnesota's Medicaid state plan, adults without children have the same income standard, benefits package and cost-sharing as caretaker relatives. Therefore, the exemption from tracking full-time school status of children age 18 will not affect the number of individuals covered nor the coverage available to these individuals.

Please see the budget neutrality worksheets at Attachment B for the projected eligible member months for MA One-Year-Olds 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.

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:

___ Yes _X_ 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:

__ Yes _X__ 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.

N/A

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

Benefits are set out under Minnesota's Medicaid state plan.

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.

N/A

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

N/A

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

N/A

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. MA One-Year-Olds will be enrolled in managed care. State plan eligibles affected by the demonstration may receive services from enrolled providers who are paid on a managed care or 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.

N/A

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

__X_ Managed care
_X_Managed Care Organization (MCO)
___ Prepaid Inpatient Health Plans (PIHP)
___ Prepaid Ambulatory Health Plans (PAHP)
_X_ 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):

External Review Process

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

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

Where there is a finding that a requirement is not met, the MCO is expected to take corrective action to come into compliance with the requirement. The External Quality Review Organization conducts an overall review of Minnesota's managed care system. The review organization's charge is to identify areas of strength and weakness and to make recommendations for change. Where the technical report describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's ATR. A copy of the 2013Annual Technical Report produced by the external quality review organization is provided at Attachment L.

Comprehensive Quality Strategy

Minnesota's Comprehensive Quality Strategy was submitted to CMS on February 12, 2015. A copy is provided at Attachment C. Minnesota's Comprehensive Quality Strategy is an overarching comprehensive and dynamic continuous quality improvement strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota's

Medicaid program. Minnesota has incorporated into its Comprehensive Quality Strategy measures and processes related to the programs affected by this demonstration.

PMAP+ Evaluation Activities

In response to CMS' request, the PMAP+ evaluation plans for the waiver period 2011 through 2013 and waiver period 2014 have been reconfigured so that each evaluation design is a standalone document. The evaluation plan for the waiver period July 1, 2011 through December 31, 2013 is provided at Attachment D. The evaluation plan for the waiver period January 1, 2014 through December 31, 2014 is provided at Attachment E.

PMAP+ Evaluation Report 2011 through 2013

The PMAP+ evaluation for waiver period July 1, 2011 through December 31, 2013 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. A final report of evaluation activities and findings for the PMAP+ waiver period July 1, 2011 through December 31, 2013 is included at Attachment F.

PMAP+ Evaluation 2014 Activities Update

This evaluation relates to the PMAP+ waiver extension period of January 1, 2014 through December 31, 2014. One goal of the waiver was to reduce the proportion of uninsured and provide high quality coverage for those who are participating in the MinnesotaCare Program. The evaluation will compare coverage levels under MinnesotaCare and coverage available under a qualified health plan purchased through MNsure.

DHS, along with representatives from MNsure's Quality Measurement and Reporting Operations Division, are in the process of compiling data required to examine and contrast MinnesotaCare and MNsure program attributes, coverage plans and coverage patterns. Once this data is compiled, rates and program attributes will be displayed to assist in making comparisons between MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

A second goal of the waiver was to provide comparable access and quality of care to the waiver populations as compared to that available through Medical Assistance. The objective was to demonstrate that access, quality of care and enrollee satisfaction was maintained under the demonstration and comparable to care provided to Medical Assistance managed care enrollees not eligible under the waiver.

The evaluation uses selected HEDIS performance measures to evaluate care for the waiver population compared to Medical Assistance managed care enrollees. A comparison and stratification of the selected HEDIS 2015 and other performance measures will be made between the waiver (MA and MinnesotaCare) populations and other public program managed care enrollees to show the ongoing improvement in care for all publicly funded program enrollees.

Beginning in May 2015, performance measurement data will be extracted from DHS' managed care encounter database to allow for a sufficient encounter run-out period. Performance measurement rates for the baseline period (CYs 2011, 2012 and 2013) will be calculated for the targeted populations and compared to CY 2014. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass to compare performance of Minnesota's populations with national and other 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 2015, with the draft final report submitted to CMS in March 2016. Below is an overview of evaluation activities and timeline:

- May 2015: DHS will calculate measurement rates for goals one and two.
- June 2015: DHS staff will review and evaluate goal rates and drawn conclusions.
- July – August 2015: DHS will calculate and stratify HEDIS 2015 performance measures.
- Sept – December 2015: HEDIS and CAHPS results will be reviewed and results evaluated.
- September 2015- March 2016: Draft and final waiver report is written, reviewed and approved.
- May 2016: Final report is submitted to CMS.

PMAP+ Evaluation Plan 2015 to 2018

The evaluation plan for the PMAP+ waiver period January 1, 2015 through December 31, 2018 is included at Attachment G.

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?

Managed care enrollment is mandatory for Medicaid state plan groups that are not otherwise exempt from mandatory managed care. Minnesota's longstanding federal authority under the PMAP+ waiver to require managed care enrollment for certain Medicaid state plan groups that

would otherwise be exempt from mandatory managed care is being sought under a separate waiver under the authority for section 1915(b).

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

Managed care is statewide.

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

Managed care is statewide. Minnesota intends to continue to operate managed care purchasing and service delivery for Medicaid recipients on a statewide basis.

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

N/A

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

DHS procures on a five-year cycle for managed care services in various 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.

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 MCO contract 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 are the rates 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.

Please refer to the November 13, 2014 actuary letter and the rates checklist submitted to CMS on December 30, 2015 as part of the Families and Children's contract submission.

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 payment incentives designed to promote access, efficiency and quality. The payments for contract year 2015 are described in Section 7.10 of the 2014 Families and Children model contract on the DHS public web site at http://www.dhs.state.mn.us/main/dhs16_174194

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.

This waiver extension requests continuing authority for a program that is already in effect. There is no need for an implementation schedule.

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

This waiver extension requests continuing authority for a program that is already operating statewide and applies equally to all one-year-old children receiving Medical Assistance in the state. If CMS approves this waiver extension, MA One-Year-Olds will continue to be enrolled in the demonstration using existing eligibility processes.

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.

The state will continue to contract with managed care organizations in the same manner as it has for many years under this demonstration. See paragraph IV. 5. e. above.

Section VI – Demonstration Financing and Budget Neutrality

1) <u>Budget Neutrality</u>

The budget neutrality worksheets are provided at Attachment B. Historical data is provided at Attachment A.

In the Historical Data tab of the worksheet provided at Attachment B, we provide five years of data on the MA one-year-olds and MA parents of 18-year-olds. Historical year 1 for MA one-year-olds is anomalous because of especially low enrollment in FY 2010. Therefore, we used four years of history instead and reference SFY 2011 for the Without Waiver (WOW) and With Waiver (WW) enrollment trend. In previous conversations with CMS, we have been advised that if historical figures suggest a negative trend CMS will allow a zero percent trend in PMPM cost. Therefore a 0% trend assumption was used in the WOW and WW worksheets.

Attachment A shows actual and projected waiver expenditures for the entire waiver period. Because budget neutrality is measured over the life of the waiver, we can see that even if expenditures in the remaining MEGs for the waiver period 2016 to 2018 exceed a 0% trend, the cumulative budget neutrality over the life of the waiver is a savings of over $400 million dollars. This demonstrates budget neutrality overall for the entire waiver period.

Section VII – List of Proposed Waivers and Expenditure Authorities

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

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.

Coverage /Benefits for Pregnant Women — **Section 1902(a)(47, as implemented by 42 CFR §§ 435.1103 and 435.1110**

To the extent necessary to exempt the State from the requirement that it limit medical assistance to certain pregnant women to ambulatory prenatal care during a presumptive eligibility period described in section 1920(d).

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

To the extent necessary to permit the State to apply different eligibility standards across populations.

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. Population 1: Expenditures for Medicaid coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medical Assistance, with incomes above 275 percent and at or below 283 percent of the Federal poverty level (FPL).

2. Expenditures for Medical Assistance coverage for pregnant women during a presumptive eligibility period described in section 1920(d), as implemented by 42 CFR §§ 435.1103 and 435.1110, to the extent that services are provided that are in addition to ambulatory prenatal care.

3. Expenditures for coverage of caretaker adults, eligible for Medical Assistance, with incomes at or below 138 percent of the FPL, after application of the 5 percent income disregard, assuming responsibility for and living with a child age 18 who is not a full time student in secondary school.

4. 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.

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, 2015 through December 31, 2017.

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.

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 May 26, 2015. This notice announced a 30-day comment period from May 26, 2015 to June 24, 2015 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 May 26, 2015 is provided as Attachment H.

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 at PMAP+ Waiver 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. After the comment period, this page 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 be posted on the PMAP+ waiver web page.

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 two public hearings. 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 June 9, 2015. There were two members of the public in attendance. No public testimony was given. The second public hearing was held at the DHS Lafayette location on June 11, 2015. There was one member of the public in attendance. No public testimony was given.

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

The State used an electronic mailing list to notify the public. On May 26, 2015 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 PMAP+ waiver web page. A second email will be sent to provide notice that the final submitted version of the waiver is on the web site and to alert stakeholders that a federal comment period on the PMAP+ renewal request is expected soon.

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

DHS received no written comments from stakeholders regarding the proposed PMAP+ waiver extension during the comment period from May 26, 2015 to June 24, 2015.

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

DHS received no written comments from stakeholders regarding the proposed PMAP+ waiver extension during the comment period from May 26, 2015 to June 24, 2015.

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 I 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 May 26, 2015 a letter was sent to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic 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 provided a link to the PMAP+ waiver web page. Please refer to Attachment J for a copy of the May 26, 2015 letter.

The State's intent to submit a request to extend the PMAP+ waiver was also included in a summary of federal waiver activity provided to Tribal Chairs and Tribal Health Directors at the May 27, 2015 Tribal Health Work Group meeting.

8) Summary of the state's compliance with the post-implementation forum requirements in the transparency regulations

DHS held a post-award public forum on June 9, 2015 to provide the public with an opportunity to comment on the progress of the PMAP+ demonstration. A notice was published in the Minnesota State Register on May 11, 2015 informing the public of the date, time and location of the forum (Attachment K). DHS published the date, time and location of the forum on the PMAP Waiver Web page. An email was also sent to all PMAP+ waiver stakeholders on May 11, 2015 announcing the date, time and location of the forum. There were no members of the public in attendance at the forum.

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

Jan Kooistra, Federal Relations
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P.O. Box 64983
St. Paul, MN 55164-0983

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Attachment C

Minnesota Department of Human services

Comprehensive Quality Strategy

Minnesota Department of Human Services

February 2015

For More Information Contact:

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Table of Contents

I. Introduction, Overview and History

A. Introduction

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

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

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

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

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

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

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

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

B. Overview of Minnesota's Medicaid program

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

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

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

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

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

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

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

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

C. History of Minnesota's Medicaid Program

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

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

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

Dual Eligibles

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

Programs for Seniors (MSHO/SNPs/MSC+)

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

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

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

Program for People with Disabilities (SNBC)

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

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

Authorities for Managed Care

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

Prepaid Medical Assistance Program (PMAP)

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

MinnesotaCare

- Minnesota Statutes, § 256L.12

Minnesota Senior Health Options (MSHO)

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

Special Needs Basic Care (SNBC)

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

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

Other Health Care Delivery Models

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

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

D. Strategy Objectives

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

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

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

II. Managed Care Introduction

A. Quality Strategy Program

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

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

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

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

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

Components of the Quality Strategy

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

External Review Process

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

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

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

Performance Improvement Projects

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

B. Summary of Managed Care Contracts

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

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

C. Summary of the PMAP+ Demonstration Waiver

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

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

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

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

- Medical assistance for groups not included in Minnesota's Medicaid state plan; specifically, children ages 12 through 23 months with incomes above 275 percent FPL and at or below 283 percent of the FPL, and parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18 year old who is not a full time secondary school student;

- Full Medical assistance benefits for pregnant women during their hospital presumptive eligibility period;

- Mandatory enrollment into prepaid managed care of certain groups that are excluded from such under section 1932 of the Act and;

- GME payments through the MERC fund.

D. Summary of MSC+ Waiver

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

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

III. Outcomes and Assessment

A. Quality Improvement Principles

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

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

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

B. Expected Managed Care Outcomes

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

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

IV. Federal BBA Managed Care Regulations

A. Compliance with Federal Regulation 42 CRF §438

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

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

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

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

B. Integration of Medicare and NCQA standards

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

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

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

V. State Managed Care Standards

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

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

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

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

B. EQR Activities

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

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

VI. Quality Strategy Oversight

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

A. Other DHS Quality Improvement Activities and Relevant Reports

1. Voluntary Changes in MCO Enrollment

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

2. Consumer Satisfaction

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

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

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

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

3. Managed Care Grievance System Information Summary, DHS

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

4. MCO Internal Quality Improvement System

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

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

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

5. BBA managed care validation requirements

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

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

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

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

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

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

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

8. Self-reported MCO quality improvement initiatives

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

• Quality Program Transparency and Accountability Blue Cross and Blue Shield:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742A-ENG

• Quality Program Transparency and Accountability HealthPartners:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742B-ENG

• Quality Program Transparency and Accountability Hennepin Health:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742C-ENG

• Quality Program Transparency and Accountability IMCare:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742D-ENG

• Quality Program Transparency and Accountability Medica:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742E-ENG

• Quality Program Transparency and Accountability MHP:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742F-ENG

• Quality Program Transparency and Accountability PrimeWest:
https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742G-ENG

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

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

9. Annual Report of Managed Care in Minnesota Health Care Programs
A comprehensive report providing a summary of oversight activities of Minnesota's state managed care programs. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6742I-ENG

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

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

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

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

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

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

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

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

VIII. Other Demonstration Waivers

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

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

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

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

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

Reform 2020
Minnesota is redesigning its personal care assistance benefit to expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after the Community First Choice Option. It will reduce pressure on the system as people use the service-option flexibility within CFSS instead of accessing the expanded service menu of one of the state's five home and community based services (HCBS) waivers to meet gaps in what they need.

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

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

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

A. Expected Outcomes for Other Waivers

Family Planning
Under the demonstration Minnesota expects to achieve the following objectives:

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

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

Reform 2020
The Reform 2020 demonstration will assist the state in its goals to:
- Achieve better health outcomes,
- Increase and support independence and recovery,
- Increase community integration,
- Reduce reliance on institutional care,
- Simplify the administration of the program and access to the program, and
- Create a program that is more fiscally sustainable.

B. Waiver Updates

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

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

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

IX. Review of Comprehensive Quality Strategy

A. Periodic Reviews of Quality Strategies by the State

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

B. Definition of Significant Change to Quality Strategies

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

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

C. Timeframes for Updating Quality Strategies

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

X. Next Steps

A. Stakeholder Input

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

B. Catalog of Health Care Program Improvement Efforts

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

C. Comprehensive Strategy

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

XI. Appendices:

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

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

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

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

Appendix D: PMAP+ Waiver Evaluation Proposal.

Appendix E: Reform 2020 Waiver Evaluation Proposal.

Appendix F: Family Planning Waiver Evaluation Proposal.

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

Appendix A

Data Collection Burden Reduction

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

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

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

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

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

Appendix B

Managed Care Core Quality Strategy Components

ACCESS STANDARDS

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

MCO Duties

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

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

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

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

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

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

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

Special Needs Basic Care (SNBC): SNBC is a voluntary managed care program for people age18 to 64, who are certified disabled and eligible for Medical Assistance. SNBC incorporates Medicare Parts A, B and D for enrollees who qualify for that coverage. A care coordinator or navigator is assigned to each enrollee to help access health care and other support services. DHS contracts with five Medicare Advantage Special Needs Plans to provide SNBC. SNBC offers all medically necessary Medicaid State Plan Services with the exception of HCBS waivers, Personal Care Assistants, and private duty nursing (PDN). HCBS waiver services, PCA, and PDN services are paid by the MA fee-for-service program. If an enrollee is Medicare eligible, the MCO covers all Medicare services, including prescription drugs covered by Part D and any alternative services the MCO may choose to offer. The MCO pays for the first 100 days of nursing facility care for community enrollees who enter a nursing facility after enrollment. In 2013, the SNBC program expanded to serve over 35,000 enrollees. Blue Plus, HealthPartners, and Itasca Medical Care do not participate in the program.

<u>Oversight Activities</u>

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

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

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

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

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

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

Reports and Evaluation

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

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

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

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

MCO Duties

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

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

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

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

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

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

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

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

Oversight Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

Oversight

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

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

Special Health Care Needs

MCO Duties

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

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

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

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

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

Oversight

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

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

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

Reports and Evaluation

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

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

MCO Duties

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

services[1] are covered unless specifically excluded from the contract. The MCO must have in place policies for authorization of services and inform enrollees how services may be accessed (whether direct access is permitted, when a referral is necessary, and from whom). In the contract, federal, and state laws specify time frames for decisions and whether standard or expedited. (See Grievances and Appeals in Article 8 of the contract) The EOC must inform enrollees how to access State Plan services not covered by the MCO's contract.

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

Oversight Activities

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

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

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

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

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

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

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

STRUCTURE AND OPERATIONAL STANDARDS

42 C.F.R. §438.214 Provider selection

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

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

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

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

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

42 C.F.R. §438.218 Enrollee information

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

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

State Duties

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

MCO Duties

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

Oversight Activities

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

Reporting and Evaluation

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

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

A. Information for Potential Enrollees

State Duties

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

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

MCO Duties

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

B. Information for Enrollees

State Duties

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

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

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

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

MCO Duties

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

Oversight Activities

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

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

Reporting and Evaluation

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

42 C.F.R. §438.224 Confidentiality

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

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

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

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

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

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

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

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

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

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

Oversight Activities
The State monitors all requests for disenrollment.

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

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

42 C.F.R. §438.228 Grievance system

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

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

- The MCO must assist enrollees, as needed, in completing forms and navigating the grievance and appeal process. The appeal process must provide that oral inquiries seeking to appeal an action be treated as an appeal with the opportunity to present evidence in person as well as in writing.

- The MCO must dispose of each grievance and resolve each appeal, whether orally or in writing, and provide notice, as expeditiously as the enrollee's health condition requires, but no later than the timeframes established by state and federal laws, and that are specified in the contract.

- A State Fair Hearing must be permitted as specified by the State. The MCO must be a party to the State Fair Hearing and comply with hearing decisions promptly and expeditiously.

- The MCO must send a notice of action to each enrollee when it denies, terminates, or reduces a service or when it denies payment for a service. The notice must state the action taken; the type of service or claim that is being denied, terminated, or reduced; the reason for the action; and the rules or policies which support the action. The notice must include a rights notice, explaining the enrollee's right to appeal the action. The MCO must continue to provide previously authorized benefits when an enrollee appeals the denial, termination, or reduction of those benefits and the timelines and other conditions for continuation of benefits are met, as specified in Section 8 of the contract.

- The MCO must maintain grievance and appeal records, and provide notification to the State, as specified in the contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEASUREMENT AND IMPROVEMENT STANDARDS

42 C.F.R. §438.236 Practice guidelines

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

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

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

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

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

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

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

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

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

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

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

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

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

Oversight Activities

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

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

Reporting and Evaluation

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

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

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

MCO Duties

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

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

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

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

Oversight Activities

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

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

Reporting and Evaluation

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

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

SANCTIONS

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

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

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

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

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

Appendix C

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

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

SFY 2013 TCA Elements

1. QI Program Structure 2013 Contract Section 7.1.1

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

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

In accordance with the DHS/MCO managed care contracts for MSHO, and MSC+, the MCO must demonstrate that it offers a range of choice among Waiver providers such that there is evidence of procedures for ensuring access to an adequate range of waiver and nursing facility services so that appropriate choices among nursing facilities and/or waiver services may be offered to meet the individual need as of Enrollees who are found to require a Nursing Facility Level of Care. These procedures must also include strategies for identifying Institutionalized Enrollees whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility[2]

3. Utilization Management. 2013 Contract Section 7.1.3

[1] DHS/MCO Contracts and current NCQA Standards and Guidelines for the Accreditation of Health Plans.
[2] Evidence that choice is offered to Enrollees qualifying for a Nursing Home Level of Care is reviewed #10

A. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans." The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under and over utilization. The MCO shall:

(1) Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.

(2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under and overutilization.

(3) Conduct qualitative analysis to determine the cause and effect of all data not within thresholds.

(4) Analyze data not within threshold by medical group or practice.

(5) Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions. [3]

B. The following are the 2013 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1-4 and 10-14.

(1) ***NCQA Standard UM 1: Utilization Management Structure***
The organization clearly defines the structures and processes within its utilization management (UM) program and assigns responsibility to appropriate individuals.
(a) Element A: Written Program Description
(b) Element B: Physician Involvement
(c) Element C: Behavioral Healthcare Practitioner Involvement
(d) Element D: Annual Evaluation

(2) ***NCQA Standard UM 2: Clinical Criteria for UM Decision***
To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.
(a) Element A: UM Criteria
(b) Element B: Availability of Criteria
(c) Element C: Consistency in Applying Criteria

(3) ***NCQA Standard UM 3: Communication Services***
The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

[3] 42 C.F.R §438. 240(b)(3)

(a) Element A: Access to Staff

(4) ***NCQA Standard UM 4: Appropriate Professionals***
Qualified licensed health professionals assess the clinical information used to support UM decisions.
(a) Element D: Practitioner Review of BH Denials
(b) Element F: Affirmative Statement About Incentives

(5) ***NCQA Standard UM 10: Evaluation of New Technology***
The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefits plan. This includes medical and behavioral health procedures, pharmaceuticals, and devices.
(a) Element A: Written Process
(b) Element B: Description of the Evaluation Process

(6) ***NCQA Standard UM 11: Satisfaction with the UM Process***
The organization evaluates member and practitioner satisfaction with the UM process.
(a) Element A: Assessing Satisfaction with UM Process.

(7) ***NCQA Standard UM 12: Emergency Services***
The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.
(a) Element A: Policies and Procedures

(8) ***NCQA Standard UM 13: Procedures for Pharmaceutical Management***
The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals
(a) Element A: Policies and Procedures
(b) Element B: Pharmaceutical Restrictions/Preferences
(c) Element C: Pharmaceutical Patient Safety Issues
(d) Element D: Reviewing and Updating Procedures
(e) Element E: Considering Exceptions

(9) ***NCQA Standard UM 14: Triage and Referral for Behavior Health Care***
The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed. *This standard applies only to organizations with a centralized triage and referral process for behavioral health, both delegated and non-delegated.*
(a) Element A: Triage and Referral Protocols

4. Special Health Care Needs 2013 Contract Section 7.1.4 A-C.[4, 5]

A. The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

(1) Mechanisms to identify persons with special health care needs,

(2) Assessment of enrollees identified (Senior and SNBC contract - care plan), and

(3) Access to specialists

5. Practice Guidelines. 2013 Contract Section 7.1.5 [6]

A. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for children, adolescents, prenatal care, young adults, adults, and seniors age 65 and older, and as appropriate for people with disabilities populations.

(1) Adoption of practice guidelines. The MCO shall: adopt guidelines based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; consider the needs of the MCO enrollees; adopt in consultation with contracting Health Care Professionals; review and update them periodically as appropriate.

(2) Dissemination of guidelines. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to enrollees and potential enrollees.

(3) Application of guidelines. The MCO shall ensure that these guidelines are applied to decisions for utilization management, enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

6. Annual Evaluation. 2013 Contract Section 7.1.8 [7, 8,]

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

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[4] 42 C.F.R §438.208 (c)(1-4)
[5] MSHO/MSC+ Contract Section 7.1.4 A-C
[6] 42 C.F.R §438.236
[7] 42 C.F.R §438.240(e)
[8] MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "Quality Framework for the Elderly" in its Annual Evaluation

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

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

(1) A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service

(2) Trending of measures to assess performance in the quality and safety of clinical care and quality of service

(3) Analysis and evaluation of the overall effectiveness of the QI program, including progress toward influencing network wide safe clinical practices.

(4) Evaluation of the overall effectiveness of the QI program, including progress toward influencing network wide safe clinical practices.

7. Interim and Completed Performance Improvement Projects: 2013 Contract Section 7.2. [9, 10]

A. Interim Project Reports. By December 1st of each calendar year, the MCO must produce an interim performance improvement project report for each current project. The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight and ten as appropriate.

B. Completed PIP Project Improvements Sustained Over Time. Real changes in fundamental system processes result in sustained improvements:

(1) Were PIP intervention strategies sustained following project completion?

(2) Has the MCO monitored post PIP improvements?

8. Disease Management: 2013 Contract Section 7.3 [11]

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

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[9] 42 C.F.R §438.240 (d)(2)
[10] CMS Protocols, Conducting Performance Improvement Projects, Activity 10
[11] MSHO/MSC+ Contract Section 7.3, require only diabetes and heart DM programs. SNBC Contract Section 7.2.9

B. The MCO's Disease Management Program shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" - QI Standard Disease Management.

C. If the MCO's diabetes, asthma and heart disease management programs have achieved 100 percent compliance during the most recent NCQA Accreditation

Audit of QI Standard- Disease Management, the MCO will not need to further demonstrate compliance.

9. Advance Directives Compliance: 2013 Contract Section 16 Advance Directives Compliance[12] [13]

A. The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on advance directives and the following:

(1) Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, or other advance directive.

(2) Written policies of the MCO respecting the implementation of the right; and

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

(4) Information that complaints concerning noncompliance with the Advance Directive requirement may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 C.F.R. §422.128 as required in 42 C.F.R. §438.6(i).

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

C. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.

D. To comply with State law, whether statutory or recognized by the courts of the State on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38.

[12] MSHO/MSC+ and SNBC Contract Article 16.
[13] Pursuant to 42 U.S.C. 1396a(a)(57) and (58), 42 C.F.R. §489.100-104 and 42 C.F.R. §422.128

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

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

A. DHS will provide MDH with a Data Collection Guide for the random sample of 30 MCO enrollees (plus an over sample of 10 MCO enrollees for missing or unavailable enrollee records) for MSHO and MSC+ program. Of the 40 records sampled, 20 records will be for members new to the MCO within the past 12 months and other 20 records will be for members who have been with the MCO for more than 12 months. Instructions on selecting the sample are included in the Data Collection Guide.

B. MDH will request the MCO make available during the MDH QA Examination on-site audit the identified enrollee records. A copy of the Data Collection Guide and data collection tool will be included with MDH'S record request.

C. An eight-thirty audit methodology will be used to complete a data collection tool for each file in each sample consistent with the Data Collection Guide.

D. Within 60 days of completing the on-site MDH QA Examination, MDH will provide DHS with a brief report summarizing the data collection results, any other appropriate information and the completed data collection tools.

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

12. Other areas by mutual agreement.

[14] Families and Children, Seniors and SNBC Contract Section 7.1.2
[15] 42 C.F.R. §438.242

Appendix D

Proposed Evaluation for Section 1115 Demonstration Waiver Extension

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

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

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

1. Background on the PMAP+ Section 1115 Waiver

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

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

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

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

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

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

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

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

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

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

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

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

Summary of changes occurring between 2013 and 2014:

- Beginning January 1, 2014, a "bright line" is established between MinnesotaCare and Medical Assistance or MA. People who are eligible for MA must enroll in MA rather than MinnesotaCare. This ensures that people who are eligible for MA receive the most generous coverage they are entitled to receive.

- With more generous eligibility standards for Medical Assistance in 2014, MinnesotaCare coverage is no longer needed for certain groups. For example:

    - MinnesotaCare no longer covers adults, parents and 19-20 year olds with incomes below 133% of the FPL because these groups are enrolled in MA. In 2013, adults, parents and 19-20 year olds may be eligible for MA if they have family incomes at or below 100% of the Federal Poverty Level or FPL. In 2014, this was expanded to 133% of the FPL.

    - Pregnant women and children under age 19 with family incomes at or below 275% of the FPL were enrolled in MinnesotaCare in 2013, but were transitioned to MA in 2014. Certain children under age 19 may enroll in MinnesotaCare if they are ineligible for MA but they have family incomes at or below 200% FPL using Marketplace household composition rules.

    - In 2014, MinnesotaCare covers parents, adults and 19-20 year olds with family incomes up to 200% FPL instead of 250% or 275% FPL to align eligibility standards with requirements in the Affordable Care Act for Basic Health Plans. This change is designed to minimize disruption with the transition to a Basic Health Plan in 2015.

- In 2014, MinnesotaCare benefits for certain adults were increased to conform to benefits requirements in the Affordable Care Act and to minimize disruption with the transition to a Basic Health Plan in 2015. As before, MinnesotaCare enrollees under age 21 receive the full MA benefit set and pay MA copays.

    - Benefits: For adults without children, the $10,000 cap on inpatient hospital services is eliminated.

- Cost-sharing: For adults without children, the 10% co-pay on inpatient hospital services is eliminated.

- Reduced premiums. Premiums are reduced for adult in MinnesotaCare. Enrollees under age 21 pay no premium.

- Certain MinnesotaCare eligibility rules have changed in 2014 to align with requirements in the Affordable Care Act.
  - MinnesotaCare no longer has an asset test.
  - Affordable Care Act income calculation methods are used to determine eligibility.
  - The 4-month and 18-month eligibility waiting periods are eliminated.
  - MinnesotaCare coverage may begin while an individual is hospitalized.
  - Individuals who are eligible for minimum essential coverage are not eligible for MinnesotaCare.
  - Eligibility for certain special populations (volunteer firefighters, former foster care children) is eliminated. (Former foster care children are covered under MA).

- In 2014, MinnesotaCare eligibility was expanded to include groups that are expected to be covered by the Basic Health Plan in 2015 so that these groups would experience fewer coverage transitions.
  - MinnesotaCare provides coverage for children under age 19 who are not eligible for MA under MA household composition rules but who have family incomes at or below 200% FPL using different household composition rules.
  - MinnesotaCare provides coverage for adults who would not have family incomes at or below 200% FPL using Medicaid income calculation rules, but would have incomes at or below 200% FPL using income calculation rules that will apply under the Basic Health Plan

3. Evaluation Strategy

A. Demonstration Goals, Hypotheses and Objectives

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

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

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

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

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

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

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

  - Calculate premiums, cost-sharing and tax credit expenditures for purchase of MinnesotaCare-level coverage via MNsure for people at incomes of 200-250% FPL, by level of coverage (bronze, silver, gold and platinum).

- **Hypothesis**: Combined federal and state per capita spending on the waiver group and average enrollee cost sharing will be equal to or less than spending and cost sharing for Minnesotans at the 200-250 % FPL income level enrolled through MNsure if they to choose benefit coverage similar to what the waiver group will receive.
- **Data Source:** MNsure eligibility data; state and federal expenditure data on waiver group; CMS data on cost-sharing settle-ups.

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

- **Objectives:** Improve:
  - Utilization of preventative services for children (childhood immunizations, child access to PCP, annual dental visits, and well-child visits)
  - Utilization of preventative and chronic disease care services for adults (diabetes care, depression management, adult preventive visits, cervical cancer screening and dental visits)
  - Enrollee satisfaction with the delivery and quality of services (satisfaction survey results)

- **Measurement**: Compare waiver and non-waiver Medicaid enrollees using selected HEDIS 2015 and other performance measures of utilization, preventive and chronic disease care, physical and mental health services, and satisfaction with managed care services to compare, contrast and draw out differences between the populations.

- **Hypothesis**: Providing health care coverage to child and adult populations who would otherwise be uninsured will result in improved outcomes:

- **Data Source:** MCO submitted encounter data.

B. Evaluation Populations

Waiver Evaluation populations will consist of the following subgroups:

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

Comparison Groups:

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

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

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

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

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

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

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

C. Evaluation Plan

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

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

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

E. Evaluation Metrics

1. Measures:

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

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

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

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

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

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

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

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

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

D. Design Approaches

4. Evaluation Implementation Strategy and Timeline

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

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

1. A discussion of the demonstration goals and objectives, as well as the specific hypotheses that are being tested.

2. A discussion of the outcome measures that will be used to evaluated the impact of the demonstration during this extension period.

3. A discussion of the data sources and sampling methodology for assessing the outcomes.

4. A detailed analysis plan that describes how the effects of the demonstration will be isolated from other initiatives occurring in the State.

D. Evaluation Design

a. Management and Coordination of the Evaluation

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

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

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

Waiver Evaluation Process Steps Timeline
CY 2015

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

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

b. Integration of the Quality Improvement Strategy

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

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

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

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

c. Limitations and Opportunities

The following limitations may impact the results of this evaluation:

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

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

d. Conclusion, Best Practices, and Recommendations

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

Appendix E
Proposed Evaluation for Reform 2020
Section 1115 Demonstration Waiver

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

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

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

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

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

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

[1] 2011 unduplicated enrollment: 15,761
[2] 2011 unduplicated enrollment: 18,927 (reflects high turnover rate)
[3] 2011 unduplicated enrollment: 390
[4] 2011 unduplicated enrollment: 1,513
[5] 2011 unduplicated enrollment: 29,291 (managed care and FFS)

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

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

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

1. Background on the Reform 2020 Section 1115 Waiver

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

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

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

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

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

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

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

2. Alternative Care

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

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

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

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

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

3. Community First Services and Supports

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

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

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

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

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

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

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

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

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

3.1 Eligibility for CFSS

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

1) 1915(i)-like CFSS recipients: People eligible for MA with incomes above 150% of the federal poverty level and at or below the relevant state plan limit for categorical eligibility. These individuals meet the personal care assistance criteria. This means they have an assessed need for assistance with at least one activity of daily living or demonstrate physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person. Demonstration waiver authority is necessary for this group because they do not meet the Medicaid financial eligibility criteria to be eligible for the Section 1915(i) state plan benefit. They do not meet an institutional level of care for a NF, ICF-ID or hospital; and are categorically eligible for Medical Assistance;

2) 1915(k)-like CFSS recipients: In order to encourage utilization of CFSS instead of home and community-based services where appropriate, Minnesota has been granted authority to extend Medicaid eligibility to this group. This group is made up of people who have chosen CFSS services in lieu of home and community-based waiver services but who are financially eligible for Medical Assistance only if they utilize the eligibility rules of one of Minnesota's home and community-based waivers. This group must have incomes above a Medicaid state plan standard, meet all non-financial eligibility factors for eligibility for a home and community-based waiver, and qualify for Medicaid using the rules of the special home and community-based waiver group under 42 CFR §435.217. These individuals must need an institutional level of care and meet the personal care criteria, which means they have an assessed need for assistance with at least one activity of daily living or demonstrate physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person. This group includes people who are
    a. Age 65 or over and eligible without a spend-down with income at or below 300% of SSI and spousal impoverishment rules;
    b. Disabled, under age 65 and above age 20, and eligible without a spend-down with income at or below the relevant state plan standard with special institutional rules including an exemption from spousal deeming; or
    c. Children under age 21 using eligible using special institutional rules including exemption from parental deeming.

3.2 The CFSS Benefit

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

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

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

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

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

3.22 CFSS service delivery models

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

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

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

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

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

3.23 Services that may be accessed under the CFSS benefit

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

- **Assistance with ADLs, IADLs, and health-related tasks** through hands-on assistance, supervision, and/or cueing.

- **Acquisition, maintenance, or enhancement of skills** necessary for the participant to accomplish ADLs, IADL's, and health-related tasks.

- **Assistance in accomplishing instrumental activities of daily living** (IADLs) related to living independently in the community and an assessed need: meal planning, preparation, and shopping for food; shopping for clothing or other essential items; cooking; laundry; housecleaning; assistance with medications; assistance with managing money; assist with individualized communication needs; arranging supports; assistance with participating in the community; and other appropriate IADL services.

- **Assistance in health-related procedures and tasks** that can be delegated or assigned by licensed health-care professionals under state law.

- **Observation and redirection of Level I behaviors**, defined as physical aggression towards self or others and/or destruction of property that requires the immediate response of another person.

- **Back-up systems** or mechanisms (such as the use of personal response systems or other mobile devices selected by the participant) to ensure continuity of the participant's services and supports. Specific risks and levels of back-up support needed are addressed during the participant's initial and annual person-centered assessments, in the development of the community support plan and the service delivery plan. Each

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

- **Consultation services** provide assistance to support the participant in making informed choices regarding CFSS services in general and self-directed tasks in particular; eliminate barriers to services and streamlines access; assist the person in developing a quality person centered service delivery plan, and offer support with compliance and quality outcomes. Consultation services provided to participants may include, but are not limited to: an orientation to CFSS, including assistance selecting a service model; assistance with the development, implementation, management and evaluation of the service delivery plan; assistance with recruiting, selecting, training, managing, directing, evaluating, supervising, and dismissing support workers; and facilitating the use of informal and community supports, goods or resources.

- **Worker training and development services** to enhance the support worker's skills as required by the participant's service delivery plan. Services provided to the direct support worker may include but are not limited to: training, education, direct observation, consultation, and performance evaluation.

- **Expenditures for environmental modifications, or goods**, including assistive technology. Such expenditures must relate to a need identified in a participant's CFSS community support plan; be priced at fair market value; increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed needs; and fit within the annual limit of the participant's approved service allocation or budget.

- **Financial management services** to provide payroll services for participants who choose the budget model.

CFSS does not cover:

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

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

4. Evaluation Strategy for Alternative Care

4.1 Demonstration Goals, Hypotheses and Objectives for Alternative Care

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

4.11 Goal One: Access

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

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

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

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

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

4.12 Goal Two: Quality

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

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

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

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

Data Sources: MMIS claims data.

4.13 Goal Three: Sustainability

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

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

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

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

Data Sources: MMIS claims data.

4.2 Evaluation Populations for Alternative Care

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

4.3 Evaluation Metrics for Alternative Care

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

4.4 Plan for Analysis of Alternative Care

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

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

Overview of Populations, Measures and Years

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

4.42 External Evaluation

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

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

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

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

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

5. Evaluation Strategy for Consumer First Services and Supports

5.1 Demonstration Goals, Hypotheses and Objectives for CFSS

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

5.11 Goal 1: Comparable Access for Waiver Groups

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

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

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

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

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

Data Source: MMIS

5.12 Goal 2: Comparable Quality for Waiver Groups

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

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

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

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

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

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

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

Data Sources: MMIS and Annual CFSS participant survey

5.13 Goal 3: Comparable Program Sustainability for Waiver Groups

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

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

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

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

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

Data Source: MMIS

5.2 Evaluation Populations for CFSS

The waiver evaluation populations will consist of the following subgroups:

1) **CFSS 1915(i)-like group**. This group is comprised of people who are eligible for Medicaid with incomes above 150% of the federal poverty level who do not have an assessed need for an institutional level of care. This group will be compared to people receiving CFSS under the 1915(i) state plan option.

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

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

1) **People receiving CFSS under 1915(i) state plan option.** This group is comprised of people enrolled in Medicaid with incomes under 150% of the federal poverty level who do not have an assessed need for an institutional level of care. This state plan group will be compared to the waiver population called the "CFSS 1915(i)-like group."

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

5.3 Evaluation Metrics for CFSS

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

5.4 Evaluation Plan for CFSS

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

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

Overview of Populations, Measures and Years

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

5.42 External Evaluation

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

6. Evaluation Implementation Strategy

6.1 Management and Coordination of the Alternative Care and CFSS Evaluations

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

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

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

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

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

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

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

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

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

6.3 Conclusion, Best Practices, and Recommendations

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

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

Short Term Objectives

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

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

Long Term Objectives

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

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

Objective 1

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

Measurement

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

Hypothesis

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

Indicators

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

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

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

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

Data Sources

MMIS eligibility data

Definitions:

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

Objective 2

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

Measurement

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

Hypothesis

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

Indicators

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

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

Data Sources

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

Definitions

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

Objective 3

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

Measurement

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

Hypothesis

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

Indicators

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

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

Data Sources

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

Definitions

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

Objective 4

Reduce the teen birth rate among MHCP enrollees.

Measurement

Access the teen birth rate among MHCP enrollees.

Hypothesis

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

Indicators

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

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

Data Sources

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

Definitions

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

Table 1. MFPP Short-Term Objectives and Associated Indicators

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

Table 2. MFPP Long-Term Objectives and Associated Indicators

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

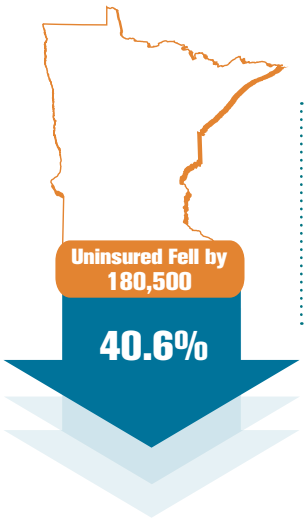
JUNE 2014

shadac
STATE HEALTH ACCESS DATA ASSISTANCE CENTER

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

Executive Summary

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



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

- Between September 30, 2013 and May 1, 2014, the number of uninsured Minnesotans fell by 180,500, a reduction of 40.6 percent. The number of uninsured in Minnesota fell from 445,000 (8.2 percent of the population) to about 264,500 (4.9 percent of the population).

- This increase in health insurance coverage was primarily driven by an increase in the number of Minnesotans enrolled in state health insurance programs, Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare. Enrollment increased by over 155,000 for these two programs combined.

- Coverage in the private health insurance market also increased. The total number of Minnesotans with private group coverage (primarily employer-sponsored coverage) was relatively stable with a decline of about 6,000 (a 0.2 percent change); growth in self-insured plans was balanced by a decline in fully-insured coverage. The nongroup market grew by almost 36,000 and included gains both inside and outside of MNsure.

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

Introduction

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

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

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

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

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Methods

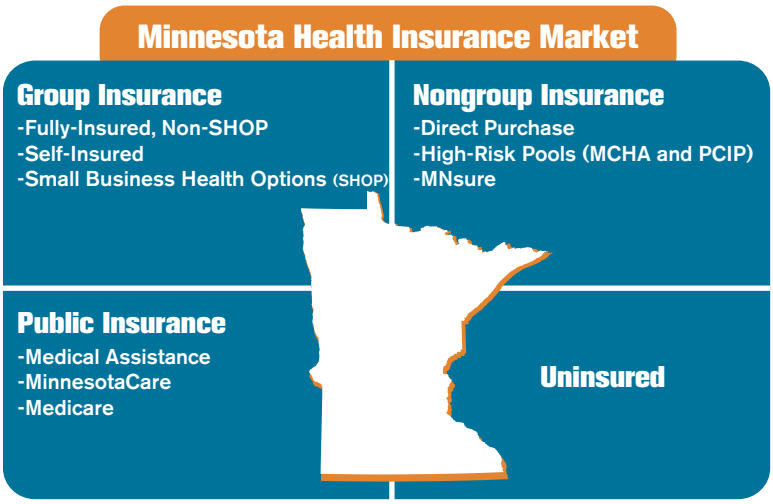
SHADAC collected information from private and public payers on the number of Minnesota residents enrolled in their health plans at two points in time: September 30, 2013 and May 1, 2014.[3] These data provide a snapshot of coverage in Minnesota just before the MNsure open enrollment period began, and one month after it closed, allowing for processing of enrollments that had been started but not completed prior to the end of open enrollment.

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

The methodology used in this analysis is similar to one that has been used by the State of Minnesota to estimate the distribution of health insurance coverage in Minnesota since the early 1990s.[4] The data come from a variety of sources, including private health plans, MNsure, the Minnesota Department of Human Services (DHS), the U.S. Census Bureau, the Minnesota Health Access Survey, and other sources as detailed below. The analysis begins with the total population of the state, and then accounts for the number of people with each type of health insurance coverage, for which data are available. Since enrollment in self-insured plans is not subject to state regulation and is not reported publicly, this coverage type is calculated as a residual for September 2013.[5] In other words, the estimated number of people

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

FIGURE 1. MINNESOTA HEALTH INSURANCE MARKET



Total population

According to the most recent estimates from the U.S. Census Bureau, Minnesota's population was 5,420,380 as of July 1, 2013.[6] SHADAC calculated an average monthly growth rate for the period from July 1, 2010 to July 1, 2013 and applied this growth rate to estimate Minnesota's population on October 1, 2013 and on May 1, 2014.

Private group coverage

Enrollment counts as of September 30, 2013 and May 1, 2014 for Minnesota residents in fully-insured group coverage, outside of MNsure's SHOP exchange, were provided to SHADAC by the Minnesota Council of Health Plans (MCHP) for its members.[7] SHADAC adjusted this number upward to account for the market share held by plans that are not members of MCHP. Market share was calculated by using information on premiums and market shares in the fully-insured market as a whole[8] and subtracting premiums for nongroup coverage.[9] SHADAC estimated that the MCHP member plans account for 88.9 percent of the fully-insured group market, and adjusted the MCHP enrollment counts accordingly to represent the total market.

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

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

Private nongroup coverage

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

monthly reports that participating carriers submit to the federal government.

Medical Assistance and MinnesotaCare

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

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

Medicare

The most recent publicly available enrollment counts for Minnesota residents in Medicare are for July 1, 2012.[14] SHADAC calculated average monthly enrollment growth rates in Medicare for Minnesota residents for July 2009 to July 2012, and applied this average monthly growth rate to the 2012 enrollment count to estimate enrollment of Minnesota residents in Medicare as of October 1, 2013 and May 1, 2014.

Uninsured

The estimated number of uninsured in September 2013 comes from the Minnesota Health Access Survey (MNHA), a bi-annual survey of Minnesota households that is conducted jointly by the Minnesota Department of Health and SHADAC. Approximately 445,000 Minnesotans were uninsured in the fall of 2013. This estimate reflects the most recent survey of nearly 12,000 Minnesota households conducted between mid-August and mid-November 2013.[15]

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

Results

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

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

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

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

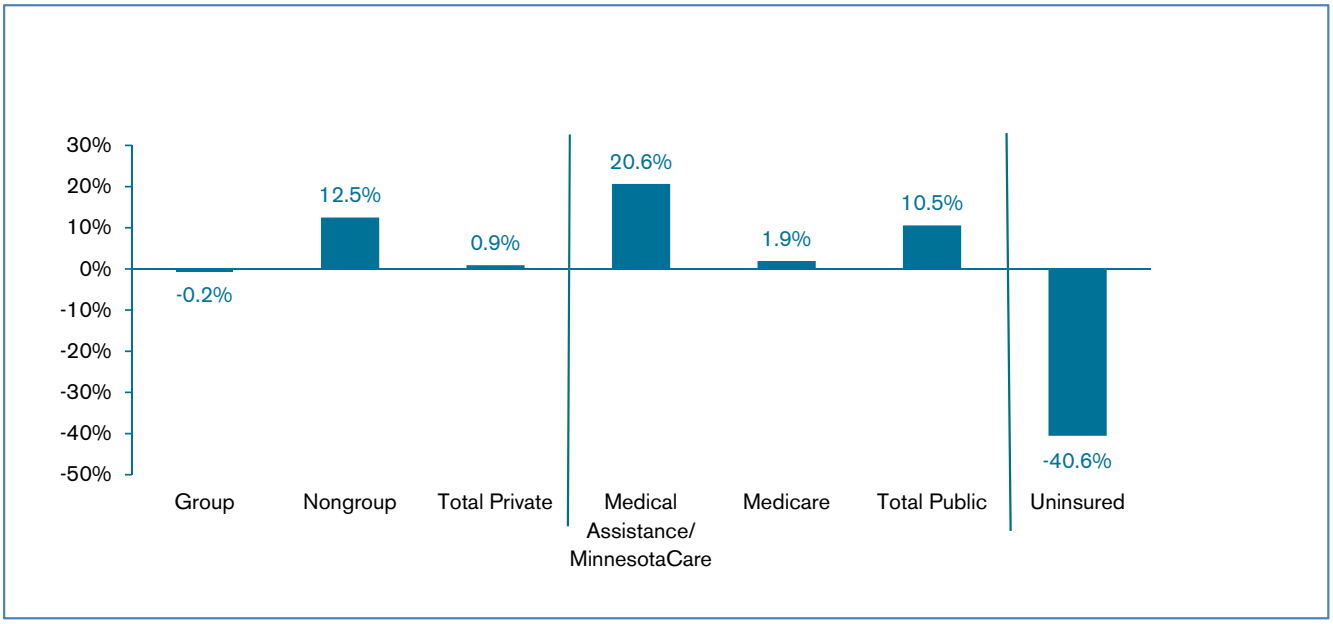
exhibited an enrollment growth rate of 20.6 percent from the end of September 2013 to the beginning of May 2014. Given that two-thirds of Minnesotans who were uninsured in 2013 were estimated to be eligible for public health insurance coverage, this rapid growth in state public program coverage is not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

Although nearly all of the information that we relied on for this study was reported to us directly from the entities that provide health insurance coverage in the state of Minnesota, we did make some assumptions about portions of the market for which we couldn't collect data. For example, we assumed that enrollment in MCHP members' plans represented 88.9 percent and 91.5 percent of the group and nongroup markets, respectively, at both the start and the conclusion of the open enrollment period. We performed a sensitivity analysis to determine how much our results would change under different assumptions for changes in enrollment in portions of the market for which we did not collect enrollment data directly from payers. This assumption had little impact on our conclusion about the size of the reduction in Minnesota's uninsured population.[20] In addition, we assumed that total enrollment in self-insured plans grew at the same rate reported to us by members of MCHP for their self-insured enrollment.

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

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

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



Discussion

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

To our knowledge, this analysis provides the first state-level estimate of the ACA's early impacts on the number of people without health insurance coverage. This analysis was possible due to Minnesota's strong data infrastructure and voluntary participation in this study by the Minnesota Council of Health Plans (MCHP) and its members, MNsure, Minnesota's Department of Human Services (DHS) and the Minnesota Comprehensive Health Association (MCHA). Their willingness to provide enrollment data to support this effort was critical to our ability to estimate total enrollment in a timely manner. In addition, the availability and timing of the 2013 Minnesota Health Access Survey provided a high quality, well-established baseline for the number of uninsured in Minnesota. The methods that we used are fairly straightforward, and could be readily replicated in other states if the appropriate data are available and if both public and private payers are willing to provide enrollment counts.

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

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

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

insurance between September 2013 and March 2014.[22] The Gallup Corporation has also published survey findings showing a drop in the share of U.S. adults who lack health insurance, from 17.1 percent in the fourth quarter of 2013 to 13.4 percent in April 2014,[23] with larger declines in states that have implemented the ACA's Medicaid expansion than in those that have not.[24]

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

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

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

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

Acknowledgements

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

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

ENDNOTES

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

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

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

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

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

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

[7]Excluding dental-only plans.

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

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

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

[11]Ibid.

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

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

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

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

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

ENDNOTES (CONTINUED)

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

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

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

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

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

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

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

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

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

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

State Health Access Data Assistance Center (SHADAC)

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

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

The State Health Reform Assistance Network

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

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Attachment D

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

Evaluation Plan 2011-2013

1. Introduction

This proposed evaluation plan relates to the demonstration periods July 1, 2011 through December 31, 2013 for the Prepaid Medicaid Assistance Project Plus (PMAP+) Section 1115 waiver. The State of Minnesota has provided care to eligible individuals under a Section 1115 demonstration waiver for many years. One of the primary components of the waiver has been the MinnesotaCare program, which was created in 1992 to help people who struggled with the high cost of private insurance but earned too much to qualify for Medicaid. This program, which requires payment of a monthly premium and higher cost sharing than Medicaid, has been credited with keeping Minnesota's uninsured rate lower than the national average.

During the 2011-2013 demonstration period, the primary purpose of the demonstration was to provide cost-effective and comprehensive health insurance coverage to people with family incomes above Medicaid state plan income levels. In July of 2012, midway through the 2011-2013 demonstration period, there were over 120,000 people covered under the demonstration.

On August 1st, 2011, Minnesota received authority to add coverage for a category of adults without children to the MinnesotaCare program. Over 30,000 adults received coverage under the waiver every month. This group was previously covered under state-funded programs.

Coverage became available under Minnesota's health insurance exchange, MNsure, in January of 2014. The PMAP+ waiver was amended to reflect the expansion of eligibility in Minnesota's Medicaid program, and to modify the MinnesotaCare program to ease the planned transition to Basic Health Plan authority in 2015.

2. Background on the PMAP+ Section 1115 Waiver

Minnesota has long been known for its low rates of uninsurance, high quality of care, mature managed care environment, and generous publicly funded health care programs.
Enrollees began receiving services from health plans on a prepaid capitated basis under the first Prepaid Medical Assistance Project (PMAP) Section 1115 waiver in July of 1985, almost thirty years ago. The project required that Medical Assistance or MA recipients (other than persons with disabilities) be enrolled with a health plan for a 12-month period. PMAP was initially limited to a few Minnesota counties.

In April 1995, CMS approved a statewide health care reform amendment to the PMAP waiver. This 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 federal poverty guidelines (FPG) into the Medicaid program. An amendment approved in 1999 expanded the program to include parents enrolled in MinnesotaCare. A subsequent amendment in 2000 allowed for administrative simplification and mandatory enrollment of certain MA populations in managed care.

With promulgation of managed care regulations in 2002, states were able to implement mandatory enrollment in managed care through their Medicaid state plans. Minnesota now provides prepaid managed care coverage to infants, children, pregnant women, parents and adults without children via the state plan. Nevertheless, the PMAP+ 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 population under the MinnesotaCare program and mandatory managed care for certain MA populations, such as American Indians and children with special needs.

In March of 2011, Minnesota included adults without dependent children with family incomes at or below 75 percent FPG in its state plan for the first time under authority granted by the Affordable Care Act. Effective August 1, 2011, Minnesota was also granted authority to cover adults without dependent children with family incomes above 75 and at or below 250 percent of the FPG as an expansion population under the PMAP+ waiver.
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 does not have fee-for-service data for comparison.

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

3. The PMAP+ § 1115 Waiver July 1, 2011 through December 31, 2013

The 2011 renewal marked a significant turning point for the PMAP+ waiver. Effective August 1, 2011, Minnesota received authority to add coverage for a category of adults newly eligible for Medicaid under ACA. Over 30,000 adults received coverage under the waiver every month. This group was previously covered under state-funded programs.

The 2011-2013 PMAP+ waiver allows Minnesota to receive federal financial participation to provide coverage to the following eligibility groups:

1. **MinnesotaCare Children**. This group includes children under 21 years of age with family incomes at or below 275 percent of the FPG. MinnesotaCare income methodologies and eligibility rules apply.

2. **MinnesotaCare Pregnant Women**. This group includes pregnant women with family incomes at or below 275 percent of the FPG. MinnesotaCare income methodologies and eligibility rules apply.

3. **MinnesotaCare Caretaker Adults**. This group includes parents and other caretaker relatives with family incomes at or below 275 percent of the FPG. MinnesotaCare income methodologies and eligibility rules apply.

4. **MinnesotaCare Adults without Dependent Children**. This group includes adults age 21 to 64 without dependent children with incomes above 75 percent and at or below 250 percent of the FPG. MinnesotaCare income methodologies and eligibility rules apply.

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

The benefit offered to MinnesotaCare Children, MinnesotaCare Pregnant Women, and MA One-Year-Olds during the 2011-2013 waiver renewal was 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 (which does not include pregnant women) and MinnesotaCare Adults without Dependent Children is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid state plan, except that the services listed in (1) through (8) below are excluded and inpatient hospital services are limited for certain participants as described in (9) below.

1. Services included in an individual's education plan;
2. Private duty nursing;
3. Orthodontic services;
4. Non-emergency medical transportation services;
5. Personal care services;
6. Targeted case management (except that mental health targeted case management services are provided);
7. Nursing facility services; and
8. ICF/MR services.
9. Inpatient Hospital Limit: MinnesotaCare Caretaker Adults (which does not include pregnant women) with income above 215 percent of the FPL are subject to a $10,000 annual limit on inpatient hospitalization. MinnesotaCare Adults without Dependent Children are subject to a $10,000 annual limit on inpatient hospitalization and a 10 percent copay on inpatient hospital stays. The copay is capped at $1,000 per year.

4. Evaluation Strategy for the 2011-2013 Waiver

4.1 Demonstration Goals, Hypotheses and Objectives for 2011-2013

The goal of the waiver is to provide comparable access and quality of health care to waiver populations as compared to Minnesota's other public health care program enrollees in managed care. Both preventive care and treatment of chronic conditions will be assessed. The objective of the evaluation is to demonstrate that access, quality of care and enrollee satisfaction is maintained and is comparable to care provided to Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.

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

4.11 Goal 1: Provide access and quality comparable to national Medicaid averages.

Objective: Provide coverage for expansion groups provided under this waiver so that access and quality of care for child and adult waiver populations are comparable to national Medicaid averages.

Measurement: Access and quality will be evaluated using HEDIS adult, postpartum and child preventive care measures for PMAP+ waiver populations and for a national Medicaid sample.

Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access and quality of care for child and adult waiver populations that is comparable to national Medicaid averages.

Data Sources: MMIS claims data and national Medicaid NCQA Quality Compass data.

4.12 Goal 2: Provide access and quality comparable to Medicaid managed care enrollees who are not eligible under the waiver.

Objective: Provide coverage for expansion groups provided under this waiver so that access and quality of care for child and adult waiver populations are comparable to access and quality for Minnesota Health Care Program recipients who are not enrolled under the demonstration.

Measurement: Access and quality will be evaluated using HEDIS adult, postpartum and child measures for PMAP+ waiver populations and for Minnesota Medicaid enrollees.

Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access and quality of care for child and adult waiver populations that is

comparable to access and quality of care for Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.

Data Sources: MMIS claims data

4.13 Goal 3: Achieve satisfaction rates comparable to Medicaid managed care enrollees who are not eligible under the waiver.

Objective: Achieve satisfaction rates for expansion groups provided under this waiver that are comparable to satisfaction rates of Minnesota Health Care Program recipients who are not enrolled under the demonstration.

Measurement: Compare CAHPS data for MinnesotaCare and CAHPS data for the two groups.

Hypothesis: Satisfaction rates for Medicaid expansion groups under the PMAP+ waiver will be comparable to satisfaction rates for Minnesota Medicaid enrollees who are not enrolled under the PMAP+ waiver.

Data Sources: CAHPS data

4.14 Goal 4: Provide access and quality comparable to Medicaid managed care enrollees who are not eligible under the waiver.

Objective: Provide coverage for expansion groups under this waiver so that access, quality of care and enrollee satisfaction is maintained over time and is comparable to access, quality of care, and enrollee satisfaction for non-waiver Medicaid enrollees.

Measurement: Satisfaction, access and quality will be evaluated using CAHPS data and HEDIS measures for adult, postpartum and child care measures for PMAP+ waiver populations and for Minnesota Medicaid enrollees.

Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access, quality of care and enrollee satisfaction for waiver populations that is maintained over time and is comparable to access, quality of care and enrollee satisfaction for Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.

Data Sources: CAHPS and MMIS claims data

4.2 Evaluation Populations for the 2011-2013 Waiver

Evaluation populations will consist of the following groups:
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Waiver population subgroups:

- MinnesotaCare Children. Children under age 21 in MinnesotaCare with family incomes at or below 275 percent of the FPG. [1]
- MinnesotaCare Pregnant Women. Pregnant women enrolled in MinnesotaCare with incomes at or below 275 percent of the FPG.[2]
- MinnesotaCare Caretaker Adults. Parents or adults caring for children with family incomes at or below 275 percent of the FPG.[3]
- MinnesotaCare Adults without Children. Adults age 21 or older without dependent children, and incomes at or below 250 percent of the FPG.[4]
- Medical Assistance One-Year-Olds. Children enrolled in MA ages 12-23 months and family incomes 133-275 percent of the FPG.[5]

Medical Assistance (MA) Comparison Groups:

- MA Children. Children under age 21 in MA with family incomes at or below 275 percent of the FPG.
- MA Pregnant Women. Pregnant women enrolled in MinnesotaCare with incomes at or below 275 percent of the FPG.
- MA Caretaker Adults. Parents or adults caring for children with family incomes at or below 100 percent of the FPG, enrolled in managed care.
- MA Adults without Children. Adults age 21 or older without dependent children, and incomes at or below 75 percent of the FPG.

Comparison groups are limited to those enrolled in managed care to provide the most accurate comparison. Most people are required to enroll in managed care, with the exception of disabled children and adults.

4.3 2011-2013 Waiver Evaluation Metrics

Goals one through four:

The HEDIS 2013 performance measures in the table below have been selected to evaluate care for children, adults, and pregnant women covered under the waiver compared to people served in Medicaid managed care under the state plan. Performance measure data for the period through calendar year 2013 will be extracted from Minnesota Department of Human Services' managed care encounter data base.

The table below provides a list of the annual HEDIS 2013 performance measures that will be analyzed in the evaluation. These performance measures were chosen to provide insight into several domains of care, including primary care, care for special health needs such as asthma and diabetes, and behavioral health. Due to limitations in the data available for prenatal care, certain

[1] DHS program/eligibility codes: LL/C1, C2, I1, I2
[2] DHS program/eligibility codes: LL/P1, P2
[3] DHS program/eligibility codes: FF/A2, M2
[4] DHS program/eligibility codes: BB/M1, M5
[5] DHS program/eligibility codes: MA/CB and MAXIS financial information

measures are not available for pregnant women. Comparison of performance measures will also be conducted by race.

Children (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)
Medication Management for People with Asthma
Follow-up After Hospitalization for Mental Illness
Adults
Diabetes A1c screening
Diabetes LDL screening
Adult access preventive/ambulatory health services
Cervical CA screening
Medication Management for People with Asthma
Follow-up After Hospitalization for Mental Illness Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Pregnant Women
Postpartum Care
Medication Management for People with Asthma
Follow-up After Hospitalization for Mental Illness

The quality of managed care organization (MCO) encounters is essential to the validity of the evaluation. The Minnesota Department of Human Services (DHS) contracts with MetaStar Inc., a NCQA-certified HEDIS auditor. MetaStar annually validates that 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.

The performance measures will be evaluated for evidence of measurement period changes:

- **Utilization of services for children.** DHS will conduct a comparative analysis of performance trends over measurement periods for children in the waiver population subgroups and children in the non-waiver comparison groups. Measures will include childhood immunizations, child access to PCP, annual dental visits, well-child visits, medication management for people with asthma and follow-up after hospitalization for mental illness.

- **Improved health and utilization of preventative and chronic disease care services for adults.** DHS will conduct a comparative analysis of performance trends over measurement periods of the adult caretaker and adults without children waiver populations and non-waiver adult caretaker and adults without children populations.

Measures will include diabetes screening, adult preventive visits, cervical cancer screening, medical management for people with asthma, follow-up after hospitalization for people with mental illness, and initiation and engagement of alcohol and other drug dependence treatment.

- **Improved utilization of postpartum care services for pregnant women.** DHS will conduct a comparative analysis of performance trends over the baseline measurement period of the pregnant women waiver population and pregnant women non-waiver population. The measure of this hypothesis component will be postpartum care, medication management for people with asthma and follow-up after hospitalization for mental illness.

- **Enrollee satisfaction.** DHS will conduct an analysis and comparison of satisfaction and disenrollment survey results reflecting the enrollee's perspective on the delivery and quality of health care services. The annual CAHPS satisfaction survey of adults and the monthly disenrollment surveys will be used.

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 2013 and April 2013.

For the past ten years, DHS has been conducting monthly surveys of enrollees who voluntarily change from one MCO to another. The one-page survey includes a brief explanation of the survey's purpose. Survey questions are 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. Survey results are 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 and to ensure 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.

4.4 Plan for Analysis of 2011-2013 Waiver

The selected HEDIS 2013 performance measures will be compared 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 2009 through 2010) will be calculated for the targeted populations and compared to the first three calendar years (CYs 2011 and 2012) 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. Performance measurement rates will be presented in a series of tables to analyze and compare performance as outlined in the table below:

Overview of Populations, Measures and Years

Waiver Populations	Comparison Populations	Measures	Measurement/Reference Years
1. MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)	1. MA Children (DHS program/eligibility codes: MA/CB, CK, CX)	1. Childhood immunizations (2 yrs) 2. Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs) 3. Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs) 4. Well –child visits first 5. 15months 5. Well-child visits 3 to 6 yrs. 6. Medication Management for People with Asthma 7. Follow-up After Hospitalization for Mental Illness	MYs = 2011 through 2012 RYs = 2009 through 2010
2.MinnesotaCare Pregnant Women (DHS program/eligibility codes: LL/P1, P2)	3. MA Pregnant Women (DHS program/eligibility codes: MA/PX)	1. Postpartum Care 2. Medication Management for People with Asthma 3. Follow-up After Hospitalization for Mental Illness	MYs = 2011 through 2012 RYs = 2009 through 2010
3. MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)	2. MA Adults (DHS program/eligibility codes: MA/AA)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness	MYs = 2011 through 2012 RYs = 2009 through 2010
5. MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)	5. MA Adults w/o Children (DHS program/eligibility codes: AX)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness 7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	MY = 2012 RY = 2009
4. MA Children 12-24 Mos. 133 to 275 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	4. MA Children 12-24 Mos. less than 133 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	1. Child access to PCP (age groups 12-24 mos) 2. Well–child visits first 15months	MYs = 2011 through 2012 RYs = 2009 through 2010

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) The 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.

5. Evaluation Implementation Strategy and Timeline

5.1 Management and Coordination of the 2011-2013 Waiver Evaluation

DHS will conduct the PMAP+ waiver evaluation. The evaluation will be conducted by DHS staff from the Health Care Research and Quality Division. Below is an overview of the evaluation and activities and timeline:

- June through August 2014 - Calendar years 2009 through 2013 HEDIS rates are calculated and performance measure validation process is completed. The calculation of annual HEDIS-based performance measurement process starts each June for the current measurement year and the previous three years. The previous three years of rates provide comparisons calculated using the same set of technical specifications. More frequent calculation of annual HEDIS measures is inappropriate and an inefficient utilization of state resources.
- September through December 2014- An analysis of the rates is conducted.
- January through March 2015 - The draft and final waiver report is written, reviewed and approved.
- May 1, 2015- The final report is submitted to CMS.

A subset of HEDIS 2013 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.

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.

2011-2013 Waiver Evaluation Process Steps Timeline
CY 2014

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CAHPS Data Collection		X	X	X	X	X						
CAHPS Data Analysis							X	X				
Performance Measures Validation			X	X	X	X						
Performance Measures Calculation & Stratification						X	X	X				
Performance Measure Analysis									X	X		
Draft Report- March 2015												
Final Report & Approval – May 2015												

5.2 Integration of the Quality Improvement Strategy

Compliance, oversight and improvement activities for all Minnesota managed health care programs are conducted in a comprehensive manner across all managed care programs. These activities are not segregated according to the waiver. Annually, DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCOs' compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the Annual Technical Report (ATR). Since 2004, the ATR is the most comprehensive evaluation of quality, access and timeliness of Minnesota's health care programs.

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

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

5.3 Limitations and Opportunities

The following limitations may impact the results of this evaluation:

- Unexpected consequences due to changes in state law regarding public programs.
- Future changes to HEDIS technical specifications influence future coding or data reporting that would bias this type of longitudinal analysis. If these types of changes occur the biases and potential consequences will be reported in the final report limitation section. Changes that will result from transitioning from ICD-9 to ICD-10 codes are not expected to have an impact.
- Measures with high rates of utilization 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.

5.4 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.

Attachment E

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

Evaluation Plan 2014

1. Introduction

This proposed evaluation plan relates to the demonstration period January 1, 2014 through December 31, 2014 for the Prepaid Medicaid Assistance Project Plus (PMAP+) Section 1115 waiver. The State of Minnesota has provided care to eligible individuals under a Section 1115 demonstration waiver for many years. One of the primary components of the waiver has been the MinnesotaCare program, which was created in 1992 to help people who struggled with the high cost of private insurance but earned too much to qualify for Medicaid. This program, which requires payment of a monthly premium and higher cost sharing than Medicaid, has been credited with keeping Minnesota's uninsured rate lower than the national average. During the 2011-2013 demonstration period, the primary purpose of the demonstration was to provide cost-effective and comprehensive health insurance coverage to people with family incomes above Medicaid state plan income levels. In July of 2012, midway through the 2011-2013 demonstration period, there were over 120,000 people covered under the demonstration. On August 1st, 2011, Minnesota received authority to add coverage for a category of adults without children to the MinnesotaCare program. Over 30,000 adults received coverage under the waiver every month. This group was previously covered under state-funded programs. Coverage became available under Minnesota's health insurance exchange, MNsure, in January of 2014. The PMAP+ waiver was amended to reflect the expansion of eligibility in Minnesota's Medicaid program, and to modify the MinnesotaCare program to ease the planned transition to Basic Health Plan authority in 2015.

2. Background on the PMAP+ Section 1115 Waiver

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

Enrollees began receiving services from health plans on a prepaid capitated basis under the first Prepaid Medical Assistance Project (PMAP) Section 1115 waiver in July of 1985, almost thirty years ago. The project required that Medical Assistance or MA recipients (other than persons with disabilities) be enrolled with a health plan for a 12-month period. PMAP was initially limited to a few Minnesota counties.

In April 1995, CMS approved a statewide health care reform amendment to the PMAP waiver. This 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 federal poverty guidelines (FPG) into the Medicaid program. An amendment approved in 1999 expanded the program to include parents enrolled in

MinnesotaCare. A subsequent amendment in 2000 allowed for administrative simplification and mandatory enrollment of certain MA populations in managed care.

With promulgation of managed care regulations in 2002, states were able to implement mandatory enrollment in managed care through their Medicaid state plans. Minnesota now provides prepaid managed care coverage to infants, children, pregnant women, parents and adults without children via the state plan. Nevertheless, the PMAP+ 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 population under the MinnesotaCare program and mandatory managed care for certain MA populations, such as American Indians and children with special needs.

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

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 does not have fee-for-service data for comparison.

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

3. The PMAP+ § 1115 Waiver January 1, 2014 through December 31, 2014

With the implementation of many aspects of the ACA in 2014, Minnesota expanded eligibility for its Medicaid program, which necessitated some corresponding changes in MinnesotaCare. Minnesota also sought to amend MinnesotaCare at the beginning of the operation of Minnesota's MNsure health care exchange to smooth the transition to Basic Health Plan authority in 2015.

Beginning January 1, 2014, a "bright line" is established between MinnesotaCare and MA. People who are eligible for MA must enroll in MA rather than MinnesotaCare. This ensures that people who are eligible for MA receive the most generous coverage they are entitled to receive.

With more generous eligibility standards for Medical Assistance in 2014, MinnesotaCare coverage is no longer needed for certain groups. For example:

- MinnesotaCare no longer covers adults, parents and 19-20 year-olds with incomes below 133% of the FPL because these groups are enrolled in MA. In 2013, adults, parents and 19-20 year-olds have been eligible for MA if they have family incomes at or below 100% of the Federal Poverty Level or FPL. In 2014, this was expanded to 133% of the FPL.

- Pregnant women and children under age 19 with family incomes at or below 275% of the FPL were enrolled in MinnesotaCare in 2013, but were transitioned to MA in 2014.

- In 2014, MinnesotaCare covers parents, adults and 19-20 year-olds with family incomes up to 200% FPL instead of 250% or 275% FPL to align eligibility standards with requirements for the Basic Health Plan.

In 2014, MinnesotaCare benefits for certain adults were increased to conform to benefits requirements in the Affordable Care Act and to minimize disruption with the transition to a Basic Health Plan in 2015. As before, MinnesotaCare enrollees under age 21 receive the full MA benefit set.

- Benefits: For adults without children, the $10,000 cap on inpatient hospital services is eliminated.
- Cost-sharing: For adults without children, the 10% co-pay on inpatient hospital services is eliminated.
- Reduced premiums. Premiums are reduced for adult in MinnesotaCare. Enrollees under age 21 pay no premium.

The benefit set offered to MinnesotaCare Children and MA One-Year-Olds under the 2014 waiver 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). The benefit offered to MinnesotaCare Caretaker Adults and MinnesotaCare Adults without Children is identical to the benefits offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (a) through (h) below are excluded.

1. Services included in an individual's education plan;
2. Private duty nursing;
3. Orthodontic services;
4. Non- emergency medical transportation services;
5. Personal Care Services;
6. Targeted case management services (except mental health targeted case management);
7. Nursing facility services; and
8. ICF/MR services.

In 2014, MinnesotaCare eligibility rules were changed to align with requirements in the Affordable Care Act. MinnesotaCare no longer has an asset test. The 4-month and 18-month eligibility waiting periods were eliminated. MinnesotaCare coverage may begin while an

individual is hospitalized. Eligibility for certain special populations (volunteer firefighters, former foster care children) is eliminated. (Former foster care children are covered under MA).

In 2014, MinnesotaCare eligibility was expanded to include groups that are expected to be covered by the Basic Health Plan in 2015 so that these groups would experience fewer coverage transitions.

- MinnesotaCare provides coverage for children under age 19 who are not eligible for MA under MA household composition rules but who have family incomes at or below 200% FPL using different household composition rules.
- MinnesotaCare provides coverage for adults who would not have family incomes at or below 200% FPL using Medicaid income calculation rules, but would have incomes at or below 200% FPL using income calculation rules that will apply under the Basic Health Plan.

Following these changes, the 2014 waiver makes coverage available to 19- and 20-year olds and adults with incomes between 133% and 200% of the federal poverty level, providing a more generous benefit set and lower cost sharing than people at these income levels are likely to be able to purchase with federal tax credits through MNsure.

In addition, the demonstration allows Minnesota to provide coverage to additional groups under a "designated state health program" during the interim year prior to the BHP: children who are barred from Medicaid due to Medicaid income methodologies; and adults and children who would not otherwise qualify for MinnesotaCare using Medicaid income methodologies but would be eligible under Marketplace income methodologies.

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

4. Evaluation Strategy for the 2014 Waiver

4.1 Demonstration Goals, Hypotheses and Objectives for 2014

The goal of the waiver is to reduce the proportion of uninsured and provide better coverage and better value for those who are participating in the program as compared to people who are not covered under Medicaid expansion. The evaluation will compare coverage levels under MinnesotaCare and coverage available under a qualified health plan purchased through MNsure. The demonstration also seeks to provide comparable access and quality of care to the waiver populations as compared to Medicaid managed care enrollees not eligible under the waiver. The objective is to demonstrate that access, quality of care and enrollee satisfaction is maintained

under the demonstration and is comparable to care provided to Medicaid managed care enrollees not eligible under the waiver.

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

4.11 Goal 1: Provide better coverage for insured.

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

Objective: Increase the proportion of Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance as compared with the Minnesotans at 200-250% FPL with coverage purchased 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 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, MNsure coverage data.

4.12 Goal 2: Provide value.

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

Objective: Provide Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance in a cost effective manner.

Measurement:

- Compare MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

- Calculate premiums, cost-sharing and tax credit expenditures for purchase of MinnesotaCare-level coverage via MNsure for people at incomes of 200-250% FPL, by level of coverage (bronze, silver, gold and platinum).

Hypothesis: Combined federal and state per capita spending on the waiver group and average enrollee cost sharing will be equal to or less than spending and cost sharing for Minnesotans at the 200-250 % FPL income level enrolled through MNsure if they choose coverage similar to what the waiver group will receive.

Data Source: MNsure eligibility data; state expenditure data on waiver group; CMS data on cost-sharing settle-ups.

4.13 Goal 3: Improve the quality of care.

The goal of the waiver is to provide comparable access and quality of health care to waiver populations as compared to Minnesota's other public health care program enrollees in managed care.

Objectives: Improve:

- Utilization of services for children (childhood immunizations, child access to PCP, annual dental visits, well-child visits, medication management for people with asthma and follow-up after hospitalization for mental illness.)
- Utilization of services for adults (diabetes care, depression management, adult preventive visits, cervical cancer screening, dental visits, medication management for people with asthma, initiation and engagement of alcohol and other drug dependence treatment, and follow-up after hospitalization for mental illness.)
- Enrollee satisfaction with the delivery and quality of services (satisfaction survey results)

Measurement: Compare waiver and non-waiver Medicaid enrollees using selected HEDIS 2015 and other performance measures of utilization, preventive and chronic disease care, physical and mental health services, and satisfaction with managed care services to compare, contrast and draw out differences between the populations.

Hypothesis: Providing health care coverage to child and adult populations who would otherwise be uninsured will result in improved outcomes:

Data Source: Encounter data.

5. Evaluation Populations for 2014 Waiver

Waiver evaluation populations will consist of the following subgroups:

Waiver population subgroups:

- MinnesotaCare Children. Children ages 19 and 20 years old with family incomes 133-200% of the FPG and DSHP Children ages 0-18 with family incomes at or below 200% of the FPG.
- MinnesotaCare Caretaker Adults. Parents and adults caring for children with family incomes 133-200% of the FPG.
- MinnesotaCare Adults without Children. Adults age 21 or older without dependent children, and incomes 133-200% of the FPL.
- Medical Assistance One-Year-Olds. Children enrolled in MA ages 12-23 months and family incomes 133-275 percent of the FPG.

Medical Assistance (MA) Comparison Groups:

- MA Children. Children in MA ages 0-20.
- MA Caretaker Adults. Parents or adults caring for children with family incomes at or below 100 percent of the FPG, enrolled in managed care.
- MA Caretaker Adults. Adults caring for children with family incomes at or below 133 percent of the FPG, enrolled in managed care.
- MA Adults without Children. Adults age 21 or older without dependent children, and incomes at or below 133 percent of the FPG.

5.1 Evaluation Plan for the 2014 Waiver

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

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

Overview of Populations, Measures and Years

Waiver Populations	Comparison Populations	Measures	Measurement/Reference Years
2. MinnesotaCare Children 0-20 to 200% FPG (DHS program/eligibility codes: LL/C1, C2, I1, I2.)	2. MA Children0-20	1. Childhood immunizations (2 yrs) 2. Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs) 3. Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs) 4. Well –child visits first 5. 15months 5. Well-child visits 3 to 6 yrs.	MY = CY 2014 RYs = 2011 through 2013

		6. Adolescent well-care visits (12-19 yrs) 7. Medication Management for People with Asthma 8. Follow-up After Hospitalization for Mental Illness	
3. MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)	3. MA Caretaker Adults (DHS program/eligibility codes: MA/AA)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness	MYs = CY 2014 RYs = 2011 through 2013
4. MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)	4. MA Adults w/o Children (DHS program/eligibility codes: AX)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness 7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	MYs = CY 2014 RYs = 2011 through 2013
1. MA Children 12-24 Mos. 133 to 275 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	1. MA Children 12-24 Mos. less than 133 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	1. Child access to PCP (age groups 12-24 mos) 2. Well–child visits first 15months	MY = CY 2014 RYs = 2011 through 2013

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

5.2 Evaluation Metrics for the 2014 Waiver

1. Measures:

Rates and program attributes will be displayed to assist in making comparisons between MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

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

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

Children (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)
Adults
Adult access preventive/ambulatory health services
Annual Dental Visit
Medication Management for People with Asthma
Follow-up After Hospitalization for Mental Illness
Comprehensive Diabetes Care
Cervical CA screening

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

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

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

2. Comparison Metrics between CYs 2011-2013 and CY 2014. The key factor that would limit the comparison metric is subpopulation size. Modification of the planned metrics may be needed based upon the initial data analytical step to determine subpopulation enrollment

characteristics. Public program eligibility changes will also influence metric comparisons and would need to be assessed during the initial data analytical step.

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

6. Evaluation Implementation Strategy and Timeline

6.1 Management and Coordination of the 2014 Waiver Evaluation

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

- May 2015: DHS will calculate measurement rates for goals one and two.
- June 2015: DHS staff will review and evaluate goal rates and drawn conclusions.
- July – August 2015: DHS will calculate and stratify HEDIS 2015 performance measures.
- Sept – December 2015: HEDIS and CAHPS results will be reviewed and results evaluated.
- September 2015- March 2016: Draft and final waiver report is written, reviewed and approved.
- May 2016: Final report is submitted to CMS.

2014 Waiver Evaluation Process Steps Timeline
CY 2015

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

2016												
Final Report & Approval- May 2016												

6.2 Integration of the Quality Improvement Strategy

Compliance, oversight and improvement activities for all Minnesota managed health care programs are conducted in a comprehensive manner across all managed care programs. These activities are not segregated according to the waiver. Annually, DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCOs' compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the Annual Technical Report (ATR). Since 2004, the ATR is the most comprehensive evaluation of quality, access and timeliness of Minnesota's health care programs.

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

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

6.3 Limitations and Opportunities

The following limitations may impact the results of this evaluation:

- Unexpected consequences due to changes in state law regarding public programs.

- Future changes to HEDIS technical specifications influence future coding or data reporting that would bias this type of longitudinal analysis. If these types of changes occur the biases and potential consequences will be reported in the final report limitation section. Changes that will result from transitioning from ICD-9 to ICD-10 codes are not expected to have an impact.
- Measures with high rates of utilization 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.

6.4 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.

Attachment F

Minnesota Department of Human Services

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

Evaluation Report

Waiver Period July 1, 2011 through December 31, 2013

March 2015

Table of Contents

1. Evaluation Goals

This evaluation report relates to the demonstration period July 1, 2011 through December 31, 2013 for the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. The goal of the waiver is to provide comparable access and quality of health care to waiver populations as compared to Minnesota's other public health care program enrollees in managed care. Both preventive care and treatment of chronic conditions will be assessed. The objective of the evaluation is to demonstrate that access, quality of care and enrollee satisfaction is maintained and is comparable to care provided to Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.

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

Goal 1: Provide access and quality comparable to national Medicaid averages.

- Objective: Provide coverage for expansion groups provided under this waiver so that access and quality of care for child and adult waiver populations are comparable to national Medicaid averages.
- Measurement: Access and quality will be evaluated using HEDIS adult, postpartum and child preventive care measures for PMAP+ waiver populations and for a national Medicaid sample.
- Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access and quality of care for child and adult waiver populations that is comparable to national Medicaid averages.
- Data Sources: MMIS claims data and national Medicaid NCQA Quality Compass data.

Goal 2: Provide access and quality comparable to Medicaid managed care enrollees who are not eligible under the waiver.

- Objective: Provide coverage for expansion groups provided under this waiver so that access and quality of care for child and adult waiver populations are comparable to access and quality for Minnesota Health Care Program recipients who are not enrolled under the demonstration.
- Measurement: Access and quality will be evaluated using HEDIS adult, postpartum and child measures for PMAP+ waiver populations and for Minnesota Medicaid enrollees.
- Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access and quality of care for child and adult waiver populations that is comparable to access and quality of care for Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.
- Data Sources: MMIS claims data

Goal 3: Achieve satisfaction rates comparable to Medicaid managed care enrollees who are not eligible under the waiver.

- Objective: Achieve satisfaction rates for expansion groups provided under this waiver that are comparable to satisfaction rates of Minnesota Health Care Program recipients who are not enrolled under the demonstration.

- Measurement: Compare Annual DHS CAHPS results for all MinnesotaCare and MA adults.
- Hypothesis: Satisfaction rates for Medicaid expansion groups under the PMAP+ waiver will be comparable to satisfaction rates for Minnesota Medicaid enrollees who are not enrolled under the PMAP+ waiver.
- Data Sources: Annual DHS CAHPS composite results for all MinnesotaCare and MA adults

Goal 4: Provide access and quality comparable to Medicaid managed care enrollees who are not eligible under the waiver.

- Objective: Provide coverage for expansion groups under this waiver so that access, quality of care and enrollee satisfaction is maintained over time and is comparable to access, quality of care, and enrollee satisfaction for non-waiver Medicaid enrollees.
- Measurement: Satisfaction, access and quality will be evaluated using CAHPS data (adults only) and HEDIS measures for adult, postpartum and child care measures for PMAP+ waiver populations and for Minnesota Medicaid enrollees.
- Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access, quality of care and enrollee satisfaction for waiver populations that is maintained over time and is comparable to access, quality of care and enrollee satisfaction for Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.
- Data Sources: Annual DHS CAHPS results for all MinnesotaCare and MA adults and MMIS claims data

2. Evaluation Populations: Waiver (W) Compared to Medical Assistance (MA)

Evaluation populations consist of the following groups:

Waiver population subgroups:

- MinnesotaCare Children. Children under age 21 in MinnesotaCare with family incomes at or below 275 percent of the FPG.
- MinnesotaCare Pregnant Women. Pregnant women enrolled in MinnesotaCare with incomes at or below 275 percent of the FPG.
- MinnesotaCare Caretaker Adults. Parents or adults caring for children with family incomes at or below 275 percent of the FPG.
- MinnesotaCare Adults without Children. Adults age 21 or older without dependent children, and incomes at or below 250 percent of the FPG.
- Medical Assistance One-Year-Olds. Children enrolled in MA ages 12-23 months and family incomes 133-275 percent of the FPG.

Medical Assistance (MA) Comparison Groups:

- MA Children. Children under age 21 in MA with family incomes at or below 275 percent of the FPG.

- MA Pregnant Women. Pregnant women enrolled in MinnesotaCare with incomes at or below 275 percent of the FPG.
- MA Caretaker Adults. Parents or adults caring for children with family incomes at or below 100 percent of the FPG, enrolled in managed care.
- MA Adults without Children. Adults age 21 or older without dependent children, and incomes at or below 75 percent of the FPG.

Comparison groups are limited to those enrolled in managed care to provide the most accurate comparison. Most people are required to enroll in managed care, with the exception of disabled children and adults.

3. Evaluation Overview

The selected HEDIS 2013 performance measures are compared between the waiver populations and other public program managed care enrollees. Performance measurement rates for the baseline period (CYs 2009 through 2010) have been calculated for the targeted populations and compared to the first three calendar years (CYs 2011, 2012 and 2013) of the waiver period. Performance measurement rates used for this comparative analysis are presented in a series of 26 tables at Appendix A: Waiver and MA Measurement Rate Tables. In addition, national benchmarks have been obtained from NCQA's Medicaid Quality Compass data to compare performance of Minnesota's waiver and other public program managed care population's performance measurement rates. Please refer to the table at Appendix B for an overview of the HEDIS National Medicaid Quality Compass 2014 benchmark rates used for this analysis.

Waiver Populations	MA Comparison Populations	Measures	Measurement Years
1. MinnesotaCare Children	MA Children	1. Childhood immunizations (2 yrs) 2a. Child access to PCP (12-24 mos) 2b. Child access to PCP (25 mos-6 yrs) 2c. Child access to PCP (7-11 yrs) 2d. Child access to PCP (12-19 yrs) 3a. Annual Dental Visit (2-3 yrs) 3b. Annual Dental Visit (4-6 yrs;) 3c. Annual Dental Visit (7-10 yrs) 3d. Annual Dental Visit (11-14 yrs) 3e. Annual Dental Visit 15-18 yrs) 4. Well-child visits: first 15 mos. 6+ visits 5. Well-child visits: 3-6 yrs 6. Adolescent Well-child visits (12-19 yrs) 7a. Asthma Medication Management (5-11 yrs) 7b. Asthma Medication Management (12-20 yrs) 8.a F/U After Hospitalization 7 days (6-20 yrs) 8.b F/U After Hospitalization 30 days (6-20 yrs)	CYs 2009 through 2013
2.MinnesotaCare Pregnant Women	MA Pregnant Women	9. Postpartum Care	CYs 2009 through 2013
3. MinnesotaCare Caretaker Adults	MA Adults	10a. Diabetes A1c Screening (21-64 yrs) 10b. Diabetes LDL Screening (21-64 yrs) 11a. Adult Access Preventive (21-44 yrs) 11b. Adult Access Preventive (45-64 yrs) 12. Annual Dental Visit (21-64 yrs) 13. Cervical Cancer Screening (21-64 yrs)	CYs 2009 through 2013

		14a. Asthma Medication Management (21-50 yrs) 14b. Asthma Medication Management (51-64 yrs) 15a. F/U Hospitalization 7 Days (21-64 yrs) 15b. F/U Hospitalization 30 Days (21-64 yrs) 16a. Initiation Alcohol Tx (21-64 yrs) 16b. Engagement Alcohol Tx (21-64 yrs)	
4. MinnesotaCare Adults w/o Children	MA Adults w/o Children	17a. Diabetes A1c Screening (21-64 yrs) 17b. Diabetes LDL Screening (21-64 yrs) 18a. Adult Access Preventive (21-44 yrs) 18b. Adult Access Preventive (45-64 yrs) 19. Annual Dental Visit (21-64 yrs) 20. Cervical Cancer Screening (21-64 yrs) 21a. Asthma Medication Management (21-50 yrs) 21b. Asthma Medication Management (51-64 yrs) 22a. F/U Hospitalization 7 Days (21-64 yrs) 22b. F/U Hospitalization 30 Days (21-64 yrs) 23a. Initiation Alcohol Tx (21-64 yrs) 23b. Engagement Alcohol Tx (21-64 yrs)	CYs 2009 through 2013
5. MA Children 12-24 Mos. 133 to 275 % FPG	MA Children 12-24 Mos. less than 133 %	24. Childhood immunizations (2 yrs) 25. Child access to PCP (12-24 mos) 26. Well-child visits: first 15 mos.	CYs 2009 through 2013

4. Waiver Compared to MA Analysis

4.1 MinnesotaCare Children (W) Compared to MA Children (MA)

HEDIS rates were calculated for each Waiver and MA population based on DHS encounter and enrollment data. Rates were compared for a difference of 5 percentage points to evaluate differences between Waiver and MA population performance, identify rate trends over a five year period, and compare to the HEDIS National Medicaid Quality Compass benchmark rates.

Summary Chart I: Waiver compared to MA Childhood Measurement Rates 1-8.

Measure	**W-MA Comparison** (<, >, ≈) [1]	**W Rate Trend** (≈,↑, ↓) [2]	**MA Rate Trend** (≈,↑, ↓) [2]	**CY 2013 W/QC Ave. Comparison** (≈,↑, ↓) [3]
1. Childhood immunizations (2 yrs)	W ≈ MA	≈	≈	↓
2a. Child access to PCP (12-24 mos)	W ≈ MA	≈	≈	≈
2b. Child access to PCP (25 mos-6 yrs)	W ≈ MA	≈	≈	≈
2c. Child access to PCP (7-11 yrs)	W ≈ MA	≈	≈	≈
2d. Child access to PCP (12-19 yrs)	W ≈ MA	≈	≈	≈
3a. Annual Dental Visit (2-3 yrs)	W ≈ MA	↑	≈	≈
3b. Annual Dental Visit (4-6 yrs;)	W > MA	↓	≈	↑
3c. Annual Dental Visit (7-10 yrs)	W > MA	↓	≈	↑
3d. Annual Dental Visit (11-14 yrs)	W > MA	↓	≈	↑
3e. Annual Dental Visit 15-18 yrs)	W > MA	↓	≈	↑
4. Well-child visits: first 15 mos. 6+ visits	W > MA	↑	≈	↑

5. Well-child visits: 3-6 yrs	W ≈ MA	≈	≈	↓
6. Adolescent Well-child visits (12-19 yrs)	W ≈ MA	≈	≈	NA[4]
7a. Asthma Medication Management (5-11 yrs)	W ≈ MA	≈	≈	↑
7b. Asthma Medication Management (12-20 yrs)	W ≈ MA	≈	≈	≈
8a. F/U After Hospitalization 7 Days (6-20 yrs)	W > MA	≈	≈	NA[4]
8b. F/U After Hospitalization 30 Days (6-20 yrs)	W > MA	≈	≈	NA[4]

1. < - W is less than MA by 5 percentage points; > - W is greater than MA by 5 percentage points; ≈ - W is approximately the same as MA rates.
2. ≈ - Rates have remained approximately the same over the measurement periods; ↑ - Rates have increased by at least 5 percentage points over the measurement periods; ↓ - Rates have decreased by at least 5 percentage points over the measurement periods.
3. ≈ - CY 2013 W rates are approximately the same as National Quality Compass average rate; ↑ - CY 2013 W rates are greater by at least 5 percentage points then National Quality Compass average rate; ↓ - CY 2013 W rates are at least 5 percentage points below National Quality Compass average rate. See Appendix C for the Medicaid National Quality Compass benchmark rates.
4. NA - For these two measures the Waiver and MA age groups are not consistent with national Medicaid benchmark age groupings.

Highlights of Summary Charts I: Waiver Compared to MA Childhood Measurement Rates 1-8.

- MinnesotaCare Children's waiver populations were within five percentage points of the MA population for ten out of the seventeen measures reviewed. The other seven measures show the Waiver population's rates were greater than the MA rates by 5 or more percentage points.
- Waiver population trends over the annual measurements for calendar years 2009 through 2013 remained stable for eleven of the seventeen measures. Of the remaining six measures, four measurement trends were downward by at least five percentage points while the remaining two measurements increased by more than five percentage points. All of the MA population measures remained relatively stable over the entire five year period.
- When calendar year 2013 measurement rates were compared to HEDIS National Medicaid Quality Compass benchmark rates; six measures were above the QC rates, and only two measures were below the national benchmark average rates.

4.2 MinnesotaCare Pregnant Women (W) Compared to MA Pregnant Women (MA)

Summary Chart II: Postpartum Care

Measure	**W-MA Comparison** (<, >, ≈)	**W Rate Trend** (≈,↑, ↓)	**MA Rate Trend** (≈,↑, ↓)	**CY 2013 W/QC Ave. Comparison** (≈,↑, ↓)
9. Postpartum Care	W > MA	↓	↓	↓

Highlights of Summary Chart II.

- The Waiver population postpartum care rates are higher than the comparison MA population (CY 2013- 43.9% vs 38.4%).
- Waiver and MA rates have trended downward over the past several years, and both population rates were below the National 2013 QC average rate of 61.29%.

4.3 MinnesotaCare Caretaker Adults (W) Compared to MA Adults (MA)

Summary Chart III: Adult Measures 10-16

Measure	W-MA Comparison (<, >, ≈)	W Rate Trend (≈,↑, ↓)	MA Rate Trend (≈,↑, ↓)	CY 2013 W/QC Ave. Comparison (≈,↑, ↓)
10a. Diabetes A1c Screening (21-64 yrs)	W > MA	≈	≈	NA[5]
10b. Diabetes LDL Screening (21-64 yrs)	W > MA	≈	↑	NA[5]
11a. Adult Access Preventive (21-44 yrs)	W ≈ MA	≈	≈	NA[5]
11b. Adult Access Preventive (45-64 yrs)	W ≈ MA	≈	≈	≈
12. Annual Dental Visit (21-64 yrs)	W > MA	↓	↓	NA[5]
13. Cervical Cancer Screening (21-64 yrs)	W ≈ MA	↓	≈	NA[5]
14a. Asthma Medication Management (21-50 yrs)	W > MA	≈	≈	NA[5]
14b. Asthma Medication Management (51-64 yrs)	W ≈ MA	↓	↑	↑
15a. F/U Hospitalization 7 Days (21-64 yrs)	W > MA	↓	≈	NA[5]
15b. F/U Hospitalization 30 Days (21-64 yrs)	W > MA	≈	≈	NA[5]
16a. **Initiation** /Engagement Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[5]
16.b Initiation /**Engagement** Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[5]

5. NA – QC Benchmark rates are for different age groups for these measures and are not appropriate comparisons.

Highlights of Summary Chart III.

- All eleven of the MinnesotaCare Caretaker Adults measures are similar or above the MA Adult rates.
- Most (7) of the eleven MinnesotaCare Caretaker Adult measures have remained stable over the past five years. While, almost all (10) of the MA trends have remained stable or increased over the measurement periods.
- Five of the MinnesotaCare Caretaker Adult measures are at least similar to, or greater than, the 2013 HEDIS National Medicaid Quality Compass average rates.

4.4 MinnesotaCare Adults without Children (W) Compared to MA Adults without Children (MA)

In contrast to the other waiver population comparisons only three years of data (CYs 2011 – 2013) is available due to DHS program changes.

Summary Chart IV: Adults w/o children Measures 17-20

Measure	W-MA Comparison (<, >, ≈)	W Rate Trend (≈,↑, ↓)	MA Rate Trend (≈,↑, ↓)	CY 2013 W/QC Ave. Comparison (≈,↑, ↓)
17a. Diabetes A1c Screening (21-64 yrs)	W ≈ MA	≈	≈	NA[6]
17b. Diabetes LDL Screening (21-64 yrs)	W ≈ MA	↑	≈	NA[6]
18a. Adult Access Preventive (21-44 yrs)	W ≈ MA	≈	≈	NA[6]
18b. Adult Access Preventive (45-64 yrs)	W ≈ MA	≈	≈	↑
19. Annual Dental Visit (21-64 yrs)	W ≈ MA	↓	↓	NA[6]
20. Cervical Cancer Screening (21-64 yrs)	W ≈ MA	≈	≈	↓
21a. Asthma Medication Management (21-50 yrs)	W > MA	≈		NA[6]
21b. Asthma Medication Management (51-64 yrs)	W ≈ MA	≈	≈	↑
22a. F/U Hospitalization 7 Days (21-64 yrs)	W > MA	≈	≈	NA[6]
22b. F/U Hospitalization 30 Days (21-64 yrs)	W > MA	≈	≈	NA[6]
23a. **Initiation**/Engagement Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[6]
23b. Initiation/**Engagement** Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[6]

6. NA – QC Benchmark rates are for different age groups for these measures and are not appropriate comparisons.

Highlights of Summary Chart IV.

- All of the MinnesotaCare Adults without children comparisons are similar to or greater then MA.
- The majority of measures for both the Waiver and MA populations are stable over the past three years.
- Four out of five Waiver population rates when compared to the QC rates were greater than the QC averages.

4.5 MA Children 12-24 Months with Income 133 to 275% FPG (W) Compared to MA Children 12-24 Months with Income and Less Than 133% FPG

Summary Chart V: 12-24 Month Old Measures 24-26

Measure	W-MA Comparison (<, >, ≈)	W Rate Trend (≈,↑, ↓)	MA Rate Trend (≈,↑, ↓)	CY 2013 W/QC Ave. Comparison (≈,↑, ↓)
24. Childhood immunizations (2 yrs) Combo 3	W > MA	↑	↑	NA[7]
25. Child access to PCP (12-24 mos)	W ≈ MA	≈	≈	≈
26. Well-child visits: first 15 mos. 6+ visits	W ≈ MA	↑	↑	↓

7. NA – QC Benchmark rate is for a different age group and is not an appropriate comparison.

Highlights of Summary Chart V.

- For all three 12-24 month measures, the waiver population is similar or greater than the comparison MA population.
- Trending patterns for the Waiver and MA populations are same over the past five years.
- Children's access measures are similar to the national Medicaid average rate while the first 15 months well-child measure is below.

5. Waiver and MA Stratification Analysis

Each of the 26 tables presented in Appendix C have been stratified by race and ethnicity for calendar years 2009 through 2013. A number of comparisons have not been done due to the small number of enrollees in MinnesotaCare Waiver or MA populations.

Waiver and MA populations were stratified by the following race and ethnicity subgroups. Race/ethnicity is a characteristic combined from two fields (Race and Ethnicity) and has the following six subgroups:

1. White
2. African American (Black)
3. American Indian, Alaskan Native, Native American (NA)
4. Asian or Pacific Islander (AS/PI)
5. Unknown
6. Hispanic (Hisp)

Assigning recipients to one of the six race/ethnicity subgroups:

- If a recipient identified him/herself by a single race, and did not identify as Hispanic, s/he was assigned to the appropriate one of the first 4 subgroups above.
- If a recipient identified him/herself as having more than one race, such as being White and Black, or Black and White, or Black and NA, and so on, and did not identify as Hispanic, s/he was assigned to Unknown.
- If the Recipient did not identify any race, and did not identify as being of Hispanic ethnicity, s/he was also assigned to Unknown.
- If the recipient identified him or herself as of Hispanic Ethnicity, s/he was assigned to the category Hispanic, no matter what race or combination of races, if any, s/he may also have identified.

Several stratification tables were not analyzed since there were dominators smaller than 30 eligible enrollees (indicated in the charts by "SD"). The following Charts have been removed from the text due to the small dominators across all subgroups:

Summary Chart 7a-S: Asthma Medication Management (5-11 yrs.)
Summary Chart 7b-S: Asthma Medication Management (12-20 yrs.)
Summary Chart 8a-S: F/U After Hospitalization 7 Days (6-20 yrs.).

Summary Chart 8b-S: F/U After Hospitalization 30 Days (6-20 yrs.).
Summary Chart 14a-S: Asthma Medication Management (21-50 yrs.).
Summary Chart 14b-S: Asthma Medication Management (51-64 yrs.)
Summary Chart 15a-S: F/U Hospitalization 7 Days (21-64 yrs.).
Summary Chart 15b-S: F/U Hospitalization 30 Days (21-64 yrs.).
Summary Chart 16-S: **Initiation** /Engagement Alcohol Tx (21-64 yrs.).
Summary Chart 21a-S: Asthma Medication Management (21-50 yrs.).
Summary Chart 21b-S: Asthma Medication Management (51-64 yrs.).
Summary Chart 22a-S: F/U Hospitalization 7 Days (21-64 yrs.).
Summary Chart 22b-S: F/U Hospitalization 30 Days (21-64 yrs.)
Summary Chart 23-S: Initiation/**Engagement** Alcohol Tx (21-64 yrs.).

5.1 MinnesotaCare Children (W) compared to MA Children (MA)

As seen in the following summary charts almost all of the Waiver subgroups rates were similar or greater than the MA Children's populations. Stratification of these measures did not show consistent trends or a pattern indicating the Waiver race/ethnic subgroup's utilization was different than the MA population.

Summary Charts 1-8-S:

Summary Chart 1-S: Childhood immunizations (2 yrs.) Combo 3. For the Waiver and MA children that had their second birthday during the measurement year receiving; four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV and 4 PCV vaccinations (Combo 3)

	CY 2013 Rates W-MA Comparison (<, >, ≈)[8]	**CY 2012 Rates W-MA Comparison** (<, >, ≈)	**CY 2011 Rates W-MA Comparison** (<, >, ≈)	**CY 2010 Rates W-MA Comparison** (<, >, ≈)	**CY 2009 Rates W-MA Comparison** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W < MA
Black	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA
NA	SD[9]	SD	SD	SD	SD
White	W ≈ MA	W ≈ MA	W < MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W < MA	W < MA	W ≈ MA	W ≈ MA

8. < - W rate is less than MA by 5 percentage points; > - W rate is greater than MA by 5 percentage points; ≈ - W rate is approximately the same as MA rates.
9. SD = Small dominators, less than 30 enrollees.

Summary Chart 2a –S: Child access to PCP (12-24 mos.). Children age twelve to twenty-four months who had a primary care visit during the year was similar to the comparison MA subgroup over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	SD	SD	SD	SD	SD
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 2b –S: Child access to PCP (25 mos-6 yrs.). Children age twenty-five months to six years of age who had a primary care visit during the year was similar to the comparison MA subgroup over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W ≈ MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W > MA	W ≈ MA	W ≈ MA =
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA =
NA	W ≈ MA	W > MA	W > MA	W ≈ MA	W ≈ MA =
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA =
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA =

Summary Chart 2c –S: Child access to PCP (7-11 yrs.). Children age seven to eleven years of age who had a primary care visit during the year or the year prior was similar to the comparison MA subgroup over the five year period with the exception of the Waiver AS/PI subgroup that was consistently seen more frequently than the MA comparison subgroup.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W ≈ MA	W ≈ MA	W > MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W > MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA

Summary Chart 2d –S: Child access to PCP (12-19 yrs.). Children age twelve to nineteen years of age who had a primary care visit during the year or the year prior was similar to the comparison MA subgroup over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W > MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA

Summary Chart 3a-S: Annual Dental Visit (2-3 yrs.). Waiver children age two to three years for all race/ethnic subgroups had similar annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W < MA	W > MA	W > MA	W ≈ MA
Black	W ≈ MA	W > MA	W > MA	W > MA	W ≈ MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	SD	SD	SD	SD
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W > MA	W ≈ MA	W ≈ MA	W ≈ MA	W < MA

Summary Chart 3b-S: Annual Dental Visit (4-6 yrs.). Waiver children age four to six years for most of the race/ethnic subgroups had similar annual dental visit rates when compared to MA population over the five year period. However, the Hispanic, White and Unknown subgroups had consistently higher rates over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W ≈ MA	W ≈ MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3c-S: Annual Dental Visit (7-10 yrs.). Waiver children age seven to ten years, for all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3d-S: Annual Dental Visit (11-14 yrs.) Waiver children age eleven to fourteen years, for all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)

AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3e-S: Annual Dental Visit (15-18 yrs.). Waiver children age fifteen to eighteen years, for all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3e-S: Annual Dental Visit (19-20 yrs.). Asian, Native American, White and Unknown subgroups of nineteen to 20 year old children had consistently higher annual dental visits than the MA comparison population.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Hisp	W ≈ MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	SD	SD
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 4-S: Well-child visits: first 15 mos. 6+ visits. The percentage of Asian children that turned fifteen months during the measurement year who had six or more well-child visits had a higher rate consistently than the Asian MA comparison group over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W > MA	W > MA	W > MA
Hisp	SD	SD	SD	SD	SD
NA	SD	SD	SD	SD	SD
White	W ≈ MA	W > MA	W > MA	W > MA	W > MA
Unknown	W ≈ MA	W > MA	W ≈ MA	W > MA	W ≈ MA

Summary Chart 5-S: Well-child visits: (3-6 yrs.). Asian, Black, and Native American children in the third, fourth, fifth and sixth years of life compared to the same race MA subgroups had consistently higher rates of one or more well-child visits during the year over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W ≈ MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 6-S: Adolescent Well-child visits (12-19 yrs.). The percentage of children age twelve to nineteen who had at least one comprehensive well-child visit during the measurement year for both the Waiver and MA subgroups were similar over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W > MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W > MA	W > MA	W > MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Charts 7a-S: Asthma Medication Management (5-11 yrs.), 7b-S: Asthma Medication Management (12-20 yrs.) 8a-S: F/U After Hospitalization 7 Days (6-20 yrs.) and 8b-S: F/U After Hospitalization 30 Days (6-20 yrs.) charts demonstrate that almost all of the subgroups had small denominators except the White Waiver subgroup which had rates approximately (within 5 percentage points) the same as the MA subgroups.

5.2 MinnesotaCare Pregnant Women (W) Compared to MA Pregnant Women (MA)

Summary Chart 9-S:

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	SD	SD	SD	SD	SD
Black	W ≈ MA	W ≈ MA	SD	SD	SD
Hisp	SD	SD	SD	SD	SD
NA	SD	SD	SD	SD	SD
White	W > MA	W > MA	W ≈ MA	W > MA	W > MA
Unknown	SD	SD	SD	SD	SD

Other than the Waiver White subgroup, there were too few enrollees to compare to the MA subgroups. The Waiver White subgroup had similar or higher rates than the MA population of pregnant women.

5.3 MinnesotaCare Caretaker Adults (W) Compared to MA Adults (MA).

The comparison between the Waiver and MA race/ethnic subgroups demonstrate that most often the Waiver subgroups rates are greater than the comparable MA race/ethnic subgroup rates and consistent over the five year period.

Summary Charts 10-16S:

Summary Chart 10a-S: Diabetes A1c Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an HbA1c test performed during the measurement year. For most of the race/ethnic subgroups the Waiver population rates were greater than the comparison MA subgroups.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	SD
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	SD	SD	SD	SD	SD

Summary Chart 10b-S: Diabetes LDL Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an LDL-C test performed during the measurement year. All of the Waiver race/ethnic subgroups rates were greater than the comparison MA subgroups over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	SD	W > MA	SD	SD
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	SD	SD	SD	SD	SD

Summary Chart 11a-S: Adult Access Preventive (21-44 yrs.). Waiver and MA comparison population adults, age twenty-one to forty-four years old that had an ambulatory or preventive care visit during the measurement year. All of the Waiver race/ethnic subgroups rates were similar to the MA comparison populations.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 11b-S: Adult Access Preventive (45-64 yrs.). Waiver and MA comparison population adults, age forty-five to sixty-four years old that had an ambulatory or preventive care visit during the measurement year. Almost all of the Waiver race/ethnic subgroups rates were similar to the MA comparison populations.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W > MA	W < MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 12-S: Annual Dental Visit (21-64 yrs.). Waiver adult's age twenty-one to sixty-four years, almost all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 13-S: Cervical Cancer Screening (21-64 yrs.). Percentage of women age twenty-one to sixty-four years old that were screened for cervical cancer (cervical cytology every 3 years or cytology/human papillomavirus co-testing every five years). Waiver and MA race/ethnic subgroups were similar or greater over the five year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 14a-S: Asthma Medication Management (21-50 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 14b-S: Asthma Medication Management (51-64 yrs.). All Waiver and MA race/ethnicity subgroups had dominators of less than 30 enrollees.

Summary Chart 15a-S: F/U Hospitalization 7 Days (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 15b-S: F/U Hospitalization 30 Days (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 16-S: Initiation /Engagement Alcohol Tx (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same than the MA subgroups.

5.4 MinnesotaCare Adults without Children (W) Compared to MA Adults without Children (MA)

Since there was a recent change in eligibility for this Wavier and MA comparison only three years of data is available to compare. The Adults without Children population rate comparisons between the Waiver and MA race/ethnic subgroups showed over the three period that Waiver and MA race/ethnic subgroups rates were comparable to MA race/ethnic subgroup rates.

Summary of Charts 17-23S :

Summary Chart 17a-S: Diabetes A1c Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an HbA1c test performed during the measurement year. For most of the race/ethnic subgroups the Waiver population rates were similar to the comparison MA subgroups over the three year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W > MA

Summary Chart 17b-S: Diabetes LDL Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an LDL-C test performed during the measurement year. Waiver race/ethnic subgroups rates were similar or greater than the comparison MA subgroups.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W ≈ MA
Black	W > MA	W > MA	W > MA
Hisp	W ≈ MA	W > MA	W ≈ MA
NA	W > MA	W ≈ MA	W > MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 18a-S: Adult Access Preventive (21-44 yrs.). Waiver and MA comparison population adults, age twenty-one to forty-four years old that had an ambulatory or preventive care visit during the measurement year. All of the Waiver race/ethnic subgroups rates were similar or greater than the MA comparison populations with the exception of the Hispanic subgroup that was consistently higher than the MA comparison group over the three years.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W > MA
Black	W ≈ MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA
NA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W > MA	W ≈ MA

Summary Chart 18b-S: Adult Access Preventive (45-64 yrs.). Waiver and MA comparison population adults, age forty-five to sixty-four years old that had an ambulatory or preventive care visit during the measurement year. All of the Waiver race/ethnic subgroups rates were similar or greater than the MA comparison populations with the exception of the Black subgroup that was consistently higher than the MA comparison group over the three years.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA
Black	W > MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA
NA	W > MA	W ≈ MA	W ≈ MA
White	W > MA	W > MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 19-S: Annual Dental Visit (21-64 yrs.) Waiver adult's age twenty-one to sixty-four years, almost all of the race/ethnic subgroups, had similar annual dental visit rates when compared to MA population over the three year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 20-S: Cervical Cancer Screening (21-64 yrs.). Percentage of women age twenty-one to sixty-four years old that were screened for cervical cancer (cervical cytology every 3 years or cytology/human papillomavirus co-testing every five years). Waiver and MA race/ethnic subgroups were similar with the exception of the Hispanic and Native American subgroups which were lower than the MA comparisons during the measurement periods.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA
Black	W > MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W < MA	W < MA
NA	W ≈ MA	W ≈ MA	W < MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W > MA	W ≈ MA	W ≈ MA

Summary Chart 21a-S: Asthma Medication Management (21-50 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 21b-S: Asthma Medication Management (51-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same as the MA subgroups.

Summary Chart 22a-S: F/U Hospitalization 7 Days (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates higher (5 percentage points or more) than the MA subgroups.

Summary Chart 22b-S: F/U Hospitalization 30 Days (21-64 yrs.) All of the subgroups had small denominators except the White Waiver subgroup that had rates higher (5 percentage points or more) than the MA subgroups.

Summary Chart 23-S: Initiation/Engagement Alcohol Tx (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same as the MA subgroups.

5.5 MA Children 12-24 Months with Income 133 to 275% FPG (W) Compared to MA Children 12-24 Months with Income Less Than 133% FPG.

The comparison between the Waiver and MA populations show the Waiver subgroups rates are generally similar or higher than the MA rates for all three measures. The race/ethnicity stratification indicates there are no apparent consistent trends or patterns to indicate a race/ethnic disparity either between or within the subgroups.

Summary Charts 24-26S

Summary Chart 24-S: Childhood immunizations (2 yrs.) Combo 3. Inferences drawn from this measure should be carefully considered since the measure is only of those children that had by their second birthday (within the measurement period) received; four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV and 4 PCV vaccinations, and were within Waiver 133 to 275 percent FPG, or the MA population less than the 133 percent of the FPG. The measure is not designed to evaluate the immunization status for all children age 12 to 23 months during the measurement year, only those children that were 24 months old in the calendar year.

Waiver children age two years old immunization rates were similar or greater than MA comparison population rates

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	SD	SD	SD
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W > MA	W > MA	W ≈ MA
NA	SD	SD	SD	SD	SD
White	W ≈ MA	W > MA	W ≈ MA	W ≈ MA	W > MA
Unknown	SD	SD	SD	SD	SD

Summary Chart 25-S: Child access to PCP (12-24 mos.). Children age twelve to twenty-four months that had a primary care visit during the year are comparable to the MA subgroup over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W < MA	W ≈ MA	W < MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W < MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 26-S: Well-child visits: first 15 mos. 6+ visits. The percentage of Waiver children that turned fifteen months during the measurement year who had six or more well-child visit rates was consistently similar with the MA comparison group over the five year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	SD	W > MA	W ≈ MA	SD	W > MA
White	W ≈ MA	W < MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W < MA	W > MA	W < MA	W < MA

6. Evaluation of CAHPS Consumer Satisfaction Results

The 2014 Minnesota Managed Care Public Programs Consumer Satisfaction Survey was conducted by DataStat, Inc., an NCQA-certified CAHPS® vendor, under contract with the Minnesota Department of Human Services (DHS).

The survey is designed to assess and compare the satisfaction of enrollees in managed care Minnesota health care programs (MC MHCP) administered by DHS on an annual basis utilizing the standardized survey instrument from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Medicaid core survey.

The core instrument is 58 questions. The instrument assessed such topics as: *how well doctors communicate; getting care without long waits; getting care that is needed; health plan customer services; shared decision making; and overall satisfaction with health plans and health care.* DHS added questions to assess topics such as immunization, behavioral health and care coordination.

The survey was administered from January 2014 through April 2014. Each respondent received up to four waves of mail with telephone interview call attempts made to non-responders. Participation in the survey was entirely voluntary and all data collected is kept confidential. The mailing materials were sent in English and contained instructions in Spanish that told respondents they could complete the questionnaire in Spanish by calling an 800 number. In addition, a language block on the backside of the letters in Hmong, Russian, Somali, and Vietnamese let respondents with these native languages know the survey was only being administered in English and Spanish, and that they could call DataStat to have their names removed from the sample list if they did not wish to participate.

The study had a goal of receiving at least 300 returned questionnaires for each health plan or group in each of the six program populations; 32 sample groups in all. To achieve this goal, the sample was designed to select an appropriate number of enrollees from each of the 32 sample groups. An oversample design was used for the Families and Children (F&C)-MA and Hennepin Health programs to address a multi-year pattern where the target number of completes was not reached. In addition, the sample design took into account a multi-year pattern of better than average response rates for the MSHO population. All seven of the MSHO groups used a smaller than typical sample size allowing for the F&C-MA / Hennepin Health groups to use a larger than typical sample size. When individual health plans did not have an adequate number of enrollees to warrant an individual sample, health plans were combined and treated as a single reporting unit. For single plans with insufficient enrollees to achieve the respective target sample, all

eligible enrollees were selected. A total of 28,230 enrollees across all programs were selected to participate in the survey.

Questionnaires were mailed to all selected enrollees. Enrollees who did not return a mail questionnaire received telephone calls and were offered the opportunity to complete the questionnaire over the telephone. During the course of the survey, some sampled enrollees were determined to be ineligible. Some were no longer enrolled; some were deceased; others had language problems or incapacities that prevented them from completing the interview.
The study response rate is the percentage of those who completed an interview among all those who were eligible to participate. Completed interviews were obtained from 9,793 enrollees. The study response rate was 37.0%.

Population	Quantity mailed	Eligible for	Response rate	Cases for analysis
F&C MA	9,230	7,382	27.5%	2,030
MinnesotaCare	5,400	5,165	37.8%	1,925

Respondent Characteristics		F&C-MA	MinnesotaCare
Gender	*Male*	38%	37%
	Female	62%	63%
Age	*18 to 24*	14%	10%
	25 to 34	26%	19%
	35 to 44	22%	16%
	45 to 54	22%	23%
	55 to 64	16%	31%
	65 to 74	1%	1%
	75 or older	0%	0%
Education Level	*HS or less*	49%	44%
	Some college	41%	42%
	College graduate	10%	14%
Self-Reported Health Status	*Excellent/Very Good*	41%	47%
	Good	36%	38%
	Fair/Poor	23%	15%
Hispanic or Latino	*Yes*	5%	4%
	No	95%	96%
Race	*White*	71%	80%
	Black/African American	9%	6%
	Asian	5%	5%
	Pacific Islander	1%	0%
	American Indian	7%	3%
	Other	4%	3%

6.1 Comparison of F&C MA and MinnesotaCare 2014 CAHPS Satisfaction Results

Composite Scores (Always)

Program	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*	*Shared Decision Making*
F&C-MA	50%	55%	77%	65%	52%
MinnesotaCare	56%	61%	80%	63%	50%
QC Benchmarks	54%	59%	72%	65%	51%

Rating Scores (9 & 10)

Program	*Rating of all health care*	*Rating of personal doctor*	*Rating of specialist seen most often*	*Rating of health plan*
F&C-MA	48%	67%	61%	56%
MinnesotaCare	51%	70%	63%	58%
QC Benchmarks	51%	63%	65%	57%

Comparison between results for the two DHS public managed care programs show satisfaction of public program managed care enrollees are very similar without regard to which program they may be enrolled. The greatest differences between the programs are seen in the Composite scores of "Getting needed care" and "Getting Care Quickly". MinnesotaCare enrollees report a six percentage point higher satisfaction.

6.2 Stratification of CAHPS Results by Race/Ethnicity.

The following tables demonstrate there is very little difference in satisfaction between MA and MinnesotaCare when rates are stratified by race/ethnicity. The shaded cells below indicate where MinnesotaCare Composites or Ratings are five percentage points lower than the MA composite/rates. Overall, MinnesotaCare composites/ratings are similar or higher than the comparable MA results.

Composites (Always)					
Race/Ethnicity	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
White-F&C MA	50.7%	56.0%	77.0%	66.9%	51.7%
White-MinnesotaCare	57.8%	63.2%	81.4%	65.4%	49.0%
Black-F&C MA	49.2%	61.4%	80.7%	64.2%	55.4%
Black-MinnesotaCare	56.3%	51.5%	80.7%	60.7%	52.8%
Asian-F&C MA	32.3%	33.1%	60.3%	41.2%	54.7%
Asian-MinnesotaCare	45.4%	43.8%	69.7%	35.2%	57.6%
Pacific Islander-F&C MA	42.3%	58.9%	78.8%	50.0%	47.6%

Pacific Islander-MinnesotaCare	46.4%	41.7%	43.8%	75.0%	88.9%
American Indian-F&C MA	45.3%	62.5%	76.1%	58.1%	45.1%
American Indian-MinnesotaCare	61.3%	63.0%	82.7%	57.1%	63.0%
Other-F&C MA	55.5%	54.4%	83.1%	73.6%	59.8%
Other-MinnesotaCare	52.1%	56.6%	77.5%	49.2%	43.1%
Hispanic-F&C MA	61.8%	53.1%	82.6%	79.0%	55.8%
Hispanic-MinnesotaCare	60.7%	52.5%	85.2%	51.9%	52.3%

Ratings (9 & 10)				
Race/Ethnicity	Health Care	Personal Doctor	Specialist	Health Plan
White-F&C MA	49.5%	68.0%	61.4%	55.4%
White-Minnesota Care	51.5%	69.5%	64.0%	58.6%
Black-F&C MA	52.9%	75.7%	62.3%	61.5%
Black-Minnesota Care	51.3%	78.1%	63.6%	60.9%
Asian-F&CMA	42.9%	48.0%	46.2%	47.5%
Asian-Minnesota Care	35.2%	54.4%	50.0%	46.9%
Pacific Islander-F&CMA	29.4%	75.0%	12.5%	52.0%
Pacific Islander-Minnesota Care	28.6%	66.7%	50.0%	50.0%
American Indian-F&CMA	41.7%	63.5%	55.0%	50.4%
American Indian Minnesota Care	49.0%	66.7%	62.1%	48.4%
Other-F&CMA	49.1%	69.2%	60.9%	53.2%
Other-Minnesota Care	51.4%	64.9%	87.5%	66.0%
Hispanic-F&CMA	51.7%	72.5%	68.2%	64.2%
Hispanic-Minnesota Care	60.4%	79.1%	65.2%	66.7%

7. Summary of Findings – Waiver Period 2011-2013 Update

The analysis of the 26 performance measures and satisfaction results demonstrate the goals of the waiver to provide comparable access and quality of health care to waiver populations as compared to Minnesota's other public health care program enrollees in managed care has been achieved. Both preventive care and treatment of chronic conditions were assessed and found to be similar or greater than the MA comparison populations. The evaluation objectives to demonstrate that access, quality of care and enrollee satisfaction is maintained and is comparable

to care provided to Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver have been met.

When waiver population performance measure rates are also compared to HEDIS National Medicaid Quality Compass benchmark rates, nine out of nineteen measures are higher than the National Medicaid averages. Six of the nineteen comparable measures are at or above HEDIS National Medicaid Quality Compass 75th percentile rates and two are in the 95th percentile.

Overall the race/ethnicity stratification did not indicate consistent trends or patterns to indicate a race/ethnic disparity either between or within the subgroups. The stratification of the performance measures or satisfaction results provided very little new or additional information.

Enrollees in MinnesotaCare reported two ratings and three composite satisfaction scores that were above the National Medicaid averages.

Appendix A

Minnesota Department of Human Services

PMAP+ Section 1115 Demonstration Waiver Evaluation Report 2011-2013

Waiver and MA Measurement Rate Tables

March 2015

Table 1: Childhood Immunizations: Combo 3

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	935	1,434	65.2%	6,366	9,676	65.8%
CY 2012	724	1,120	64.6%	5,873	8,713	67.4%
CY 2011	792	1,255	63.1%	7,503	10,819	69.4%
CY 2010	779	1,190	65.5%	6,868	10,606	64.8%
CY 2009	391	1,197	32.7%	3,635	9,967	36.5%

Table 2: Child Access to PCP

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

Age Group: 12 - 24 months Table 2a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	1,212	1,251	96.9%	12,371	12,826	96.5%
CY 2012	1,160	1,179	98.4%	12,136	12,601	96.3%
CY 2011	1,164	1,190	97.8%	12,968	13,408	96.7%
CY 2010	1,081	1,096	98.6%	13,440	13,869	96.9%
CY 2009	1,074	1,099	97.7%	12,656	13,040	97.1%

Age Group: 25 months - 6 years Table 2b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	9,036	9,915	91.1%	37,109	41,880	88.6%
CY 2012	7,542	8,156	92.5%	37,434	41,785	89.6%
CY 2011	7,773	8,381	92.7%	40,311	44,739	90.1%
CY 2010	6,813	7,385	92.3%	39,317	43,595	90.2%
CY 2009	6,210	6,740	92.1%	35,108	38,662	90.8%

Age Group: 7 - 11 years Table 2c

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	7,003	7,506	93.3%	23,291	25,709	90.6%
CY 2012	5,611	6,026	93.1%	19,712	21,808	90.4%
CY 2011	6,271	6,729	93.2%	23,151	25,582	90.5%
CY 2010	5,638	6,070	92.9%	21,060	23,095	91.2%
CY 2009	5,429	5,892	92.1%	18,297	20,175	90.7%

Age Group: 12 - 19 years Table 2d

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	11,442	12,244	93.4%	27,078	30,074	90.0%
CY 2012	9,311	9,966	93.4%	23,336	25,944	89.9%

CY 2011	10,221	10,936	93.5%	27,178	30,009	90.6%
CY 2010	9,353	9,975	93.8%	25,460	27,982	91.0%
CY 2009	9,259	9,899	93.5%	23,260	25,682	90.6%

Table 3: Annual Dental Visit

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

Age Group: 2 - 3 years Table 3a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	1,224	3,340	36.6%	5,759	16,493	34.9%
CY 2012	941	2,717	34.6%	5,744	16,809	34.2%
CY 2011	1,026	2,898	35.4%	6,111	18,664	32.7%
CY 2010	926	2,683	34.5%	6,202	19,009	32.6%
CY 2009	788	2,507	31.4%	5,326	17,335	30.7%

Age Group: 4 - 6 years Table 3b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	4,567	6,668	68.5%	16,159	26,198	61.7%
CY 2012	3,915	5,533	70.8%	16,051	25,811	62.2%
CY 2011	4,017	5,588	71.9%	16,969	27,002	62.8%
CY 2010	3,472	4,785	72.6%	16,292	25,533	63.8%
CY 2009	3,255	4,315	75.4%	14,280	22,116	64.6%

Age Group: 7 - 10 years Table 3c

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	6,413	8,506	75.4%	21,149	33,025	64.0%
CY 2012	5,545	7,119	77.9%	19,900	31,297	63.6%
CY 2011	5,833	7,289	80.0%	20,470	31,868	64.2%
CY 2010	5,307	6,507	81.6%	20,014	30,417	65.8%
CY 2009	4,914	5,996	82.0%	17,390	26,778	64.9%

Age Group: 11 - 14 years Table 3d

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	6,060	8,412	72.0%	16,966	28,857	58.8%
CY 2012	5,404	7,241	74.6%	16,063	27,527	58.4%

CY 2011	5,544	7,271	76.2%	16,369	27,633	59.2%
CY 2010	5,084	6,518	78.0%	15,713	25,861	60.8%
CY 2009	4,623	5,969	77.5%	13,957	23,029	60.6%

Age Group: 15 - 18 years Table 3e

	Waiver Population			**Comparison Population**		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	5,321	8,348	63.7%	11,126	21,785	51.1%
CY 2012	4,707	7,172	65.6%	10,747	21,167	50.8%
CY 2011	4,893	7,318	66.9%	11,442	22,023	52.0%
CY 2010	4,580	6,649	68.9%	11,814	21,555	54.8%
CY 2009	4,416	6,272	70.4%	10,733	19,970	53.7%

Table 4: Well-child visits, first 15 months 6+ Visits

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	702	1,053	66.7%	6,358	10,962	58.0%
CY 2012	617	900	68.6%	5,294	9,485	55.8%
CY 2011	700	1,000	70.0%	7,007	11,642	60.2%
CY 2010	589	915	64.4%	6,465	11,579	55.8%
CY 2009	573	928	61.7%	5,811	10,861	53.5%

Table 5: Well-child visits, 3 to 6 years

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	5,647	8,590	65.7%	20,809	34,153	60.9%
CY 2012	4,770	7,063	67.5%	21,134	34,161	61.9%
CY 2011	4,838	7,239	66.8%	22,150	36,045	61.5%
CY 2010	4,159	6,290	66.1%	21,707	34,808	62.4%
CY 2009	3,630	5,658	64.2%	18,649	30,304	61.5%

Table 6: Adolescent Well Care

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	5,882	16,668	35.3%	15,927	45,348	35.1%
CY 2012	5,081	14,349	35.4%	15,058	43,613	34.5%
CY 2011	5,040	14,597	34.5%	15,240	44,626	34.2%
CY 2010	4,646	13,247	35.1%	15,218	43,157	345.3%
CY 2009	4,103	12,188	33.7%	14,197	39,212	36.2%

Table 7: Medication Management for People with Asthma

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

Age Group: 5 - 11 years Table 7a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	254	261	97.3%	936	1,044	89.7%
CY 2012	208	220	94.5%	794	890	89.2%
CY 2011	248	266	93.2%	937	1,033	90.7%
CY 2010	190	198	96.0%	818	888	92.1%
CY 2009	184	193	95.3%	783	876	89.4%

Age Group: 12 - 20 years Table 7b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	271	308	88.0%	807	905	89.2%
CY 2012	247	284	87.0%	661	752	87.9%
CY 2011	276	316	87.3%	753	873	86.3%
CY 2010	250	286	87.4%	691	795	86.9%
CY 2009	230	267	86.1%	529	616	85.9%

Table 8: Follow-up After Hospitalization for Mental Illness (7/30 days)

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

Age Group: 6 - 20 years 7 Days Table 8a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	62	217	28.6%	397	1,756	22.6%
CY 2012	70	196	35.7%	519	1,805	28.8%
CY 2011	60	175	34.3%	398	1,631	24.4%
CY 2010	59	176	33.5%	373	1,553	24.0%
CY 2009	36	145	24.8%	394	1,529	25.8%

Age Group: 6 - 20 years 30 Days Table 8b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	117	217	53.9%	742	1,756	42.3%
CY 2012	109	196	55.6%	867	1,805	48.0%
CY 2011	107	175	61.1%	745	1,631	45.7%
CY 2010	104	176	59.1%	704	1,553	45.3%
CY 2009	77	145	53.1%	704	1,529	46.0%

Table 9: Postpartum Care

Waiver population: MinnesotaCare Pregnant Women (DHS program/eligibility codes: LL/P1, P2)

Comparison population: MA Pregnant Women (DHS program/eligibility codes: MA/PX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	116	264	43.9%	1,083	2,819	38.4%
CY 2012	88	186	47.3%	1,182	2,848	41.5%
CY 2011	83	197	42.1%	1,108	2,629	42.1%
CY 2010	79	161	49.1%	1,147	2,704	42.4%
CY 2009	83	150	55.3%	1,101	2,402	45.8%

Table 10a: Diabetes A1c Screening

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	1,564	1,700	92.0%	2,618	3,173	82.5%
CY 2012	1,418	1,555	91.2%	2,468	3,041	81.2%
CY 2011	1,398	1,528	91.5%	2,516	3,089	81.5%
CY 2010	1,186	1,322	89.7%	2,269	2,862	79.3%
CY 2009	976	1,111	87.8%	1,978	2,597	76.2%

Table 10b: Diabetes LDL Screening

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	1,420	1,700	83.5%	2,222	3,173	70.0%
CY 2012	1,283	1,555	82.5%	2,046	3,041	67.3%
CY 2011	1,285	1,528	84.1%	2,060	3,089	66.7%
CY 2010	1,084	1,322	82.0%	1,890	2,862	66.0%
CY 2009	885	1,111	79.7%	1,639	2,597	63.1%

Table 11: Adult Access to Preventive / Ambulatory Health Services

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

Age Group: 21 - 44 years Table 11a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	14,510	16,579	87.5%	32,566	35,950	90.6%
CY 2012	13,498	15,378	87.8%	32,444	35,818	90.6%
CY 2011	14,616	16,608	88.0%	34,576	38,159	90.6%
CY 2010	12,570	14,310	87.8%	33,927	37,355	90.8%
CY 2009	11,214	12,775	87.8%	30,418	33,299	91.3%

Age Group: 45 - 64 years Table 11b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	9,149	10,186	89.8%	6,883	7,482	92.0%
CY 2012	8,401	9,406	89.3%	6,266	6,848	91.5%
CY 2011	8,682	9,765	88.9%	6,377	7,021	90.8%
CY 2010	7,588	8,537	88.9%	5,990	6,590	90.9%
CY 2009	6,555	7,355	89.1%	5,339	5,849	91.3%

Table 12: Annual Dental Visit

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

Age Group: 21 - 64 years

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	13,592	26,765	50.8%	18,784	43,707	43.0%
CY 2012	12,352	24,784	49.8%	18,713	42,980	43.5%
CY 2011	13,849	26,373	52.5%	20,743	45,539	45.5%
CY 2010	12,969	22,847	56.8%	21,435	44,376	48.3%
CY 2009	12,008	20,130	59.7%	20,024	39,566	50.6%

Table 13: Cervical Cancer Screening

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

Age Group: 21 - 64 years

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	10,857	14,880	73.0%	21,012	29,078	72.3%
CY 2012	10,317	13,774	74.9%	20,902	28,214	74.1%
CY 2011	11,055	14,602	75.7%	22,077	29,636	74.5%
CY 2010	9,748	12,692	76.8%	21,536	28,658	75.1%
CY 2009	8,832	11,243	78.6%	19,132	25,554	74.9%

Table 14: Medication Management for People with Asthma

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

Age Group: 21 - 50 years Table 14a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	323	378	85.4%	584	726	80.4%
CY 2012	278	330	84.2%	498	643	77.4%
CY 2011	334	386	86.5%	576	748	77.0%
CY 2010	302	354	85.3%	499	645	77.4%
CY 2009	269	314	85.7%	469	606	77.4%

Age Group: 51 - 64 years Table 14b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	89	105	84.8%	53	59	89.8%
CY 2012	70	79	88.6%	44	47	93.6%
CY 2011	77	90	85.6%	44	58	75.9%
CY 2010	46	52	88.5%	40	53	75.5%
CY 2009	39	43	90.7%	27	35	77.1%

Table 15a: Follow-up after Hospitalization for Mental Illness within 7 Days

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	33	108	30.6%	222	903	24.6%
CY 2012	49	148	33.1%	265	1,060	25.0%
CY 2011	52	141	36.9%	294	1,034	28.4%
CY 2010	44	126	34.9%	270	1,015	26.6%
CY 2009	43	119	36.1%	253	977	25.9%

Table 15b: Follow-up after Hospitalization for Mental Illness within 30 Days

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	56	108	51.9%	424	903	47.0%
CY 2012	91	148	61.5%	506	1,060	47.7%
CY 2011	87	141	61.7%	510	1,034	49.3%
CY 2010	72	126	57.1%	500	1,015	49.3%
CY 2009	73	119	61.3%	499	977	51.1%

Table 16: Initiation and Engagement of Alcohol and Other Drug Dependence Treat

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

Age Group: 21 - 64 years Table 16b Initiation

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	285	772	36.9%	1,292	3,500	36.9%
CY 2012	237	657	36.1%	1,265	3,404	37.2%
CY 2011	273	739	36.9%	1,339	3,546	37.8%
CY 2010	224	606	37.0%	1,276	3,283	38.9%
CY 2009	170	458	37.1%	1,286	3,124	41.2%

Age Group: 21 - 64 years Table 16b Engagement

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	121	772	15.7%	492	3,575	13.8%
CY 2012	88	657	13.4%	490	3,471	14.1%
CY 2011	121	739	16.4%	544	3,649	14.9%
CY 2010	91	606	15.0%	500	3,389	14.8%
CY 2009	71	458	15.5%	483	3,244	14.9%

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Table 17a: Diabetes A1c Screening

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	2,473	2,635	93.9%	3,145	3,448	91.2%
CY 2012	2,288	2,454	93.2%	2,767	3,050	90.7%
CY 2011	2,423	2,615	92.7%	1,814	1,993	91.0%

Table 17b: Diabetes LDL Screening

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	2,330	2,635	88.4%	2,840	3,448	82.4%
CY 2012	2,107	2,454	85.9%	2,487	3,050	81.5%
CY 2011	2,194	2,615	83.9%	1,612	1,993	80.9%

Table 18: Adult Access to Preventive / Ambulatory Health Services

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

Age Group: 21 - 44 years Table 18a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	6,725	7,597	88.5%	12,242	14,557	84.1%
CY 2012	6,288	7,148	88.0%	11,451	13,754	83.3%
CY 2011	7,633	8,624	88.5%	8,698	10,362	83.9%

Age Group: 45 - 64 years Table 18b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	12,592	13,587	92.7%	14,454	16,451	87.9%
CY 2012	11,809	12,830	92.0%	12,929	14,775	87.5%
CY 2011	12,670	13,708	92.4%	8,148	9,159	89.0%

Table 19: Annual Dental Visit

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

Age Group: 21 - 64 years

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	7,909	21,184	37.3%	12,201	31,008	39.3%
CY 2012	8,442	19,978	42.3%	11,383	28,529	39.9%
CY 2011	10,576	22,332	47.4%	8,624	19,521	44.2%

Table 20: Cervical Cancer Screening

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

Age Group: 21 - 64 years

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	6,268	10,952	57.2%	5,584	10,155	55.0%
CY 2012	6,087	10,445	58.3%	5,284	9,432	56.0%
CY 2011	6,790	11,564	58.7%	4,013	6,770	59.3%

Table 21: Medication Management for People with Asthma

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

Age Group: 21 - 50 years Table 21a

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	165	195	84.6%	343	449	76.4%
CY 2012	155	185	83.8%	193	255	75.7%
CY 2011	162	201	80.6%	199	240	82.9%

Age Group: 51 - 64 years Table 21b

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	155	201	77.1%	153	189	81.0%
CY 2012	127	173	73.4%	81	106	76.4%
CY 2011	152	195	77.9%	78	94	83.0%

Table 22a: Follow-up after Hospitalization for Mental Illness within 7 Days

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	62	221	28.1%	481	2,307	20.8%
CY 2012	57	182	31.3%	364	2,094	17.4%
CY 2011	69	211	32.7%	311	1,643	18.9%

Table 22b: Follow-up after Hospitalization for Mental Illness within 30 Days

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	127	221	57.5%	955	2,307	41.4%
CY 2012	107	182	58.8%	827	2,094	39.5%
CY 2011	121	211	57.3%	668	1,643	40.7%

Table 23: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

Age Group: 21 - 64 years Table 23a Initiation

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	388	1,128	34.4%	2,389	6,093	39.2%
CY 2012	353	1,044	33.8%	2,160	5,465	39.5%
CY 2011	430	1,215	35.4%	2,182	5,054	43.2%

Age Group: 21 - 64 years Table 23b Engagement

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	133	1,128	11.8%	931	6,093	15.3%
CY 2012	122	1,044	11.7%	835	5,465	15.3%
CY 2011	168	1,215	13.8%	957	5,054	18.9%

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Table 24: Childhood Immunizations: Combo 3

Waiver population: MA Children 12-24 months. 133 - 275% FPG (DHS program/eligibility codes: MA/CB)

Comparison population: MA Children 12-24 months. Less than 133% FPG (DHS program/eligibility codes: MA/CB)

Age Group: 12 - 24 months

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	305	470	64.9%	1,221	2,113	57.8%
CY 2012	363	511	71.0%	1,285	2,189	58.7%
CY 2011	400	566	70.7%	1,303	2,021	64.5%
CY 2010	328	535	61.3%	1,226	2,103	58.3%
CY 2009	238	468	50.9%	929	2,081	44.6%

Table 25: Child Access to PCP

Waiver population: MA Children 12-24 months. 133 - 275% FPG (DHS program/eligibility codes: MA/CB)

Comparison population: MA Children 12-24 months. Less than 133% FPG (DHS program/eligibility codes: MA/CB)

Age Group: 12 - 24 months

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	4,303	4,666	92.2%	11,289	11,937	94.6%
CY 2012	4,382	4,820	90.9%	11,364	12,006	94.7%
CY 2011	4,754	5,196	91.5%	11,568	12,167	95.1%
CY 2010	4,876	5,359	91.0%	11,977	12,624	94.9%
CY 2009	4,584	5,082	90.2%	12,463	13,160	94.7%

Table 26: Well-child visits, first 15 months 6+ Visits

Waiver population: MA Children 12-24 months. 133 - 275% FPG (DHS program/eligibility codes: MA/CB)

Comparison population: MA Children 12-24 months. Less than 133% FPG (DHS program/eligibility codes: MA/CB)

Age Group: 12 - 24 months

	Waiver Population			Comparison Population		
	Numerator	**Denominator**	**Rate**	**Numerator**	**Denominator**	**Rate**
CY 2013	1,819	3,687	49.3%	5,159	9,961	51.8%
CY 2012	1,773	3,749	47.3%	4,958	9,852	50.3%
CY 2011	2,059	4,112	50.1%	5,354	10,029	53.4%
CY 2010	1,907	4,150	46.0%	5,079	10,386	48.9%
CY 2009	1,644	3,949	41.6%	4,848	10,665	45.5%

Evaluation for PMAP+ Section 1115 Demonstration Waiver

Notes

1) The adjacent tables provide HEDIS metrics for specific subpopulations identified by Major Program (MP) and Eligibility Type (ET).

2) The MP and ET are associated with an individual as of December of the reporting year.

3) Individuals must be enrolled in a health plan for at least 11 months in the reporting year (including December) to be included in the denominator.

4) All measures were calculated according to the HEDIS specifications for the reporting year.

5) The HEDIS programs were run in the 12/30/2014 warrant cycle.

6) The FPL for the MA children 12-24 months group could not be established for about a quarter of the covered population. These children are excluded from the three reports for this group (orange tabs).

7) The measures are provided for measurement years 2009 to 2013, where available. The Adults w/o children expansion began in 2011. This is reflected in the reports for this group (purple tabs).

Program Run Date: Dec 30, 2014 warrant cycle

Code and Report Data: HRQ: JDB_2015_R355: /AA_Projects/Req 355 - PMAP Waiver Demo

Appendix B: HEDIS National Medicaid Quality Compass 2014 Benchmark Rates

Measure	National Medicaid QC HMO Average Rates	National Medicaid QC HMO 75th Percentile Rates	National Medicaid QC HMO 95th Percentile Rates
1. Childhood immunizations (2 yrs) Comb 3	70.85	77.78	85.26
2a. Child access to PCP (12-24 mos)	96.14	97.86	98.82
2b. Child access to PCP (25 mos-6 yrs)	88.25	91.73	94.2
2c. Child access to PCP (7-11 yrs)	90.02	93.5	97.21
2d. Child access to PCP (12-19 yrs)	88.52	92.17	95.77
3a. Annual Dental Visit (2-3 yrs)	34.74	43.98	55.62
3b. Annual Dental Visit (4-6 yrs)	56.54	68.85	77.11
3c. Annual Dental Visit (7-10 yrs)	58.61	71.57	79.48
3d. Annual Dental Visit (11-14 yrs)	53.32	65.61	74.12
3e. Annual Dental Visit 15-18 yrs)	46.05	56.52	64.27
4. Well-child visits: first 15 mos. 6+ visits	61.55	69.75	86.31
5. Well-child visits: 3-6 yrs	71.49	77.26	86.23
6. Adolescent Well-child visits (12-21 yrs)	50.03	59.21	68.75
7a. Asthma Medication Management (5-11 yrs)	90.18	93.59	95.81
7b. Asthma Medication Management (12-18 yrs)	86.93	89.52	94.46
9. Postpartum Care	61.29	69.47	76.63
10a. Diabetes A1c Screening (18-75 yrs)	83.81	87.59	93.98
10b. Diabetes LDL Screening (18-75 yrs)	75.97	80.18	88.98
11a. Adult Access Preventive (20-44 yrs)	80.7	86.21	89.67
11b. Adult Access Preventive (45-64 yrs)	87.31	90.98	93.02
13. Cervical Cancer Screening (21-64 yrs)*	NA	NA	NA
14a. Asthma Medication Management (19-50 yrs)	74.36	80.12	86.57
14b. Asthma Medication Management (51-64 yrs)	70.2	77.21	84.44
15a. F/U Hospitalization 7 Days (6+ yrs)	42.11	54.45	68.83
15b. F/U Hospitalization 30 Days (6+ yrs)	61.02	74.09	85.94
16a. **Initiation** /Engagement Alcohol Tx (18+ yrs)	38.2	43.48	51.91
16b. Initiation /**Engagement** Alcohol Tx (18+ yrs)	10.11	14.97	21.39

Highlighted measures indicated the Waiver population rates were above either the 75th or 95th National Quality Compass Medicaid benchmark rates.

* CY 2012 rates provided since NCQA did not report rates for the measure due to the significant specification change in CY 2013.

Appendix C

Minnesota Department of Human Services

PMAP+ Section 1115 Demonstration Waiver Evaluation Report 2011-2013

Waiver and MA Stratification Tables

March 2015

Tables and Descriptions

Report Tab (color coded)	Table	Measures	Waiver Populations	Comparison Populations	Measurement Years
Child - CIS	**Table 1**	Childhood immunizations (2 yrs)	1. MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)	1. MA Children (DHS program/eligibility codes: MA/CB, CK, CX)	CYs 2009 through 2013
Child - CAP	**Table 2a-d**	Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs)			
Child - ADV	**Table 3a-e**	Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs)			
Child - W15	**Table 4**	Well –child visits first 15months			
Child - W34	**Table 5**	Well-child visits 3 to 6 yrs.			
Child - AWC	**Table 6**	Adolescent will-care visits (12-19 yrs)			
Child - ASM	**Table 7a-b**	Medication Management for People with Asthma (5-11, 12-20 yrs)			
Child - FUH	**Table 8a-b**	Follow-up After Hospitalization for Mental Illness (6-20 yrs)			
Pregnant - PPC	**Table 9**	Postpartum Care	2.MinnesotaCare Pregnant Women (DHS program/eligibility codes: LL/P1, P2)	2. MA Pregnant Women (DHS program/eligibility codes: MA/PX)	CYs 2009 through 2013
Adult - CDC_HbA1c	**Table 10a**	Diabetes A1c screening (21-64 yrs)	3. MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)	3. MA Adults (DHS program/eligibility codes: MA/AA)	CYs 2009 through 2013
Adult - CDC_LDL	**Table 10b**	Diabetes LDL screening (21-64 yrs)			
Adult - AAP	**Table 11a-b**	Adult access preventive/ambulatory health services (21-50, 12-18 yrs)			
Adult - ADV	**Table 12**	Annual Dental Visit (21-64 yrs)			
Adult - CCS	**Table 13**	Cervical CA screening (21-64 yrs)			
Adult - ASM	**Table 14a-b**	Medication Management for People with Asthma (21-50, 51-64 yrs)			
Adult - FUH_7 days	**Table 15a**	Follow-up After Hospitalization for Mental Illness within 7 Days (21-64 yrs)			
Adult - FUH_30 days	**Table 15b**	Follow-up After Hospitalization for Mental Illness within 30 Days (21-64 yrs)			
Adult - IET	**Table 16a-b**	Initiation and Engagement of Alcohol and Other Drug Dependence Treatement (21-64 yrs)			
AdNoChild - CDC_HbA1c	**Table 17a**	Diabetes A1c screening (21-64 yrs)	4. MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)	4. MA Adults w/o Children (DHS program/eligibility codes: AX)	CYs 2009 through 2013
AdNoChild - CDC_LDL	**Table 17b**	Diabetes LDL screening (21-64 yrs)			
AdNoChild - AAP	**Table 18a-b**	Adult access preventive/ambulatory health services (21-50, 12-18 yrs)			
AdNoChild - ADV	**Table 19**	Annual Dental Visit (21-64 yrs)			
AdNoChild - CCS	**Table 20**	Cervical CA screening (21-64 yrs)			
AdNoChild - ASM	**Table 21a-b**	Medication Management for People with Asthma (21-50, 51-64 yrs)			
AdNoChild - FUH_7 days	**Table 22a**	Follow-up After Hospitalization for Mental Illness within 7 & 30 Days (21-64 yrs)			
AdNoChild - FUH_30 days	**Table 22b**	Follow-up After Hospitalization for Mental Illness within 7 & 30 Days (21-64 yrs)			
AdNoChild - IET	**Table 23a-b**	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (21-64 yrs)			
MA 12-24 mths - CIS	**Table 24**	Childhood immunizations (2 yrs)	5. MA Children 12-24 Mos. 133 to 275 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	5. MA Children 12-24 Mos. less than 133 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	CYs 2009 through 2013
MA 12-24 mths - CAP	**Table 25**	Child access to PCP (age groups 12-24 mos;)			
MA 12-24 mths - W15	**Table 26**	Well –child visits first 15months			

Table 1: Childhood Immunizations: Combo 3

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

Measure	Age Grp	Year	Race	MinnesotaCare Children			MA Children		
				Num	Den	Rate	Num	Den	Rate
		2013		**935**	**1,434**	**65.2%**	**6,366**	**9,676**	**65.8%**
			Asian-Pacific Is	72	92	78.3%	505	820	61.6%
			Black	79	136	58.1%	1,569	2,588	60.6%
			Hispanic	58	80	72.5%	917	1,281	71.6%
			Native American	16	20	80.0%	364	544	66.9%
			White	537	835	64.3%	2,675	3,931	68.0%
			Unknown	173	271	63.8%	336	512	65.6%
		2012		**724**	**1,120**	**64.6%**	**5,873**	**8,713**	**67.4%**
			Asian-Pacific Is	42	61	68.9%	414	683	60.6%
			Black	63	93	67.7%	1,393	2,217	62.8%
			Hispanic	36	48	75.0%	900	1,184	76.0%
			Native American	10	15	66.7%	345	548	63.0%
			White	465	709	65.6%	2,564	3,716	69.0%
			Unknown	108	194	55.7%	257	365	70.4%
		2011		**792**	**1,255**	**63.1%**	**7,503**	**10,819**	**69.4%**
			Asian-Pacific Is	59	79	74.7%	473	785	60.3%
			Black	75	114	65.8%	1,864	2,814	66.2%
			Hispanic	54	67	80.6%	1,329	1,705	77.9%
			Native American	5	6	83.3%	422	653	64.6%
			White	488	795	61.4%	3,165	4,505	70.3%
			Unknown	111	194	57.2%	250	357	70.0%
		2010		**779**	**1,190**	**65.5%**	**6,868**	**10,606**	**64.8%**
			Asian-Pacific Is	53	70	75.7%	382	690	55.4%
			Black	74	104	71.2%	1,717	2,734	62.8%
			Hispanic	43	59	72.9%	1,196	1,695	70.6%
			Native American	6	9	66.7%	415	712	58.3%
			White	466	733	63.6%	2,949	4,449	66.3%
			Unknown	137	215	63.7%	209	326	64.1%

2009		**391**	**1,197**	**32.7%**	**3,635**	**9,967**	**36.5%**
	Asian-Pacific Is	17	51	33.3%	245	625	39.2%
	Black	53	105	50.5%	971	2,507	38.7%
	Hispanic	24	61	39.3%	520	1,521	34.2%
	Native American	3	7	42.9%	295	641	46.0%
	White	223	753	29.6%	1,476	4,326	34.1%
	Unknown	71	220	32.3%	128	347	36.9%
Grand Total		**3,621**	**6,196**	**58.4%**	**30,245**	**49,781**	**60.8%**

Table 2: Child Access to PCP

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

				MinnesotaCare Children			MA Children		
Measure	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	12-24 months								
		2013		**1,212**	**1,251**	**96.9%**	**12,371**	**12,826**	**96.5%**
			Asian-Pacific Is	69	69	100.0%	975	1,021	95.5%
			Black	111	112	99.1%	2,996	3,085	97.1%
			Hispanic	38	39	97.4%	1,633	1,666	98.0%
			Native American	8	8	100.0%	496	525	94.5%
			White	532	557	95.5%	5,384	5,603	96.1%
			Unknown	454	466	97.4%	887	926	95.8%
		2012		**1,160**	**1,179**	**98.4%**	**12,136**	**12,601**	**96.3%**
			Asian-Pacific Is	77	78	98.7%	984	1,037	94.9%
			Black	99	100	99.0%	2,799	2,902	96.5%
			Hispanic	40	40	100.0%	1,600	1,631	98.1%
			Native American	9	9	100.0%	601	631	95.2%
			White	654	667	98.1%	5,417	5,649	95.9%
			Unknown	281	285	98.6%	735	751	97.9%
		2011		**1,164**	**1,190**	**97.8%**	**12,968**	**13,408**	**96.7%**
			Asian-Pacific Is	75	76	98.7%	958	1,009	94.9%
			Black	111	111	100.0%	3,078	3,151	97.7%
			Hispanic	38	38	100.0%	1,851	1,882	98.4%
			Native American	7	7	100.0%	683	698	97.9%
			White	666	683	97.5%	5,797	6,048	95.8%
			Unknown	267	275	97.1%	601	620	96.9%
		2010		**1,081**	**1,096**	**98.6%**	**13,440**	**13,869**	**96.9%**
			Asian-Pacific Is	62	62	100.0%	921	961	95.8%
			Black	93	94	98.9%	3,081	3,139	98.2%
			Hispanic	39	39	100.0%	2,082	2,109	98.7%
			Native American	5	5	100.0%	746	770	96.9%
			White	647	656	98.6%	6,124	6,382	96.0%
			Unknown	235	240	97.9%	486	508	95.7%

2009		**1,074**	**1,099**	**97.7%**	**12,656**	**13,040**	**97.1%**
	Asian-Pacific Is	66	67	98.5%	789	824	95.8%
	Black	105	107	98.1%	2,809	2,882	97.5%
	Hispanic	34	35	97.1%	1,981	2,003	98.9%
	Native American	7	7	100.0%	757	781	96.9%
	White	604	619	97.6%	5,809	6,019	96.5%
	Unknown	258	264	97.7%	511	531	96.2%
25mos - 6yr							
2013		**9,036**	**9,915**	**91.1%**	**37,109**	**41,880**	**88.6%**
	Asian-Pacific Is	600	660	90.9%	2,906	3,479	83.5%
	Black	972	1,024	94.9%	10,306	11,455	90.0%
	Hispanic	796	858	92.8%	5,808	6,330	91.8%
	Native American	128	141	90.8%	2,219	2,574	86.2%
	White	5,430	5,988	90.7%	14,671	16,718	87.8%
	Unknown	1,110	1,244	89.2%	1,199	1,324	90.6%
2012		**7,542**	**8,156**	**92.5%**	**37,434**	**41,785**	**89.6%**
	Asian-Pacific Is	435	486	89.5%	2,732	3,202	85.3%
	Black	689	725	95.0%	9,915	10,980	90.3%
	Hispanic	548	575	95.3%	6,106	6,615	92.3%
	Native American	88	92	95.7%	2,301	2,657	86.6%
	White	4,789	5,180	92.5%	15,205	17,029	89.3%
	Unknown	993	1,098	90.4%	1,175	1,302	90.2%
2011		**7,773**	**8,381**	**92.7%**	**40,311**	**44,739**	**90.1%**
	Asian-Pacific Is	471	524	89.9%	2,872	3,397	84.5%
	Black	731	758	96.4%	10,714	11,790	90.9%
	Hispanic	553	575	96.2%	6,501	7,053	92.2%
	Native American	91	95	95.8%	2,558	2,881	88.8%
	White	4,886	5,295	92.3%	16,480	18,300	90.1%
	Unknown	1,041	1,134	91.8%	1,186	1,318	90.0%
2010		**6,813**	**7,385**	**92.3%**	**39,317**	**43,595**	**90.2%**
	Asian-Pacific Is	384	417	92.1%	2,478	2,931	84.5%
	Black	620	650	95.4%	10,040	11,091	90.5%
	Hispanic	423	438	96.6%	6,669	7,183	92.8%
	Native American	68	73	93.2%	2,673	2,984	89.6%
	White	4,373	4,768	91.7%	16,348	18,170	90.0%

	Unknown	945	1,039	91.0%	1,109	1,236	89.7%
2009		**6,210**	**6,740**	**92.1%**	**35,108**	**38,662**	**90.8%**
	Asian-Pacific Is	332	364	91.2%	2,215	2,589	85.6%
	Black	586	613	95.6%	8,786	9,604	91.5%
	Hispanic	376	389	96.7%	5,748	6,154	93.4%
	Native American	57	63	90.5%	2,554	2,792	91.5%
	White	4,022	4,378	91.9%	14,841	16,450	90.2%
	Unknown	837	933	89.7%	964	1,073	89.8%
7-11 years							
2013		**7,003**	**7,506**	**93.3%**	**23,291**	**25,709**	**90.6%**
	Asian-Pacific Is	421	477	88.3%	1,871	2,293	81.6%
	Black	637	657	97.0%	6,007	6,545	91.8%
	Hispanic	547	568	96.3%	3,709	3,950	93.9%
	Native American	96	102	94.1%	1,543	1,768	87.3%
	White	4,477	4,819	92.9%	9,680	10,631	91.1%
	Unknown	825	883	93.4%	481	522	92.1%
2012		**5,611**	**6,026**	**93.1%**	**19,712**	**21,808**	**90.4%**
	Asian-Pacific Is	310	340	91.2%	1,690	2,046	82.6%
	Black	412	431	95.6%	4,824	5,300	91.0%
	Hispanic	368	378	97.4%	2,731	2,945	92.7%
	Native American	80	85	94.1%	1,480	1,635	90.5%
	White	3,802	4,092	92.9%	8,614	9,472	90.9%
	Unknown	639	700	91.3%	373	410	91.0%
2011		**6,271**	**6,729**	**93.2%**	**23,151**	**25,582**	**90.5%**
	Asian-Pacific Is	374	411	91.0%	1,875	2,243	83.6%
	Black	480	505	95.0%	5,975	6,604	90.5%
	Hispanic	373	384	97.1%	3,565	3,812	93.5%
	Native American	77	83	92.8%	1,600	1,750	91.4%
	White	4,278	4,591	93.2%	9,705	10,694	90.8%
	Unknown	689	755	91.3%	431	479	90.0%
2010		**5,638**	**6,070**	**92.9%**	**21,060**	**23,095**	**91.2%**
	Asian-Pacific Is	334	361	92.5%	1,790	2,101	85.2%
	Black	448	463	96.8%	5,088	5,596	90.9%
	Hispanic	330	344	95.9%	2,964	3,161	93.8%

	Native American	58	61	95.1%	1,612	1,728	93.3%
	White	3,890	4,210	92.4%	9,217	10,090	91.3%
	Unknown	578	631	91.6%	389	419	92.8%
2009		**5,429**	**5,892**	**92.1%**	**18,297**	**20,175**	**90.7%**
	Asian-Pacific Is	318	351	90.6%	1,707	2,007	85.1%
	Black	383	394	97.2%	4,315	4,745	90.9%
	Hispanic	302	310	97.4%	2,342	2,506	93.5%
	Native American	43	46	93.5%	1,456	1,574	92.5%
	White	3,811	4,172	91.3%	8,180	9,011	90.8%
	Unknown	572	619	92.4%	297	332	89.5%
12-19 years							
2013		**11,442**	**12,244**	**93.4%**	**27,078**	**30,074**	**90.0%**
	Asian-Pacific Is	705	814	86.6%	3,231	3,958	81.6%
	Black	838	885	94.7%	6,844	7,541	90.8%
	Hispanic	621	656	94.7%	2,908	3,173	91.6%
	Native American	177	186	95.2%	1,642	1,828	89.8%
	White	8,156	8,706	93.7%	12,134	13,231	91.7%
	Unknown	945	997	94.8%	319	343	93.0%
2012		**9,311**	**9,966**	**93.4%**	**23,336**	**25,944**	**89.9%**
	Asian-Pacific Is	545	632	86.2%	3,038	3,724	81.6%
	Black	550	574	95.8%	5,551	6,136	90.5%
	Hispanic	362	388	93.3%	1,995	2,214	90.1%
	Native American	127	133	95.5%	1,600	1,725	92.8%
	White	7,021	7,477	93.9%	10,823	11,785	91.8%
	Unknown	706	762	92.7%	329	360	91.4%
2011		**10,221**	**10,936**	**93.5%**	**27,178**	**30,009**	**90.6%**
	Asian-Pacific Is	621	703	88.3%	3,395	4,100	82.8%
	Black	654	691	94.6%	6,876	7,578	90.7%
	Hispanic	372	388	95.9%	2,458	2,658	92.5%
	Native American	114	126	90.5%	1,772	1,905	93.0%
	White	7,737	8,255	93.7%	12,175	13,221	92.1%
	Unknown	723	773	93.5%	502	547	91.8%
2010		**9,353**	**9,975**	**93.8%**	**25,460**	**27,982**	**91.0%**
	Asian-Pacific Is	504	554	91.0%	3,350	4,060	82.5%

	Black	577	614	94.0%	6,220	6,818	91.2%
	Hispanic	300	310	96.8%	2,024	2,163	93.6%
	Native American	103	108	95.4%	1,797	1,901	94.5%
	White	7,256	7,737	93.8%	11,573	12,507	92.5%
	Unknown	613	652	94.0%	496	533	93.1%
2009		**9,259**	**9,899**	**93.5%**	**23,260**	**25,682**	**90.6%**
	Asian-Pacific Is	483	539	89.6%	3,304	3,989	82.8%
	Black	509	533	95.5%	5,555	6,047	91.9%
	Hispanic	279	292	95.5%	1,673	1,809	92.5%
	Native American	91	101	90.1%	1,576	1,692	93.1%
	White	7,376	7,881	93.6%	10,698	11,633	92.0%
	Unknown	521	553	94.2%	454	512	88.7%
Grand Total		**122,603**	**131,635**	**93.1%**	**484,673**	**532,465**	**91.0%**

Table 3: Annual Dental Visit

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

			MinnesotaCare Children			MA Children		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	2 - 3 years								
		2013		**1,224**	**3,340**	**36.6%**	**5,759**	**16,493**	**34.9%**
			Asian-Pacific Is	79	222	35.6%	555	1,397	39.7%
			Black	124	335	37.0%	1,499	4,463	33.6%
			Hispanic	134	235	57.0%	1,082	2,268	47.7%
			Native American	23	47	48.9%	378	929	40.7%
			White	669	1,979	33.8%	2,021	6,696	30.2%
			Unknown	195	522	37.4%	224	740	30.3%
		2012		**941**	**2,717**	**34.6%**	**5,744**	**16,809**	**34.2%**
			Asian-Pacific Is	45	161	28.0%	481	1,285	37.4%
			Black	94	247	38.1%	1,409	4,357	32.3%
			Hispanic	77	149	51.7%	1,193	2,586	46.1%
			Native American	10	22	45.5%	428	1,041	41.1%
			White	599	1,739	34.4%	2,044	6,960	29.4%
			Unknown	116	399	29.1%	189	580	32.6%
		2011		**1,026**	**2,898**	**35.4%**	**6,111**	**18,664**	**32.7%**
			Asian-Pacific Is	71	174	40.8%	484	1,434	33.8%
			Black	105	262	40.1%	1,498	4,888	30.6%
			Hispanic	93	168	55.4%	1,321	2,906	45.5%
			Native American	12	24	50.0%	421	1,127	37.4%
			White	595	1,809	32.9%	2,209	7,745	28.5%
			Unknown	150	461	32.5%	178	564	31.6%
		2010		**926**	**2,683**	**34.5%**	**6,202**	**19,009**	**32.6%**
			Asian-Pacific Is	57	137	41.6%	446	1,300	34.3%
			Black	85	233	36.5%	1,461	4,820	30.3%
			Hispanic	80	134	59.7%	1,376	2,994	46.0%
			Native American	6	17	35.3%	458	1,255	36.5%
			White	559	1,718	32.5%	2,265	8,068	28.1%
			Unknown	139	444	31.3%	196	572	34.3%

2009		**788**	**2,507**	**31.4%**	**5,326**	**17,335**	**30.7%**
	Asian-Pacific Is	39	116	33.6%	322	1,106	29.1%
	Black	76	226	33.6%	1,231	4,272	28.8%
	Hispanic	62	126	49.2%	1,156	2,715	42.6%
	Native American	11	21	52.4%	406	1,233	32.9%
	White	487	1,591	30.6%	2,026	7,423	27.3%
	Unknown	113	427	26.5%	185	586	31.6%
4 - 6 years							
2013		**4,567**	**6,668**	**68.5%**	**16,159**	**26,198**	**61.7%**
	Asian-Pacific Is	308	442	69.7%	1,435	2,138	67.1%
	Black	441	701	62.9%	4,252	7,205	59.0%
	Hispanic	466	627	74.3%	2,857	4,142	69.0%
	Native American	65	94	69.1%	1,069	1,687	63.4%
	White	2,762	4,060	68.0%	6,161	10,380	59.4%
	Unknown	525	744	70.6%	385	646	59.6%
2012		**3,915**	**5,533**	**70.8%**	**16,051**	**25,811**	**62.2%**
	Asian-Pacific Is	241	329	73.3%	1,344	1,985	67.7%
	Black	349	483	72.3%	4,036	6,820	59.2%
	Hispanic	331	431	76.8%	2,886	4,151	69.5%
	Native American	51	70	72.9%	1,070	1,666	64.2%
	White	2,437	3,503	69.6%	6,227	10,430	59.7%
	Unknown	506	717	70.6%	488	759	64.3%
2011		**4,017**	**5,588**	**71.9%**	**16,969**	**27,002**	**62.8%**
	Asian-Pacific Is	249	358	69.6%	1,342	2,027	66.2%
	Black	363	508	71.5%	4,296	7,138	60.2%
	Hispanic	323	409	79.0%	3,016	4,279	70.5%
	Native American	44	71	62.0%	1,147	1,805	63.5%
	White	2,529	3,544	71.4%	6,649	10,963	60.6%
	Unknown	509	698	72.9%	519	790	65.7%
2010		**3,472**	**4,785**	**72.6%**	**16,292**	**25,533**	**63.8%**
	Asian-Pacific Is	218	284	76.8%	1,095	1,697	64.5%
	Black	325	426	76.3%	4,014	6,519	61.6%
	Hispanic	238	305	78.0%	3,094	4,325	71.5%
	Native American	37	56	66.1%	1,152	1,784	64.6%
	White	2,208	3,100	71.2%	6,485	10,507	61.7%

	Unknown	446	614	72.6%	452	701	64.5%
2009		**3,255**	**4,315**	**75.4%**	**14,280**	**22,116**	**64.6%**
	Asian-Pacific Is	192	252	76.2%	989	1,518	65.2%
	Black	295	398	74.1%	3,462	5,532	62.6%
	Hispanic	217	266	81.6%	2,497	3,542	70.5%
	Native American	30	43	69.8%	1,024	1,598	64.1%
	White	2,123	2,825	75.2%	5,954	9,395	63.4%
	Unknown	398	531	75.0%	354	531	66.7%
7 - 10 years							
2013		**6,413**	**8,506**	**75.4%**	**21,149**	**33,025**	**64.0%**
	Asian-Pacific Is	432	571	75.7%	1,859	2,812	66.1%
	Black	642	893	71.9%	5,403	8,794	61.4%
	Hispanic	606	755	80.3%	3,663	5,267	69.5%
	Native American	100	136	73.5%	1,310	2,047	64.0%
	White	3,919	5,241	74.8%	8,467	13,402	63.2%
	Unknown	714	910	78.5%	447	703	63.6%
2012		**5,545**	**7,119**	**77.9%**	**19,900**	**31,297**	**63.6%**
	Asian-Pacific Is	362	458	79.0%	1,696	2,628	64.5%
	Black	465	616	75.5%	4,837	7,958	60.8%
	Hispanic	419	519	80.7%	3,384	4,937	68.5%
	Native American	82	106	77.4%	1,277	1,965	65.0%
	White	3,584	4,622	77.5%	8,277	13,121	63.1%
	Unknown	633	798	79.3%	429	688	62.4%
2011		**5,833**	**7,289**	**80.0%**	**20,470**	**31,868**	**64.2%**
	Asian-Pacific Is	372	484	76.9%	1,728	2,632	65.7%
	Black	490	633	77.4%	4,974	8,188	60.7%
	Hispanic	418	502	83.3%	3,406	4,906	69.4%
	Native American	65	87	74.7%	1,262	2,027	62.3%
	White	3,841	4,783	80.3%	8,585	13,393	64.1%
	Unknown	647	800	80.9%	515	722	71.3%
2010		**5,307**	**6,507**	**81.6%**	**20,014**	**30,417**	**65.8%**
	Asian-Pacific Is	301	376	80.1%	1,605	2,443	65.7%
	Black	394	486	81.1%	4,740	7,572	62.6%
	Hispanic	313	383	81.7%	3,185	4,541	70.1%

	Native American	55	73	75.3%	1,311	1,971	66.5%
	White	3,681	4,503	81.7%	8,741	13,273	65.9%
	Unknown	563	686	82.1%	432	617	70.0%
2009		**4,914**	**5,996**	**82.0%**	**17,390**	**26,778**	**64.9%**
	Asian-Pacific Is	296	370	80.0%	1,504	2,263	66.5%
	Black	348	439	79.3%	4,123	6,609	62.4%
	Hispanic	292	353	82.7%	2,511	3,663	68.6%
	Native American	46	63	73.0%	1,021	1,894	53.9%
	White	3,416	4,159	82.1%	7,865	11,847	66.4%
	Unknown	516	612	84.3%	366	502	72.9%
11 - 14 years							
2013		**6,060**	**8,412**	**72.0%**	**16,966**	**28,857**	**58.8%**
	Asian-Pacific Is	414	576	71.9%	1,727	2,920	59.1%
	Black	496	774	64.1%	4,355	7,545	57.7%
	Hispanic	491	675	72.7%	2,562	3,932	65.2%
	Native American	99	138	71.7%	921	1,714	53.7%
	White	3,975	5,456	72.9%	7,145	12,361	57.8%
	Unknown	585	793	73.8%	256	385	66.5%
2012		**5,404**	**7,241**	**74.6%**	**16,063**	**27,527**	**58.4%**
	Asian-Pacific Is	345	478	72.2%	1,626	2,798	58.1%
	Black	386	546	70.7%	3,952	7,070	55.9%
	Hispanic	374	467	80.1%	2,141	3,453	62.0%
	Native American	70	108	64.8%	891	1,663	53.6%
	White	3,754	5,007	75.0%	7,221	12,156	59.4%
	Unknown	475	635	74.8%	232	387	59.9%
2011		**5,544**	**7,271**	**76.2%**	**16,369**	**27,633**	**59.2%**
	Asian-Pacific Is	350	502	69.7%	1,698	2,926	58.0%
	Black	364	538	67.7%	3,915	7,106	55.1%
	Hispanic	302	384	78.6%	1,973	3,168	62.3%
	Native American	67	97	69.1%	974	1,724	56.5%
	White	4,012	5,159	77.8%	7,549	12,287	61.4%
	Unknown	449	591	76.0%	260	422	61.6%
2010		**5,084**	**6,518**	**78.0%**	**15,713**	**25,861**	**60.8%**
	Asian-Pacific Is	305	413	73.8%	1,642	2,699	60.8%

	Black	353	470	75.1%	3,736	6,498	57.5%
	Hispanic	228	281	81.1%	1,732	2,774	62.4%
	Native American	58	77	75.3%	916	1,637	56.0%
	White	3,735	4,746	78.7%	7,453	11,860	62.8%
	Unknown	405	531	76.3%	234	393	59.5%
2009		**4,623**	**5,969**	**77.5%**	**13,957**	**23,029**	**60.6%**
	Asian-Pacific Is	256	358	71.5%	1,624	2,650	61.3%
	Black	283	380	74.5%	3,268	5,715	57.2%
	Hispanic	180	235	76.6%	1,334	2,227	59.9%
	Native American	49	62	79.0%	803	1,520	52.8%
	White	3,489	4,477	77.9%	6,721	10,579	63.5%
	Unknown	366	457	80.1%	207	338	61.2%
15 - 18 years							
2013		**5,321**	**8,348**	**63.7%**	**11,126**	**21,785**	**51.1%**
	Asian-Pacific Is	337	585	57.6%	1,490	3,027	49.2%
	Black	403	708	56.9%	2,853	5,770	49.4%
	Hispanic	321	472	68.0%	1,093	2,071	52.8%
	Native American	79	144	54.9%	596	1,214	49.1%
	White	3,773	5,835	64.7%	4,942	9,422	52.5%
	Unknown	408	604	67.5%	152	281	54.1%
2012		**4,707**	**7,172**	**65.6%**	**10,747**	**21,167**	**50.8%**
	Asian-Pacific Is	284	459	61.9%	1,501	3,011	49.9%
	Black	305	511	59.7%	2,578	5,411	47.6%
	Hispanic	218	326	66.9%	925	1,807	51.2%
	Native American	78	110	70.9%	579	1,183	48.9%
	White	3,486	5,270	66.1%	4,981	9,423	52.9%
	Unknown	336	496	67.7%	183	332	55.1%
2011		**4,893**	**7,318**	**66.9%**	**11,442**	**22,023**	**52.0%**
	Asian-Pacific Is	316	508	62.2%	1,558	3,136	49.7%
	Black	294	500	58.8%	2,714	5,607	48.4%
	Hispanic	188	270	69.6%	940	1,799	52.3%
	Native American	62	93	66.7%	581	1,203	48.3%
	White	3,731	5,499	67.8%	5,375	9,783	54.9%
	Unknown	302	448	67.4%	274	495	55.4%

2010		**4,580**	**6,649**	**68.9%**	**11,814**	**21,555**	**54.8%**
	Asian-Pacific Is	261	410	63.7%	1,597	3,093	51.6%
	Black	266	424	62.7%	2,714	5,369	50.5%
	Hispanic	136	211	64.5%	857	1,604	53.4%
	Native American	55	78	70.5%	644	1,240	51.9%
	White	3,606	5,170	69.7%	5,690	9,763	58.3%
	Unknown	256	356	71.9%	312	486	64.2%
2009		**4,416**	**6,272**	**70.4%**	**10,733**	**19,970**	**53.7%**
	Asian-Pacific Is	236	350	67.4%	1,496	2,930	51.1%
	Black	243	393	61.8%	2,440	4,934	49.5%
	Hispanic	126	183	68.9%	709	1,356	52.3%
	Native American	47	69	68.1%	623	1,280	48.7%
	White	3,547	4,970	71.4%	5,175	8,989	57.6%
	Unknown	217	307	70.7%	290	481	60.3%
Grand Total		**102,775**	**147,621**	**69.6%**	**342,746**	**607,762**	**56.4%**

Table 4: Well-child visits, first 15 months 6+ Visits

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

			MinnesotaCare Children			MA Children		
Measu Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
First 15 mths								
	2013		**702**	**1,053**	**66.7%**	**6,358**	**10,962**	**58.0%**
		Asian-Pacific Is	44	65	67.7%	554	960	57.7%
		Black	62	90	68.9%	1,520	2,771	54.9%
		Hispanic	29	34	85.3%	1,089	1,532	71.1%
		Native American	7	11	63.6%	164	450	36.4%
		White	326	501	65.1%	2,569	4,523	56.8%
		Unknown	234	352	66.5%	462	726	63.6%
	2012		**617**	**900**	**68.6%**	**5,294**	**9,485**	**55.8%**
		Asian-Pacific Is	40	58	69.0%	434	836	51.9%
		Black	50	77	64.9%	1,250	2,278	54.9%
		Hispanic	26	34	76.5%	805	1,173	68.6%
		Native American	3	7	42.9%	189	471	40.1%
		White	365	524	69.7%	2,296	4,188	54.8%
		Unknown	133	200	66.5%	320	539	59.4%
	2011		**700**	**1,000**	**70.0%**	**7,007**	**11,642**	**60.2%**
		Asian-Pacific Is	45	61	73.8%	472	871	54.2%
		Black	71	89	79.8%	1,690	2,868	58.9%
		Hispanic	29	35	82.9%	1,304	1,797	72.6%
		Native American	6	7	85.7%	267	646	41.3%
		White	398	575	69.2%	2,938	4,967	59.2%
		Unknown	151	233	64.8%	336	493	68.2%
	2010		**589**	**915**	**64.4%**	**6,465**	**11,579**	**55.8%**
		Asian-Pacific Is	32	55	58.2%	391	811	48.2%
		Black	52	83	62.7%	1,545	2,824	54.7%
		Hispanic	27	31	87.1%	1,304	1,941	67.2%
		Native American	5	6	83.3%	224	637	35.2%
		White	332	534	62.2%	2,765	4,953	55.8%
		Unknown	141	206	68.4%	236	413	57.1%

2009		**573**	**928**	**61.7%**	**5,811**	**10,861**	**53.5%**
	Asian-Pacific Is	32	53	60.4%	324	719	45.1%
	Black	60	83	72.3%	1,336	2,543	52.5%
	Hispanic	16	29	55.2%	1,183	1,828	64.7%
	Native American	4	4	100.0%	219	628	34.9%
	White	334	543	61.5%	2,488	4,715	52.8%
	Unknown	127	216	58.8%	261	428	61.0%
Grand Total		**3,181**	**4,796**	**66.3%**	**30,935**	**54,529**	**56.7%**

Table 5: Well-child visits, 3 to 6 years

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)
Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

			MinnesotaCare Children			MA Children		
Measure Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
3-6 years								
	2013		**5,647**	**8,590**	**65.7%**	**20,809**	**34,153**	**60.9%**
		Asian-Pacific Is	403	571	70.6%	1,765	2,798	63.1%
		Black	645	894	72.1%	6,203	9,420	65.8%
		Hispanic	580	790	73.4%	3,594	5,301	67.8%
		Native American	72	123	58.5%	1,119	2,152	52.0%
		White	3,335	5,214	64.0%	7,559	13,557	55.8%
		Unknown	612	998	61.3%	569	925	61.5%
	2012		**4,770**	**7,063**	**67.5%**	**21,134**	**34,161**	**61.9%**
		Asian-Pacific Is	301	425	70.8%	1,697	2,640	64.3%
		Black	454	626	72.5%	5,923	9,054	65.4%
		Hispanic	386	533	72.4%	3,858	5,471	70.5%
		Native American	57	83	68.7%	1,161	2,200	52.8%
		White	2,989	4,493	66.5%	7,874	13,814	57.0%
		Unknown	583	903	64.6%	621	982	63.2%
	2011		**4,838**	**7,239**	**66.8%**	**22,150**	**36,045**	**61.5%**
		Asian-Pacific Is	315	458	68.8%	1,684	2,720	61.9%
		Black	508	661	76.9%	6,226	9,615	64.8%
		Hispanic	383	515	74.4%	3,918	5,681	69.0%
		Native American	58	88	65.9%	1,187	2,361	50.3%
		White	2,956	4,560	64.8%	8,471	14,616	58.0%
		Unknown	618	957	64.6%	664	1,052	63.1%
	2010		**4,159**	**6,290**	**66.1%**	**21,707**	**34,808**	**62.4%**
		Asian-Pacific Is	255	358	71.2%	1,507	2,329	64.7%
		Black	395	553	71.4%	5,885	8,912	66.0%
		Hispanic	295	388	76.0%	4,116	5,812	70.8%
		Native American	43	66	65.2%	1,151	2,389	48.2%
		White	2,630	4,088	64.3%	8,447	14,393	58.7%
		Unknown	541	837	64.6%	601	973	61.8%

2009		**3,630**	**5,658**	**64.2%**	**18,649**	**30,304**	**61.5%**
	Asian-Pacific Is	221	317	69.7%	1,247	2,030	61.4%
	Black	386	526	73.4%	5,055	7,630	66.3%
	Hispanic	252	339	74.3%	3,331	4,870	68.4%
	Native American	39	56	69.6%	1,124	2,223	50.6%
	White	2,281	3,677	62.0%	7,375	12,741	57.9%
	Unknown	451	743	60.7%	517	810	63.8%
Grand Total		**23,044**	**34,840**	**66.1%**	**104,449**	**169,471**	**61.6%**

Table 6: Adolescent Well Care

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

			MinnesotaCare Children			MA Children		
Meası Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
12 - 19 year								
	2013		**5,882**	**16,668**	**35.3%**	**15,927**	**45,348**	**35.1%**
		Asian-Pacific Is	451	1,176	38.4%	2,038	5,674	35.9%
		Black	655	1,469	44.6%	4,773	11,974	39.9%
		Hispanic	506	1,065	47.5%	2,208	5,038	43.8%
		Native American	93	286	32.5%	771	2,582	29.9%
		White	3,689	11,377	32.4%	5,917	19,510	30.3%
		Unknown	488	1,295	37.7%	220	570	38.6%
	2012		**5,081**	**14,349**	**35.4%**	**15,058**	**43,613**	**34.5%**
		Asian-Pacific Is	373	986	37.8%	1,985	5,584	35.5%
		Black	439	1,040	42.2%	4,318	11,211	38.5%
		Hispanic	292	724	40.3%	1,734	4,368	39.7%
		Native American	70	207	33.8%	751	2,516	29.8%
		White	3,519	10,325	34.1%	6,068	19,283	31.5%
		Unknown	388	1,067	36.4%	202	651	31.0%
	2011		**5,040**	**14,597**	**34.5%**	**15,240**	**44,626**	**34.2%**
		Asian-Pacific Is	370	1,013	36.5%	2,087	5,768	36.2%
		Black	451	1,060	42.5%	4,333	11,485	37.7%
		Hispanic	263	613	42.9%	1,603	4,117	38.9%
		Native American	75	189	39.7%	779	2,634	29.6%
		White	3,505	10,747	32.6%	6,137	19,752	31.1%
		Unknown	376	975	38.6%	301	870	34.6%
	2010		**4,646**	**13,247**	**35.1%**	**15,218**	**43,157**	**35.3%**
		Asian-Pacific Is	340	819	41.5%	2,323	5,627	41.3%
		Black	394	887	44.4%	4,334	10,869	39.9%
		Hispanic	214	444	48.2%	1,448	3,666	39.5%
		Native American	57	161	35.4%	752	2,622	28.7%
		White	3,319	10,124	32.8%	6,052	19,534	31.0%
		Unknown	322	812	39.7%	309	839	36.8%

2009		**4,103**	**12,188**	**33.7%**	**14,197**	**39,212**	**36.2%**
	Asian-Pacific Is	261	701	37.2%	2,083	5,409	38.5%
	Black	322	759	42.4%	4,158	9,812	42.4%
	Hispanic	167	390	42.8%	1,220	3,014	40.5%
	Native American	47	124	37.9%	714	2,520	28.3%
	White	3,064	9,547	32.1%	5,712	17,662	32.3%
	Unknown	242	667	36.3%	310	795	39.0%
Grand Total		**24,752**	**71,049**	**34.8%**	**75,640**	**215,956**	**35.0%**

Table 7: Medication Management for People with Asthma

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

			MinnesotaCare Children			MA Children		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	5 - 11 years								
		2013		**254**	**261**	**97.3%**	**936**	**1,044**	**89.7%**
			Asian-Pacific Is	11	12	91.7%	29	35	82.9%
			Black	35	35	100.0%	369	420	87.9%
			Hispanic	27	27	100.0%	119	130	91.5%
			Native American	4	4	100.0%	53	63	84.1%
			White	151	156	96.8%	344	372	92.5%
			Unknown	26	27	96.3%	22	24	91.7%
		2012		**208**	**220**	**94.5%**	**794**	**890**	**89.2%**
			Asian-Pacific Is	4	4	100.0%	24	25	96.0%
			Black	18	20	90.0%	287	328	87.5%
			Hispanic	9	10	90.0%	108	121	89.3%
			Native American	5	5	100.0%	43	52	82.7%
			White	146	155	94.2%	313	342	91.5%
			Unknown	26	26	100.0%	19	22	86.4%
		2011		**248**	**266**	**93.2%**	**937**	**1,033**	**90.7%**
			Asian-Pacific Is	9	9	100.0%	33	35	94.3%
			Black	20	25	80.0%	341	380	89.7%
			Hispanic	19	20	95.0%	126	136	92.6%
			Native American	4	4	100.0%	44	50	88.0%
			White	171	181	94.5%	363	401	90.5%
			Unknown	25	27	92.6%	30	31	96.8%
		2010		**190**	**198**	**96.0%**	**818**	**888**	**92.1%**
			Asian-Pacific Is	5	5	100.0%	29	29	100.0%
			Black	17	19	89.5%	288	316	91.1%
			Hispanic	14	14	100.0%	109	117	93.2%
			Native American	3	3	100.0%	43	46	93.5%
			White	131	136	96.3%	330	358	92.2%
			Unknown	20	21	95.2%	19	22	86.4%

2009		**184**	**193**	**95.3%**	**783**	**876**	**89.4%**
	Asian-Pacific Is	5	5	100.0%	30	34	88.2%
	Black	20	21	95.2%	280	325	86.2%
	Hispanic	15	15	100.0%	85	92	92.4%
	Native American	3	3	100.0%	42	44	95.5%
	White	120	127	94.5%	327	360	90.8%
	Unknown	21	22	95.5%	19	21	90.5%
12 - 20 years							
2013		**271**	**308**	**88.0%**	**807**	**905**	**89.2%**
	Asian-Pacific Is	10	11	90.9%	21	25	84.0%
	Black	24	27	88.9%	276	313	88.2%
	Hispanic	10	12	83.3%	62	75	82.7%
	Native American	3	4	75.0%	30	35	85.7%
	White	203	231	87.9%	409	448	91.3%
	Unknown	21	23	91.3%	9	9	100.0%
2012		**247**	**284**	**87.0%**	**661**	**752**	**87.9%**
	Asian-Pacific Is	6	6	100.0%	22	23	95.7%
	Black	20	26	76.9%	201	234	85.9%
	Hispanic	7	7	100.0%	47	53	88.7%
	Native American	3	3	100.0%	28	35	80.0%
	White	193	223	86.5%	352	396	88.9%
	Unknown	18	19	94.7%	11	11	100.0%
2011		**276**	**316**	**87.3%**	**753**	**873**	**86.3%**
	Asian-Pacific Is	10	10	100.0%	23	24	95.8%
	Black	28	34	82.4%	254	289	87.9%
	Hispanic	12	13	92.3%	43	46	93.5%
	Native American	4	5	80.0%	38	46	82.6%
	White	205	237	86.5%	389	461	84.4%
	Unknown	17	17	100.0%	6	7	85.7%
2010		**250**	**286**	**87.4%**	**691**	**795**	**86.9%**
	Asian-Pacific Is	6	6	100.0%	23	26	88.5%
	Black	29	32	90.6%	249	275	90.5%
	Hispanic	10	11	90.9%	39	43	90.7%
	Native American	3	3	100.0%	31	41	75.6%
	White	189	221	85.5%	342	401	85.3%

	Unknown	13	13	100.0%	7	9	77.8%
2009		**230**	**267**	**86.1%**	**529**	**616**	**85.9%**
	Asian-Pacific Is	6	7	85.7%	18	22	81.8%
	Black	20	20	100.0%	180	202	89.1%
	Hispanic	9	10	90.0%	25	27	92.6%
	Native American	3	3	100.0%	27	34	79.4%
	White	182	216	84.3%	274	323	84.8%
	Unknown	10	11	90.9%	5	8	62.5%
Grand Total		**2,358**	**2,599**	**90.7%**	**7,709**	**8,672**	**88.9%**

Table 8a: Follow-up After Hospitalization for Mental Illness (7 days)

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

			MinnesotaCare Children			MA Children		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	6 to 20 yrs								
		2013		**62**	**217**	**28.6%**	**397**	**1,756**	**22.6%**
			Asian-Pacific Is	1	5	20.0%	5	30	16.7%
			Black	7	23	30.4%	74	362	20.4%
			Hispanic	4	8	50.0%	48	172	27.9%
			Native American	2	7	28.6%	23	149	15.4%
			White	46	168	27.4%	235	996	23.6%
			Unknown	2	6	33.3%	12	47	25.5%
		2012		**70**	**196**	**35.7%**	**519**	**1,805**	**28.8%**
			Asian-Pacific Is	1	4	25.0%	18	43	41.9%
			Black	3	7	42.9%	99	346	28.6%
			Hispanic	7	15	46.7%	50	168	29.8%
			Native American	0	7	0.0%	37	161	23.0%
			White	57	157	36.3%	306	1,047	29.2%
			Unknown	2	6	33.3%	9	40	22.5%
		2011		**60**	**175**	**34.3%**	**398**	**1,631**	**24.4%**
			Asian-Pacific Is	3	8	37.5%	4	34	11.8%
			Black	1	10	10.0%	67	304	22.0%
			Hispanic	1	4	25.0%	34	123	27.6%
			Native American	3	7	42.9%	35	163	21.5%
			White	49	136	36.0%	247	971	25.4%
			Unknown	3	10	30.0%	11	36	30.6%
		2010		**59**	**176**	**33.5%**	**373**	**1,553**	**24.0%**
			Asian-Pacific Is	0	3	0.0%	11	41	26.8%
			Black	4	10	40.0%	64	292	21.9%
			Hispanic	0	3	0.0%	25	120	20.8%
			Native American	1	3	33.3%	27	162	16.7%
			White	53	152	34.9%	238	903	26.4%
			Unknown	1	5	20.0%	8	35	22.9%

2009		**36**	**145**	**24.8%**	**394**	**1,529**	**25.8%**
	Asian-Pacific Is	1	1	100.0%	7	27	25.9%
	Black	6	14	42.9%	49	225	21.8%
	Hispanic	1	5	20.0%	39	115	33.9%
	Native American	2	5	40.0%	35	167	21.0%
	White	25	116	21.6%	260	957	27.2%
	Unknown	1	4	25.0%	4	38	10.5%
Grand Total		**287**	**909**	**31.6%**	**2,081**	**8,274**	**25.2%**

Table 8b: Follow-up After Hospitalization for Mental Illness within 30 days

Waiver population: MinnesotaCare Children (DHS program/eligibility codes: LL/C1, C2, I1, I2.)

Comparison population: MA Children (DHS program/eligibility codes: MA/CB, CK, CX)

			MinnesotaCare Children			MA Children		
Meas	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	6 to 20 yrs								
		2013		117	217	53.9%	742	1,756	42.3%
			Asian-Pacifi	3	5	60.0%	8	30	26.7%
			Black	12	23	52.2%	141	362	39.0%
			Hispanic	5	8	62.5%	82	172	47.7%
			Native Amer	3	7	42.9%	46	149	30.9%
			White	92	168	54.8%	447	996	44.9%
			Unknown	2	6	33.3%	18	47	38.3%
		2012		109	196	55.6%	867	1,805	48.0%
			Asian-Pacifi	2	4	50.0%	22	43	51.2%
			Black	4	7	57.1%	163	346	47.1%
			Hispanic	10	15	66.7%	79	168	47.0%
			Native Amer	3	7	42.9%	54	161	33.5%
			White	86	157	54.8%	535	1,047	51.1%
			Unknown	4	6	66.7%	14	40	35.0%
		2011		107	175	61.1%	745	1,631	45.7%
			Asian-Pacifi	3	8	37.5%	6	34	17.6%
			Black	6	10	60.0%	122	304	40.1%
			Hispanic	2	4	50.0%	58	123	47.2%
			Native Amer	6	7	85.7%	59	163	36.2%
			White	83	136	61.0%	482	971	49.6%
			Unknown	7	10	70.0%	18	36	50.0%
		2010		104	176	59.1%	704	1,553	45.3%
			Asian-Pacifi	1	3	33.3%	24	41	58.5%
			Black	8	10	80.0%	120	292	41.1%
			Hispanic	0	3	0.0%	52	120	43.3%
			Native Amer	1	3	33.3%	55	162	34.0%
			White	93	152	61.2%	436	903	48.3%
			Unknown	1	5	20.0%	17	35	48.6%
		2009		77	145	53.1%	704	1,529	46.0%
			Asian-Pacifi	1	1	100.0%	9	27	33.3%
			Black	10	14	71.4%	90	225	40.0%
			Hispanic	1	5	20.0%	62	115	53.9%
			Native Amer	3	5	60.0%	62	167	37.1%
			White	60	116	51.7%	464	957	48.5%

	Unknown	2	4	50.0%	17	38	44.7%
Grand Total		**514**	**909**	**56.5%**	**3,762**	**8,274**	**45.5%**

Table 9: Postpartum Care

Waiver population: MinnesotaCare Pregnant Women (DHS program/eligibility codes: LL/P1, P2)

Comparison population: MA Pregnant Women (DHS program/eligibility codes: MA/PX)

			MinnesotaCare Pregnant Women			MA Pregnant Women		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
All Ages									
		2013		**116**	**264**	**43.9%**	**1,083**	**2,819**	**38.4%**
			Asian-Pacific Is	12	21	57.1%	129	317	40.7%
			Black	12	35	34.3%	258	695	37.1%
			Hispanic	4	10	40.0%	88	183	48.1%
			Native American	1	1	100.0%	43	158	27.2%
			White	84	186	45.2%	542	1,415	38.3%
			Unknown	3	11	27.3%	23	51	45.1%
		2012		**88**	**186**	**47.3%**	**1,182**	**2,848**	**41.5%**
			Asian-Pacific Is	8	20	40.0%	127	324	39.2%
			Black	12	30	40.0%	278	683	40.7%
			Hispanic	0	1	0.0%	101	194	52.1%
			Native American	2	4	50.0%	53	137	38.7%
			White	62	121	51.2%	597	1,447	41.3%
			Unknown	4	10	40.0%	26	63	41.3%
		2011		**83**	**197**	**42.1%**	**1,108**	**2,629**	**42.1%**
			Asian-Pacific Is	6	13	46.2%	94	240	39.2%
			Black	8	29	27.6%	218	579	37.7%
			Hispanic	0	1	0.0%	70	139	50.4%
			Native American	1	2	50.0%	45	137	32.8%
			White	66	144	45.8%	661	1,484	44.5%
			Unknown	2	8	25.0%	20	50	40.0%
		2010		**79**	**161**	**49.1%**	**1,147**	**2,704**	**42.4%**
			Asian-Pacific Is	3	12	25.0%	96	234	41.0%
			Black	5	14	35.7%	222	577	38.5%
			Hispanic	1	2	50.0%	72	154	46.8%
			Native American	1	2	50.0%	58	163	35.6%
			White	62	122	50.8%	675	1,522	44.3%
			Unknown	7	9	77.8%	24	54	44.4%

2009		**83**	**150**	**55.3%**	**1,101**	**2,402**	**45.8%**
	Asian-Pacific Is	4	7	57.1%	65	171	38.0%
	Black	10	17	58.8%	205	483	42.4%
	Hispanic	1	4	25.0%	79	160	49.4%
	Native American	0	0	#DIV/0!	59	138	42.8%
	White	66	118	55.9%	667	1,401	47.6%
	Unknown	2	4	50.0%	26	49	53.1%
Grand Total		**449**	**958**	**46.9%**	**5,621**	**13,402**	**41.9%**

Table 10a: Diabetes A1c Screening

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Adults			MA Adults		
Measur	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 - 64 years								
		2013		**1,564**	**1,700**	**92.0%**	**2,613**	**3,163**	**82.6%**
			Asian-Pacific Is	145	156	92.9%	277	312	88.8%
			Black	182	202	90.1%	769	902	85.3%
			Hispanic	92	96	95.8%	174	214	81.3%
			Native American	53	55	96.4%	274	349	78.5%
			White	1,008	1,101	91.6%	1,097	1,359	80.7%
			Unknown	84	90	93.3%	22	27	81.5%
		2012		**1,418**	**1,555**	**91.2%**	**2,459**	**3,032**	**81.1%**
			Asian-Pacific Is	118	128	92.2%	221	260	85.0%
			Black	158	169	93.5%	707	847	83.5%
			Hispanic	78	85	91.8%	163	202	80.7%
			Native American	32	36	88.9%	283	375	75.5%
			White	944	1,042	90.6%	1,061	1,316	80.6%
			Unknown	88	95	92.6%	24	32	75.0%
		2011		**1,398**	**1,528**	**91.5%**	**2,503**	**3,066**	**81.6%**
			Asian-Pacific Is	110	121	90.9%	230	260	88.5%
			Black	176	189	93.1%	754	900	83.8%
			Hispanic	72	75	96.0%	171	212	80.7%
			Native American	33	38	86.8%	280	374	74.9%
			White	943	1,035	91.1%	1,045	1,295	80.7%
			Unknown	64	70	91.4%	23	25	92.0%
		2010		**1,186**	**1,322**	**89.7%**	**2,264**	**2,850**	**79.4%**
			Asian-Pacific Is	79	87	90.8%	176	217	81.1%
			Black	138	148	93.2%	639	781	81.8%
			Hispanic	58	63	92.1%	170	202	84.2%
			Native American	28	34	82.4%	280	379	73.9%
			White	831	929	89.5%	977	1,241	78.7%
			Unknown	52	61	85.2%	22	30	73.3%

2009		**976**	**1,111**	**87.8%**	**1,974**	**2,585**	**76.4%**
	Asian-Pacific Is	64	71	90.1%	157	201	78.1%
	Black	112	126	88.9%	536	694	77.2%
	Hispanic	47	51	92.2%	133	168	79.2%
	Native American	22	26	84.6%	255	358	71.2%
	White	693	789	87.8%	877	1,145	76.6%
	Unknown	38	48	79.2%	16	19	84.2%
Grand Total		**6,542**	**7,216**	**90.7%**	**11,813**	**14,696**	**80.4%**

Table 10b: Diabetes LDL Screening

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Adults			MA Adults		
Measur	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 - 64 years								
		2013		**1,420**	**1,700**	**83.5%**	**2,219**	**3,163**	**70.2%**
			Asian-Pacific Is	138	156	88.5%	252	312	80.8%
			Black	168	202	83.2%	659	902	73.1%
			Hispanic	87	96	90.6%	158	214	73.8%
			Native American	42	55	76.4%	184	349	52.7%
			White	908	1,101	82.5%	945	1,359	69.5%
			Unknown	77	90	85.6%	21	27	77.8%
		2012		**1,283**	**1,555**	**82.5%**	**2,043**	**3,032**	**67.4%**
			Asian-Pacific Is	108	128	84.4%	198	260	76.2%
			Black	139	169	82.2%	612	847	72.3%
			Hispanic	76	85	89.4%	138	202	68.3%
			Native American	25	36	69.4%	171	375	45.6%
			White	856	1,042	82.1%	904	1,316	68.7%
			Unknown	79	95	83.2%	20	32	62.5%
		2011		**1,285**	**1,528**	**84.1%**	**2,056**	**3,066**	**67.1%**
			Asian-Pacific Is	101	121	83.5%	198	260	76.2%
			Black	162	189	85.7%	623	900	69.2%
			Hispanic	67	75	89.3%	155	212	73.1%
			Native American	30	38	78.9%	165	374	44.1%
			White	865	1,035	83.6%	896	1,295	69.2%
			Unknown	60	70	85.7%	19	25	76.0%
		2010		**1,084**	**1,322**	**82.0%**	**1,889**	**2,850**	**66.3%**
			Asian-Pacific Is	76	87	87.4%	159	217	73.3%
			Black	121	148	81.8%	548	781	70.2%
			Hispanic	56	63	88.9%	150	202	74.3%
			Native American	25	34	73.5%	183	379	48.3%
			White	758	929	81.6%	833	1,241	67.1%
			Unknown	48	61	78.7%	16	30	53.3%

2009		**885**	**1,111**	**79.7%**	**1,637**	**2,585**	**63.3%**
	Asian-Pacific Is	55	71	77.5%	130	201	64.7%
	Black	103	126	81.7%	453	694	65.3%
	Hispanic	39	51	76.5%	120	168	71.4%
	Native American	23	26	88.5%	170	358	47.5%
	White	631	789	80.0%	751	1,145	65.6%
	Unknown	34	48	70.8%	13	19	68.4%
Grand Total		**5,957**	**7,216**	**82.6%**	**9,844**	**14,696**	**67.0%**

Table 11: Adult Access to Preventive / Ambulatory Health Services

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Caretaker Adults			MA Adults		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 - 44 years								
		2013		**14,510**	**16,579**	**87.5%**	**32,147**	**35,493**	**90.6%**
			Asian-Pacific Is	978	1,197	81.7%	2,371	2,862	82.8%
			Black	1,119	1,236	90.5%	8,097	8,834	91.7%
			Hispanic	438	486	90.1%	1,382	1,548	89.3%
			Native American	215	239	90.0%	1,936	2,165	89.4%
			White	10,934	12,453	87.8%	18,118	19,812	91.4%
			Unknown	826	968	85.3%	243	272	89.3%
		2012		**13,498**	**15,378**	**87.8%**	**31,969**	**35,294**	**90.6%**
			Asian-Pacific Is	836	1,026	81.5%	2,206	2,650	83.2%
			Black	919	1,010	91.0%	7,470	8,240	90.7%
			Hispanic	352	388	90.7%	1,343	1,486	90.4%
			Native American	174	199	87.4%	2,069	2,276	90.9%
			White	10,511	11,922	88.2%	18,544	20,255	91.6%
			Unknown	706	833	84.8%	337	387	87.1%
		2011		**14,616**	**16,608**	**88.0%**	**33,922**	**37,456**	**90.6%**
			Asian-Pacific Is	892	1,063	83.9%	2,198	2,667	82.4%
			Black	984	1,089	90.4%	8,046	8,889	90.5%
			Hispanic	381	419	90.9%	1,423	1,598	89.0%
			Native American	194	213	91.1%	2,203	2,435	90.5%
			White	11,448	12,973	88.2%	19,644	21,410	91.8%
			Unknown	717	851	84.3%	408	457	89.3%
		2010		**12,570**	**14,310**	**87.8%**	**33,287**	**36,652**	**90.8%**
			Asian-Pacific Is	703	824	85.3%	1,867	2,246	83.1%
			Black	777	838	92.7%	7,403	8,131	91.0%
			Hispanic	300	323	92.9%	1,443	1,585	91.0%
			Native American	147	161	91.3%	2,306	2,492	92.5%
			White	10,038	11,461	87.6%	19,829	21,712	91.3%
			Unknown	605	703	86.1%	439	486	90.3%

2009		**11,214**	**12,775**	**87.8%**	**29,738**	**32,565**	**91.3%**
	Asian-Pacific Is	568	672	84.5%	1,707	2,036	83.8%
	Black	607	671	90.5%	6,411	7,003	91.5%
	Hispanic	253	282	89.7%	1,248	1,372	91.0%
	Native American	113	127	89.0%	2,162	2,357	91.7%
	White	9,150	10,411	87.9%	17,840	19,382	92.0%
	Unknown	523	612	85.5%	370	415	89.2%
45 - 64 years							
2013		**9,149**	**10,186**	**89.8%**	**6,883**	**7,482**	**92.0%**
	Asian-Pacific Is	747	844	88.5%	946	1,046	90.4%
	Black	697	749	93.1%	1,784	1,923	92.8%
	Hispanic	248	268	92.5%	281	298	94.3%
	Native American	132	141	93.6%	328	350	93.7%
	White	6,824	7,621	89.5%	3,490	3,803	91.8%
	Unknown	501	563	89.0%	54	62	87.1%
2012		**8,401**	**9,406**	**89.3%**	**6,266**	**6,848**	**91.5%**
	Asian-Pacific Is	619	712	86.9%	809	888	91.1%
	Black	555	606	91.6%	1,523	1,658	91.9%
	Hispanic	217	237	91.6%	217	230	94.3%
	Native American	98	105	93.3%	334	361	92.5%
	White	6,477	7,252	89.3%	3,305	3,621	91.3%
	Unknown	435	494	88.1%	78	90	86.7%
2011		**8,682**	**9,765**	**88.9%**	**6,377**	**7,021**	**90.8%**
	Asian-Pacific Is	586	665	88.1%	768	864	88.9%
	Black	553	606	91.3%	1,570	1,701	92.3%
	Hispanic	189	211	89.6%	245	270	90.7%
	Native American	99	101	98.0%	353	384	91.9%
	White	6,824	7,684	88.8%	3,348	3,691	90.7%
	Unknown	431	498	86.5%	93	111	83.8%
2010		**7,588**	**8,537**	**88.9%**	**5,990**	**6,590**	**90.9%**
	Asian-Pacific Is	450	515	87.4%	634	704	90.1%
	Black	418	457	91.5%	1,501	1,607	93.4%
	Hispanic	144	160	90.0%	217	237	91.6%
	Native American	68	78	87.2%	347	375	92.5%
	White	6,131	6,895	88.9%	3,208	3,567	89.9%

	Unknown	377	432	87.3%	83	100	83.0%
2009		**6,555**	**7,355**	**89.1%**	**5,339**	**5,849**	**91.3%**
	Asian-Pacific Is	366	416	88.0%	577	666	86.6%
	Black	341	361	94.5%	1,261	1,350	93.4%
	Hispanic	104	123	84.6%	196	219	89.5%
	Native American	53	56	94.6%	369	389	94.9%
	White	5,352	6,013	89.0%	2,866	3,146	91.1%
	Unknown	339	386	87.8%	70	79	88.6%
Grand Total		**106,783**	**120,899**	**88.3%**	**191,918**	**211,250**	**90.8%**

Table 12: Annual Dental Visit

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Caretaker Adults			MA Adults		
Measur Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
21 - 64 years								
	2013		**13,592**	**26,765**	**50.8%**	**18,541**	**42,975**	**43.1%**
		Asian-Pacific Is	1,058	2,041	51.8%	1,441	3,908	36.9%
		Black	934	1,985	47.1%	4,549	10,757	42.3%
		Hispanic	419	754	55.6%	725	1,846	39.3%
		Native American	181	380	47.6%	1,063	2,515	42.3%
		White	10,233	20,074	51.0%	10,617	23,615	45.0%
		Unknown	767	1,531	50.1%	146	334	43.7%
	2012		**12,352**	**24,784**	**49.8%**	**18,399**	**42,142**	**43.7%**
		Asian-Pacific Is	876	1,738	50.4%	1,363	3,538	38.5%
		Black	771	1,616	47.7%	4,259	9,898	43.0%
		Hispanic	319	625	51.0%	705	1,716	41.1%
		Native American	154	304	50.7%	1,150	2,637	43.6%
		White	9,560	19,174	49.9%	10,721	23,876	44.9%
		Unknown	672	1,327	50.6%	201	477	42.1%
	2011		**13,849**	**26,373**	**52.5%**	**20,312**	**44,477**	**45.7%**
		Asian-Pacific Is	905	1,728	52.4%	1,421	3,531	40.2%
		Black	823	1,695	48.6%	4,681	10,590	44.2%
		Hispanic	347	630	55.1%	777	1,868	41.6%
		Native American	167	314	53.2%	1,261	2,819	44.7%
		White	10,872	20,657	52.6%	11,893	25,101	47.4%
		Unknown	735	1,349	54.5%	279	568	49.1%
	2010		**12,969**	**22,847**	**56.8%**	**20,923**	**43,242**	**48.4%**
		Asian-Pacific Is	782	1,339	58.4%	1,255	2,950	42.5%
		Black	690	1,295	53.3%	4,659	9,738	47.8%
		Hispanic	271	483	56.1%	799	1,822	43.9%
		Native American	126	239	52.7%	1,337	2,867	46.6%
		White	10,463	18,356	57.0%	12,580	25,279	49.8%
		Unknown	637	1,135	56.1%	293	586	50.0%

2009		**12,008**	**20,130**	**59.7%**	**19,500**	**38,414**	**50.8%**
	Asian-Pacific Is	676	1,088	62.1%	1,166	2,702	43.2%
	Black	583	1,032	56.5%	4,138	8,353	49.5%
	Hispanic	214	405	52.8%	727	1,591	45.7%
	Native American	100	183	54.6%	1,352	2,746	49.2%
	White	9,839	16,424	59.9%	11,855	22,528	52.6%
	Unknown	596	998	59.7%	262	494	53.0%
Grand Total		**64,770**	**120,899**	**53.6%**	**97,675**	**211,250**	**46.2%**

Table 13: Cervical Cancer Screening

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Caretaker Adults			MA Adults		
Measur	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	24 - 64 years								
		2013		**10,857**	**14,880**	**73.0%**	**21,012**	**29,078**	**72.3%**
			Asian-Pacific Is	846	1,114	75.9%	1,459	2,209	66.0%
			Black	888	1,132	78.4%	5,605	7,401	75.7%
			Hispanic	306	383	79.9%	912	1,198	76.1%
			Native American	159	226	70.4%	1,011	1,643	61.5%
			White	8,075	11,237	71.9%	11,872	16,425	72.3%
			Unknown	583	788	74.0%	153	202	75.7%
		2012		**10,317**	**13,774**	**74.9%**	**20,902**	**28,214**	**74.1%**
			Asian-Pacific Is	752	948	79.3%	1,356	1,970	68.8%
			Black	733	907	80.8%	5,276	6,749	78.2%
			Hispanic	263	325	80.9%	851	1,087	78.3%
			Native American	121	171	70.8%	1,023	1,659	61.7%
			White	7,940	10,739	73.9%	12,182	16,458	74.0%
			Unknown	508	684	74.3%	214	291	73.5%
		2011		**11,055**	**14,602**	**75.7%**	**22,077**	**29,636**	**74.5%**
			Asian-Pacific Is	742	941	78.9%	1,295	1,925	67.3%
			Black	773	952	81.2%	5,734	7,203	79.6%
			Hispanic	257	325	79.1%	926	1,176	78.7%
			Native American	126	185	68.1%	1,087	1,777	61.2%
			White	8,619	11,506	74.9%	12,779	17,211	74.2%
			Unknown	538	693	77.6%	256	344	74.4%
		2010		**9,748**	**12,692**	**76.8%**	**21,536**	**28,658**	**75.1%**
			Asian-Pacific Is	599	748	80.1%	1,086	1,610	67.5%
			Black	579	717	80.8%	5,322	6,617	80.4%
			Hispanic	207	263	78.7%	936	1,180	79.3%
			Native American	110	144	76.4%	1,143	1,787	64.0%
			White	7,803	10,242	76.2%	12,775	17,092	74.7%
			Unknown	450	578	77.9%	274	372	73.7%

2009		**8,832**	**11,243**	**78.6%**	**19,132**	**25,554**	**74.9%**
	Asian-Pacific Is	477	609	78.3%	952	1,467	64.9%
	Black	472	578	81.7%	4,519	5,712	79.1%
	Hispanic	167	193	86.5%	781	1,025	76.2%
	Native American	82	105	78.1%	1,073	1,716	62.5%
	White	7,235	9,251	78.2%	11,569	15,325	75.5%
	Unknown	399	507	78.7%	238	309	77.0%
Grand Total		**50,809**	**67,191**	**75.6%**	**104,659**	**141,140**	**74.2%**

Table 14: Medication Management for People with Asthma

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Caretaker Adults			MA Adults		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 - 50 years								
		2013		**323**	**378**	**85.4%**	**580**	**717**	**80.9%**
			Asian-Pacific Is	8	9	88.9%	24	25	96.0%
			Black	21	24	87.5%	120	149	80.5%
			Hispanic	9	10	90.0%	15	20	75.0%
			Native American	4	5	80.0%	29	40	72.5%
			White	262	307	85.3%	389	480	81.0%
			Unknown	19	23	82.6%	3	3	100.0%
		2012		**278**	**330**	**84.2%**	**495**	**637**	**77.7%**
			Asian-Pacific Is	5	6	83.3%	22	30	73.3%
			Black	13	16	81.3%	107	126	84.9%
			Hispanic	4	7	57.1%	9	12	75.0%
			Native American	3	4	75.0%	25	38	65.8%
			White	236	276	85.5%	327	425	76.9%
			Unknown	17	21	81.0%	5	6	83.3%
		2011		**334**	**386**	**86.5%**	**573**	**744**	**77.0%**
			Asian-Pacific Is	6	6	100.0%	23	28	82.1%
			Black	17	22	77.3%	115	149	77.2%
			Hispanic	10	10	100.0%	15	24	62.5%
			Native American	4	5	80.0%	36	52	69.2%
			White	273	315	86.7%	384	488	78.7%
			Unknown	24	28	85.7%	0	3	0.0%
		2010		**302**	**354**	**85.3%**	**498**	**643**	**77.4%**
			Asian-Pacific Is	7	7	100.0%	20	25	80.0%
			Black	9	11	81.8%	104	132	78.8%
			Hispanic	9	10	90.0%	14	21	66.7%
			Native American	3	5	60.0%	30	44	68.2%
			White	257	302	85.1%	327	415	78.8%
			Unknown	17	19	89.5%	3	6	50.0%

2009		**269**	**314**	**85.7%**	**465**	**602**	**77.2%**
	Asian-Pacific Is	5	6	83.3%	19	23	82.6%
	Black	10	10	100.0%	86	109	78.9%
	Hispanic	7	8	87.5%	16	20	80.0%
	Native American	4	6	66.7%	23	36	63.9%
	White	227	267	85.0%	319	411	77.6%
	Unknown	16	17	94.1%	2	3	66.7%
51 - 64 years							
2013		**89**	**105**	**84.8%**	**53**	**59**	**89.8%**
	Asian-Pacific Is	4	4	100.0%	5	5	100.0%
	Black	8	8	100.0%	18	18	100.0%
	Hispanic	1	1	100.0%	2	2	100.0%
	Native American	2	2	100.0%	3	3	100.0%
	White	68	82	82.9%	24	30	80.0%
	Unknown	6	8	75.0%	1	1	100.0%
2012		**70**	**79**	**88.6%**	**44**	**47**	**93.6%**
	Asian-Pacific Is	3	3	100.0%	8	8	100.0%
	Black	6	7	85.7%	18	20	90.0%
	Hispanic	1	1	100.0%	2	2	100.0%
	Native American	2	2	100.0%	3	3	100.0%
	White	54	62	87.1%	12	13	92.3%
	Unknown	4	4	100.0%	1	1	100.0%
2011		**77**	**90**	**85.6%**	**44**	**58**	**75.9%**
	Asian-Pacific Is	2	3	66.7%	10	11	90.9%
	Black	3	3	100.0%	11	16	68.8%
	Hispanic	1	1	100.0%	3	3	100.0%
	Native American	1	1	100.0%	2	3	66.7%
	White	64	75	85.3%	17	23	73.9%
	Unknown	6	7	85.7%	1	2	50.0%
2010		**46**	**52**	**88.5%**	**40**	**53**	**75.5%**
	Asian-Pacific Is	3	3	100.0%	8	9	88.9%
	Black	1	1	100.0%	10	14	71.4%
	Hispanic	0	0	#DIV/0!	1	1	100.0%
	Native American	2	2	100.0%	4	5	80.0%
	White	34	40	85.0%	16	22	72.7%

	Unknown	6	6	100.0%	1	2	50.0%
2009		**39**	**43**	**90.7%**	**27**	**35**	**77.1%**
	Asian-Pacific Is	2	2	100.0%	3	4	75.0%
	Black	1	1	100.0%	6	10	60.0%
	Hispanic	0	0	#DIV/0!	1	1	100.0%
	Native American	2	2	100.0%	4	4	100.0%
	White	31	35	88.6%	12	15	80.0%
	Unknown	3	3	100.0%	1	1	100.0%
Grand Total		**1,827**	**2,131**	**85.7%**	**2,819**	**3,595**	**78.4%**

Table 15a: Follow-up after Hospitalization for Mental Illness within 7 Days

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Caretaker Adults			MA Adults		
Measu	Age G Year	Race	Num	Den	Rate	Num	Den	Rate
	2013		**33**	**108**	**30.6%**	**222**	**903**	**24.6%**
		Asian-Pacific Is	1	2	50.0%	13	41	31.7%
		Black	3	10	30.0%	32	162	19.8%
		Hispanic	2	6	33.3%	12	49	24.5%
		Native American	1	5	20.0%	6	45	13.3%
		White	24	81	29.6%	158	594	26.6%
		Unknown	2	4	50.0%	1	12	8.3%
	2012		**49**	**148**	**33.1%**	**265**	**1,060**	**25.0%**
		Asian-Pacific Is	1	4	25.0%	12	48	25.0%
		Black	3	5	60.0%	37	168	22.0%
		Hispanic	1	3	33.3%	11	34	32.4%
		Native American	0	3	0.0%	13	76	17.1%
		White	42	130	32.3%	190	723	26.3%
		Unknown	2	3	66.7%	2	11	18.2%
	2011		**52**	**141**	**36.9%**	**294**	**1,034**	**28.4%**
		Asian-Pacific Is	0	3	0.0%	8	33	24.2%
		Black	5	8	62.5%	46	184	25.0%
		Hispanic	2	6	33.3%	10	40	25.0%
		Native American	1	5	20.0%	9	70	12.9%
		White	41	112	36.6%	218	694	31.4%
		Unknown	3	7	42.9%	3	13	23.1%
	2010		**44**	**126**	**34.9%**	**270**	**1,015**	**26.6%**
		Asian-Pacific Is	1	2	50.0%	16	48	33.3%
		Black	2	7	28.6%	46	172	26.7%
		Hispanic	0	1	0.0%	10	42	23.8%
		Native American	4	5	80.0%	7	64	10.9%
		White	37	108	34.3%	189	678	27.9%
		Unknown	0	3	0.0%	2	11	18.2%
	2009		**43**	**119**	**36.1%**	**253**	**977**	**25.9%**

	Asian-Pacific Is	1	4	25.0%	5	37	13.5%
	Black	3	7	42.9%	30	166	18.1%
	Hispanic	0	2	0.0%	9	38	23.7%
	Native American	2	4	50.0%	10	63	15.9%
	White	35	98	35.7%	196	657	29.8%
	Unknown	2	4	50.0%	3	16	18.8%
Grand Total		**221**	**642**	**34.4%**	**1,304**	**4,989**	**26.1%**

Table 15b: Follow-up after Hospitalization for Mental Illness within 30 Days

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

		MinnesotaCare Caretaker Adults			MA Adults		
Measu Age G Year	Race	Num	Den	Rate	Num	Den	Rate
2013		**56**	**108**	**51.9%**	**424**	**903**	**47.0%**
	Asian-Pacific Is	2	2	100.0%	25	41	61.0%
	Black	5	10	50.0%	65	162	40.1%
	Hispanic	3	6	50.0%	22	49	44.9%
	Native American	2	5	40.0%	10	45	22.2%
	White	41	81	50.6%	299	594	50.3%
	Unknown	3	4	75.0%	3	12	25.0%
2012		**91**	**148**	**61.5%**	**506**	**1,060**	**47.7%**
	Asian-Pacific Is	2	4	50.0%	24	48	50.0%
	Black	4	5	80.0%	66	168	39.3%
	Hispanic	1	3	33.3%	16	34	47.1%
	Native American	2	3	66.7%	29	76	38.2%
	White	79	130	60.8%	365	723	50.5%
	Unknown	3	3	100.0%	6	11	54.5%
2011		**87**	**141**	**61.7%**	**510**	**1,034**	**49.3%**
	Asian-Pacific Is	1	3	33.3%	15	33	45.5%
	Black	6	8	75.0%	91	184	49.5%
	Hispanic	2	6	33.3%	17	40	42.5%
	Native American	2	5	40.0%	18	70	25.7%
	White	71	112	63.4%	365	694	52.6%
	Unknown	5	7	71.4%	4	13	30.8%
2010		**72**	**126**	**57.1%**	**500**	**1,015**	**49.3%**
	Asian-Pacific Is	2	2	100.0%	31	48	64.6%
	Black	5	7	71.4%	87	172	50.6%
	Hispanic	0	1	0.0%	23	42	54.8%
	Native American	4	5	80.0%	16	64	25.0%
	White	59	108	54.6%	338	678	49.9%
	Unknown	2	3	66.7%	5	11	45.5%
2009		**73**	**119**	**61.3%**	**499**	**977**	**51.1%**

	Asian-Pacific Is	3	4	75.0%	15	37	40.5%
	Black	4	7	57.1%	73	166	44.0%
	Hispanic	0	2	0.0%	21	38	55.3%
	Native American	3	4	75.0%	19	63	30.2%
	White	61	98	62.2%	366	657	55.7%
	Unknown	2	4	50.0%	5	16	31.3%
Grand Total		**379**	**642**	**59.0%**	**2,439**	**4,989**	**48.9%**

Table 16a: Initiation of Alcohol and Other Drug Dependence Treatment

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

			MinnesotaCare Caretaker Adults			MA Adults		
Meas	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 to 64 yr								
		2013		285	772	36.9%	1,292	3,500	36.9%
			Asian-Pacifi	4	16	25.0%	27	73	37.0%
			Black	10	31	32.3%	228	725	31.4%
			Hispanic	5	13	38.5%	55	136	40.4%
			Native Amer	13	31	41.9%	191	472	40.5%
			White	247	648	38.1%	781	2,073	37.7%
			Unknown	6	33	18.2%	10	21	47.6%
		2012		237	657	36.1%	1,265	3,404	37.2%
			Asian-Pacifi	3	8	37.5%	25	76	32.9%
			Black	6	22	27.3%	217	648	33.5%
			Hispanic	4	15	26.7%	49	132	37.1%
			Native Amer	9	21	42.9%	194	493	39.4%
			White	206	564	36.5%	767	2,020	38.0%
			Unknown	9	27	33.3%	13	35	37.1%
		2011		273	739	36.9%	1,339	3,546	37.8%
			Asian-Pacifi	0	6	0.0%	13	34	38.2%
			Black	12	32	37.5%	255	700	36.4%
			Hispanic	5	23	21.7%	59	136	43.4%
			Native Amer	10	24	41.7%	229	549	41.7%
			White	238	634	37.5%	772	2,091	36.9%
			Unknown	8	20	40.0%	11	36	30.6%
		2010		224	606	37.0%	1,276	3,283	38.9%
			Asian-Pacifi	4	15	26.7%	21	50	42.0%
			Black	8	24	33.3%	212	594	35.7%
			Hispanic	7	14	50.0%	43	110	39.1%
			Native Amer	8	16	50.0%	231	538	42.9%
			White	190	510	37.3%	756	1,958	38.6%
			Unknown	7	27	25.9%	13	33	39.4%
		2009		170	458	37.1%	1,286	3,124	41.2%
			Asian-Pacifi	4	9	44.4%	11	36	30.6%
			Black	6	20	30.0%	223	578	38.6%
			Hispanic	1	8	12.5%	40	105	38.1%
			Native Amer	4	14	28.6%	230	512	44.9%
			White	151	393	38.4%	770	1,862	41.4%

	Unknown	4	14	28.6%	12	31	38.7%
Grand Total		**1,189**	**3,232**	**36.8%**	**6,458**	**16,857**	**38.3%**

Table 16: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Waiver population: MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)

Comparison population: MA Adults (DHS program/eligibility codes: MA/AA)

		MinnesotaCare Caretaker Adult			MA Adults		
Measur Age G Year	Race	Num	Den	Rate	Num	Den	Rate
2013		**121**	**772**	**15.7%**	**486**	**3,500**	**13.9%**
	Asian-Pacific Is	2	16	12.5%	8	73	11.0%
	Black	5	31	16.1%	70	725	9.7%
	Hispanic	1	13	7.7%	17	136	12.5%
	Native American	9	31	29.0%	79	472	16.7%
	White	102	648	15.7%	309	2,073	14.9%
	Unknown	2	33	6.1%	3	21	14.3%
2012		**88**	**657**	**13.4%**	**480**	**3,404**	**14.1%**
	Asian-Pacific Is	2	8	25.0%	13	76	17.1%
	Black	0	22	0.0%	72	648	11.1%
	Hispanic	0	15	0.0%	12	132	9.1%
	Native American	2	21	9.5%	82	493	16.6%
	White	78	564	13.8%	296	2,020	14.7%
	Unknown	6	27	22.2%	5	35	14.3%
2011		**121**	**739**	**16.4%**	**536**	**3,546**	**15.1%**
	Asian-Pacific Is	0	6	0.0%	6	34	17.6%
	Black	6	32	18.8%	87	700	12.4%
	Hispanic	3	23	13.0%	17	136	12.5%
	Native American	5	24	20.8%	96	549	17.5%
	White	105	634	16.6%	323	2,091	15.4%
	Unknown	2	20	10.0%	7	36	19.4%
2010		**91**	**606**	**15.0%**	**488**	**3,283**	**14.9%**
	Asian-Pacific Is	1	15	6.7%	4	50	8.0%
	Black	3	24	12.5%	57	594	9.6%
	Hispanic	3	14	21.4%	14	110	12.7%
	Native American	3	16	18.8%	98	538	18.2%
	White	78	510	15.3%	313	1,958	16.0%
	Unknown	3	27	11.1%	2	33	6.1%
2009		**71**	**458**	**15.5%**	**474**	**3,124**	**15.2%**

	Asian-Pacific Is	1	9	11.1%	5	36	13.9%
	Black	3	20	15.0%	73	578	12.6%
	Hispanic	1	8	12.5%	9	105	8.6%
	Native American	1	14	7.1%	93	512	18.2%
	White	63	393	16.0%	292	1,862	15.7%
	Unknown	2	14	14.3%	2	31	6.5%
Grand Total		**492**	**3,232**	**15.2%**	**2,464**	**16,857**	**14.6%**

Table 17a: Diabetes A1c Screening

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

		MinnesotaCare Adults w/o Childre			MA Adults w/o Children		
Measu Age Gı Year	Race	Num	Den	Rate	Num	Den	Rate
2013		**2,473**	**2,635**	**93.9%**	**3,145**	**3,448**	**91.2%**
	Asian-Pacific Is	101	102	99.0%	179	186	96.2%
	Black	203	212	95.8%	660	718	91.9%
	Hispanic	66	70	94.3%	138	150	92.0%
	Native American	91	102	89.2%	257	303	84.8%
	White	1,896	2,022	93.8%	1,857	2,033	91.3%
	Unknown	116	127	91.3%	54	58	93.1%
2012		**2,288**	**2,454**	**93.2%**	**2,767**	**3,050**	**90.7%**
	Asian-Pacific Is	109	114	95.6%	153	162	94.4%
	Black	170	178	95.5%	537	591	90.9%
	Hispanic	71	80	88.8%	127	137	92.7%
	Native American	80	96	83.3%	233	275	84.7%
	White	1,770	1,892	93.6%	1,663	1,829	90.9%
	Unknown	88	94	93.6%	54	56	96.4%
2011		**2,423**	**2,615**	**92.7%**	**1,814**	**1,993**	**91.0%**
	Asian-Pacific Is	90	94	95.7%	97	99	98.0%
	Black	175	183	95.6%	246	277	88.8%
	Hispanic	63	71	88.7%	69	75	92.0%
	Native American	75	87	86.2%	123	156	78.8%
	White	1,929	2,077	92.9%	1,243	1,349	92.1%
	Unknown	91	103	88.3%	36	37	97.3%
Grand Total		**7,184**	**7,704**	**93.3%**	**7,726**	**8,491**	**91.0%**

Table 17b: Diabetes LDL Screening

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			MinnesotaCare Adults w/o Childr			MA Adults w/o Children		
Measur	Age Grp	Year	Num	Den	Rate	Num	Den	Rate
		2013	**2,330**	**2,635**	**88.4%**	**2,840**	**3,448**	**82.4%**
		Asian-Pacific Is	101	102	99.0%	160	186	86.0%
		Black	188	212	88.7%	588	718	81.9%
		Hispanic	64	70	91.4%	130	150	86.7%
		Native American	78	102	76.5%	201	303	66.3%
		White	1,788	2,022	88.4%	1,712	2,033	84.2%
		Unknown	111	127	87.4%	49	58	84.5%
		2012	**2,107**	**2,454**	**85.9%**	**2,487**	**3,050**	**81.5%**
		Asian-Pacific Is	100	114	87.7%	147	162	90.7%
		Black	157	178	88.2%	474	591	80.2%
		Hispanic	71	80	88.8%	112	137	81.8%
		Native American	59	96	61.5%	166	275	60.4%
		White	1,640	1,892	86.7%	1,541	1,829	84.3%
		Unknown	80	94	85.1%	47	56	83.9%
		2011	**2,194**	**2,615**	**83.9%**	**1,612**	**1,993**	**80.9%**
		Asian-Pacific Is	86	94	91.5%	89	99	89.9%
		Black	160	183	87.4%	213	277	76.9%
		Hispanic	59	71	83.1%	63	75	84.0%
		Native American	58	87	66.7%	94	156	60.3%
		White	1,749	2,077	84.2%	1,125	1,349	83.4%
		Unknown	82	103	79.6%	28	37	75.7%
Grand Total			**6,631**	**7,704**	**86.1%**	**6,939**	**8,491**	**81.7%**

Table 18: Adult Access to Preventive / Ambulatory Health Services

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			nesotaCare Adults w/o Chil			MA Adults w/o Children		
Measu Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
21 - 44 years								
	2013		**6,725**	**7,597**	**88.5%**	**12,242**	**14,557**	**84.1%**
		Asian-Pacific Is	328	420	78.1%	494	681	72.5%
		Black	556	602	92.4%	2,747	3,353	81.9%
		Hispanic	124	137	90.5%	314	378	83.1%
		Native American	145	172	84.3%	915	1,086	84.3%
		White	5,249	5,898	89.0%	7,552	8,798	85.8%
		Unknown	323	368	87.8%	220	261	84.3%
	2012		**6,288**	**7,148**	**88.0%**	**11,451**	**13,754**	**83.3%**
		Asian-Pacific Is	280	364	76.9%	450	621	72.5%
		Black	427	480	89.0%	2,442	3,064	79.7%
		Hispanic	94	102	92.2%	260	317	82.0%
		Native American	133	152	87.5%	902	1,043	86.5%
		White	5,065	5,719	88.6%	7,096	8,342	85.1%
		Unknown	289	331	87.3%	301	367	82.0%
	2011		**7,633**	**8,624**	**88.5%**	**8,698**	**10,362**	**83.9%**
		Asian-Pacific Is	308	385	80.0%	400	538	74.3%
		Black	478	521	91.7%	1,308	1,652	79.2%
		Hispanic	140	153	91.5%	162	194	83.5%
		Native American	111	124	89.5%	531	614	86.5%
		White	6,226	7,006	88.9%	6,022	7,035	85.6%
		Unknown	370	435	85.1%	275	329	83.6%
45 - 64 years								
	2013		**12,592**	**13,587**	**92.7%**	**14,454**	**16,451**	**87.9%**
		Asian-Pacific Is	466	506	92.1%	563	640	88.0%
		Black	565	590	95.8%	2,681	2,982	89.9%
		Hispanic	175	186	94.1%	367	411	89.3%
		Native American	246	260	94.6%	749	837	89.5%
		White	10,462	11,291	92.7%	9,863	11,323	87.1%
		Unknown	678	754	89.9%	231	258	89.5%

2012		**11,809**	**12,830**	**92.0%**	**12,929**	**14,775**	**87.5%**
	Asian-Pacific Is	419	458	91.5%	499	556	89.7%
	Black	545	577	94.5%	2,242	2,522	88.9%
	Hispanic	170	176	96.6%	318	346	91.9%
	Native American	231	242	95.5%	665	730	91.1%
	White	9,879	10,740	92.0%	8,951	10,318	86.8%
	Unknown	565	637	88.7%	254	303	83.8%
2011		**12,670**	**13,708**	**92.4%**	**8,148**	**9,159**	**89.0%**
	Asian-Pacific Is	348	379	91.8%	310	347	89.3%
	Black	561	590	95.1%	900	1,011	89.0%
	Hispanic	164	171	95.9%	175	188	93.1%
	Native American	209	223	93.7%	333	364	91.5%
	White	10,785	11,684	92.3%	6,225	7,029	88.6%
	Unknown	603	661	91.2%	205	220	93.2%
Grand Total		**57,717**	**63,494**	**90.9%**	**67,922**	**79,058**	**85.9%**

Table 19: Annual Dental Visit

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			innesotaCare Adults w/o Childr			MA Adults w/o Children		
Measu	Age Grp Year	Race	Num	Den	Rate	Num	Den	Rate
	21 - 64 years							
	2013		**7,909**	**21,184**	**37.3%**	**12,201**	**31,008**	**39.3%**
		Asian-Pacific Is	380	926	41.0%	545	1,321	41.3%
		Black	448	1,192	37.6%	2,400	6,335	37.9%
		Hispanic	122	323	37.8%	316	789	40.1%
		Native American	148	432	34.3%	719	1,923	37.4%
		White	6,387	17,189	37.2%	8,005	20,121	39.8%
		Unknown	424	1,122	37.8%	216	519	41.6%
	2012		**8,442**	**19,978**	**42.3%**	**11,383**	**28,529**	**39.9%**
		Asian-Pacific Is	354	822	43.1%	463	1,177	39.3%
		Black	486	1,057	46.0%	2,170	5,586	38.8%
		Hispanic	125	278	45.0%	265	663	40.0%
		Native American	156	394	39.6%	723	1,773	40.8%
		White	6,898	16,459	41.9%	7,494	18,660	40.2%
		Unknown	423	968	43.7%	268	670	40.0%
	2011		**10,576**	**22,332**	**47.4%**	**8,624**	**19,521**	**44.2%**
		Asian-Pacific Is	376	764	49.2%	397	885	44.9%
		Black	565	1,111	50.9%	1,121	2,663	42.1%
		Hispanic	144	324	44.4%	178	382	46.6%
		Native American	154	347	44.4%	412	978	42.1%
		White	8,790	18,690	47.0%	6,260	14,064	44.5%
		Unknown	547	1,096	49.9%	256	549	46.6%
Grand Total			**26,927**	**63,494**	**42.4%**	**32,208**	**79,058**	**40.7%**

Table 20: Cervical Cancer Screening

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			MinnesotaCare Adults w/o Childre			MA Adults w/o Children		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 - 64 years								
		2013		**6,268**	**10,952**	**57.2%**	**5,584**	**10,155**	**55.0%**
			Asian-Pacific Is	297	460	64.6%	275	527	52.2%
			Black	350	574	61.0%	970	1,727	56.2%
			Hispanic	85	145	58.6%	154	257	59.9%
			Native American	107	224	47.8%	346	722	47.9%
			White	5,096	8,977	56.8%	3,757	6,764	55.5%
			Unknown	333	572	58.2%	82	158	51.9%
		2012		**6,087**	**10,445**	**58.3%**	**5,284**	**9,432**	**56.0%**
			Asian-Pacific Is	269	415	64.8%	266	489	54.4%
			Black	294	509	57.8%	817	1,513	54.0%
			Hispanic	72	133	54.1%	130	216	60.2%
			Native American	93	189	49.2%	324	646	50.2%
			White	5,088	8,707	58.4%	3,635	6,365	57.1%
			Unknown	271	492	55.1%	112	203	55.2%
		2011		**6,790**	**11,564**	**58.7%**	**4,013**	**6,770**	**59.3%**
			Asian-Pacific Is	241	361	66.8%	195	331	58.9%
			Black	307	532	57.7%	467	813	57.4%
			Hispanic	90	155	58.1%	86	128	67.2%
			Native American	86	181	47.5%	181	343	52.8%
			White	5,744	9,784	58.7%	2,980	4,975	59.9%
			Unknown	322	551	58.4%	104	180	57.8%
Grand Total				**19,145**	**32,961**	**58.1%**	**14,881**	**26,357**	**56.5%**

Table 21: Medication Management for People with Asthma

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			innesotaCare Adults w/o Childr			MA Adults w/o Children		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 - 50 years								
		2013		**165**	**195**	**84.6%**	**343**	**449**	**76.4%**
			Asian-Pacific Is	4	4	100.0%	5	5	100.0%
			Black	11	12	91.7%	81	100	81.0%
			Hispanic	1	1	100.0%	8	8	100.0%
			Native American	1	1	100.0%	18	21	85.7%
			White	135	164	82.3%	228	310	73.5%
			Unknown	13	13	100.0%	3	5	60.0%
		2012		**155**	**185**	**83.8%**	**193**	**255**	**75.7%**
			Asian-Pacific Is	2	2	100.0%	9	11	81.8%
			Black	8	10	80.0%	23	26	88.5%
			Hispanic	1	1	100.0%	3	4	75.0%
			Native American	6	6	100.0%	6	11	54.5%
			White	127	155	81.9%	146	197	74.1%
			Unknown	11	11	100.0%	6	6	100.0%
		2011		**162**	**201**	**80.6%**	**199**	**240**	**82.9%**
			Asian-Pacific Is	4	4	100.0%	7	9	77.8%
			Black	2	2	100.0%	28	31	90.3%
			Hispanic	2	3	66.7%	5	5	100.0%
			Native American	4	5	80.0%	3	5	60.0%
			White	139	175	79.4%	152	184	82.6%
			Unknown	11	12	91.7%	4	6	66.7%
	51 - 64 years								
		2013		**155**	**201**	**77.1%**	**153**	**189**	**81.0%**
			Asian-Pacific Is	3	4	75.0%	8	10	80.0%
			Black	6	6	100.0%	29	35	82.9%
			Hispanic	0	1	0.0%	6	6	100.0%
			Native American	2	6	33.3%	6	10	60.0%
			White	135	172	78.5%	101	125	80.8%
			Unknown	9	12	75.0%	3	3	100.0%

2012		**127**	**173**	**73.4%**	**81**	**106**	**76.4%**
	Asian-Pacific Is	2	3	66.7%	4	4	100.0%
	Black	6	7	85.7%	9	11	81.8%
	Hispanic	1	1	100.0%	1	1	100.0%
	Native American	3	5	60.0%	3	4	75.0%
	White	108	147	73.5%	63	85	74.1%
	Unknown	7	10	70.0%	1	1	100.0%
2011		**152**	**195**	**77.9%**	**78**	**94**	**83.0%**
	Asian-Pacific Is	2	3	66.7%	4	4	100.0%
	Black	7	9	77.8%	5	5	100.0%
	Hispanic	0	1	0.0%	0	1	0.0%
	Native American	2	3	66.7%	1	3	33.3%
	White	136	171	79.5%	66	79	83.5%
	Unknown	5	8	62.5%	2	2	100.0%
Grand Total		**916**	**1,150**	**79.7%**	**1,047**	**1,333**	**78.5%**

Table 22a: Follow-up after Hospitalization for Mental Illness within 7 Days

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			nnesotaCare Adults w/o Child			MA Adults w/o Children		
Measu	Age Grp / Year	Race	Num	Den	Rate	Num	Den	Rate
	21 to 64 years							
	2013		**62**	**221**	**28.1%**	**481**	**2,307**	**20.8%**
		Asian-Pacific Is	1	4	25.0%	10	44	22.7%
		Black	3	13	23.1%	72	430	16.7%
		Hispanic	1	2	50.0%	15	54	27.8%
		Native American	0	7	0.0%	33	159	20.8%
		White	55	186	29.6%	333	1,545	21.6%
		Unknown	2	9	22.2%	18	75	24.0%
	2012		**57**	**182**	**31.3%**	**364**	**2,094**	**17.4%**
		Asian-Pacific Is	0	2	0.0%	15	45	33.3%
		Black	1	7	14.3%	66	389	17.0%
		Hispanic	0	6	0.0%	10	55	18.2%
		Native American	2	6	33.3%	14	123	11.4%
		White	50	157	31.8%	259	1,427	18.1%
		Unknown	4	4	100.0%	0	55	0.0%
	2011		**69**	**211**	**32.7%**	**311**	**1,643**	**18.9%**
		Asian-Pacific Is	0	4	0.0%	9	28	32.1%
		Black	4	8	50.0%	37	268	13.8%
		Hispanic	1	1	100.0%	5	48	10.4%
		Native American	2	7	28.6%	16	102	15.7%
		White	60	186	32.3%	235	1,152	20.4%
		Unknown	2	5	40.0%	9	45	20.0%
Grand Total			**188**	**614**	**30.6%**	**1,156**	**6,044**	**19.1%**

Table 22b: Follow-up after Hospitalization for Mental Illness within 30 Days

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			nesotaCare Adults w/o Chil			MA Adults w/o Children		
Measu	Age Grp Year	Race	Num	Den	Rate	Num	Den	Rate
	21 to 64 years							
	2013		**127**	**221**	**57.5%**	**955**	**2,307**	**41.4%**
		Asian-Pacific Is	2	4	50.0%	22	44	50.0%
		Black	9	13	69.2%	161	430	37.4%
		Hispanic	2	2	100.0%	22	54	40.7%
		Native American	4	7	57.1%	63	159	39.6%
		White	106	186	57.0%	656	1,545	42.5%
		Unknown	4	9	44.4%	31	75	41.3%
	2012		**107**	**182**	**58.8%**	**827**	**2,094**	**39.5%**
		Asian-Pacific Is	2	2	100.0%	25	45	55.6%
		Black	4	7	57.1%	143	389	36.8%
		Hispanic	3	6	50.0%	24	55	43.6%
		Native American	3	6	50.0%	31	123	25.2%
		White	91	157	58.0%	583	1,427	40.9%
		Unknown	4	4	100.0%	21	55	38.2%
	2011		**121**	**211**	**57.3%**	**668**	**1,643**	**40.7%**
		Asian-Pacific Is	2	4	50.0%	19	28	67.9%
		Black	4	8	50.0%	84	268	31.3%
		Hispanic	1	1	100.0%	14	48	29.2%
		Native American	4	7	57.1%	34	102	33.3%
		White	105	186	56.5%	498	1,152	43.2%
		Unknown	5	5	100.0%	19	45	42.2%
Grand Total			**355**	**614**	**57.8%**	**2,450**	**6,044**	**40.5%**

Table 23a: Initiation of Alcohol and Other Drug Dependence Treatment

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			MinnesotaCare Adults w/o Children			MA Adults w/o Children		
Meas Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
21 to 64 yr								
	2013		388	1,128	34.4%	2,389	6,093	39.2%
		Asian-Pacifi	2	9	22.2%	16	48	33.3%
		Black	17	55	30.9%	503	1,374	36.6%
		Hispanic	10	22	45.5%	64	160	40.0%
		Native Amer	24	67	35.8%	285	714	39.9%
		White	312	923	33.8%	1,474	3,700	39.8%
		Unknown	23	52	44.2%	47	97	48.5%
	2012		353	1,044	33.8%	2,160	5,465	39.5%
		Asian-Pacifi	3	12	25.0%	22	58	37.9%
		Black	17	34	50.0%	402	1,100	36.5%
		Hispanic	3	14	21.4%	62	144	43.1%
		Native Amer	30	68	44.1%	267	692	38.6%
		White	289	880	32.8%	1,364	3,375	40.4%
		Unknown	11	36	30.6%	43	96	44.8%
	2011		430	1,215	35.4%	2,182	5,054	43.2%
		Asian-Pacifi	3	9	33.3%	18	48	37.5%
		Black	12	32	37.5%	425	975	43.6%
		Hispanic	5	16	31.3%	49	123	39.8%
		Native Amer	18	62	29.0%	249	604	41.2%
		White	386	1,066	36.2%	1,395	3,192	43.7%
		Unknown	6	30	20.0%	46	112	41.1%
Grand Total			**1,171**	**3,387**	**34.6%**	**6,731**	**16,612**	**40.5%**

Table 23b: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Waiver population: MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)

Comparison population: MA Adults w/o Children (DHS program/eligibility codes: MA/AX)

			nesotaCare Adults w/o Child			MA Adults w/o Children		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	21 to 64 years								
		2013		**133**	**1,128**	**11.8%**	**931**	**6,093**	**15.3%**
			Asian-Pacific Is	1	9	11.1%	7	48	14.6%
			Black	8	55	14.5%	219	1,374	15.9%
			Hispanic	3	22	13.6%	24	160	15.0%
			Native American	7	67	10.4%	112	714	15.7%
			White	106	923	11.5%	550	3,700	14.9%
			Unknown	8	52	15.4%	19	97	19.6%
		2012		**122**	**1,044**	**11.7%**	**835**	**5,465**	**15.3%**
			Asian-Pacific Is	1	12	8.3%	5	58	8.6%
			Black	2	34	5.9%	185	1,100	16.8%
			Hispanic	1	14	7.1%	14	144	9.7%
			Native American	12	68	17.6%	93	692	13.4%
			White	102	880	11.6%	521	3,375	15.4%
			Unknown	4	36	11.1%	17	96	17.7%
		2011		**168**	**1,215**	**13.8%**	**957**	**5,054**	**18.9%**
			Asian-Pacific Is	2	9	22.2%	7	48	14.6%
			Black	6	32	18.8%	218	975	22.4%
			Hispanic	3	16	18.8%	16	123	13.0%
			Native American	7	62	11.3%	107	604	17.7%
			White	147	1,066	13.8%	592	3,192	18.5%
			Unknown	3	30	10.0%	17	112	15.2%
Grand Total				**423**	**3,387**	**12.5%**	**2,723**	**16,612**	**16.4%**

Table 24: Childhood Immunizations: Combo 3

Vaiver population: MA Children 12-24 months. 133 - 275% FPG (DHS program/eligibility codes: MA/CB
parison population: MA Children 12-24 months. Less than 133% FPG (DHS program/eligibility codes: MA

			MA - 133 to 275% FPG			MA - less than 133% FPG		
Measu	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	12-24 mths								
		2013		305	470	64.9%	1,221	2,113	57.8%
			Asian-Pacific Is	28	50	56.0%	118	245	48.2%
			Black	57	85	67.1%	350	692	50.6%
			Hispanic	38	54	70.4%	182	267	68.2%
			Native American	11	12	91.7%	42	75	56.0%
			Unknown	24	37	64.9%	79	118	66.9%
			White	147	232	63.4%	450	716	62.8%
		2012		363	511	71.0%	1,285	2,189	58.7%
			Asian-Pacific Is	37	51	72.5%	107	213	50.2%
			Black	51	77	66.2%	382	715	53.4%
			Hispanic	45	66	68.2%	227	342	66.4%
			Native American	11	11	100.0%	43	84	51.2%
			Unknown	28	35	80.0%	69	102	67.6%
			White	191	271	70.5%	457	733	62.3%
		2011		400	566	70.7%	1,303	2,021	64.5%
			Asian-Pacific Is	26	40	65.0%	104	180	57.8%
			Black	53	80	66.3%	360	603	59.7%
			Hispanic	82	101	81.2%	249	330	75.5%
			Native American	6	9	66.7%	61	97	62.9%
			Unknown	24	35	68.6%	48	65	73.8%
			White	209	301	69.4%	481	746	64.5%
		2010		328	535	61.3%	1,226	2,103	58.3%
			Asian-Pacific Is	23	51	45.1%	80	178	44.9%
			Black	51	79	64.6%	342	622	55.0%
			Hispanic	50	74	67.6%	238	360	66.1%
			Native American	8	15	53.3%	58	109	53.2%
			Unknown	16	30	53.3%	57	90	63.3%
			White	180	286	62.9%	451	744	60.6%

2009		**238**	**468**	**50.9%**	**929**	**2,081**	**44.6%**
	Asian-Pacific Is	16	36	44.4%	72	174	41.4%
	Black	30	58	51.7%	230	555	41.4%
	Hispanic	32	66	48.5%	191	370	51.6%
	Native American	5	7	71.4%	40	101	39.6%
	Unknown	23	40	57.5%	44	92	47.8%
	White	132	261	50.6%	352	789	44.6%
Grand Total		**1,634**	**2,550**	**64.1%**	**5,964**	**10,507**	**56.8%**

Table 25: Child Access to PCP

Waiver population: MA Children 12-24 months. 133 - 275% FPG (DHS program/eligibility codes: MA/CB)
Comparison population: MA Children 12-24 months. Less than 133% FPG (DHS program/eligibility codes: MA/CB)

			MA - 133 to 275% FPG			MA - less than 133% FPG		
Measur	Age Grp	Year	Race	Num	Den	Rate	Num	Den	Rate
	12-24 mths								
		2013		4,303	4,666	92.2%	11,289	11,937	94.6%
			Asian-Pacific Is	361	399	90.5%	868	944	91.9%
			Black	519	547	94.9%	2,828	2,971	95.2%
			Hispanic	534	553	96.6%	1,576	1,626	96.9%
			Native American	69	72	95.8%	335	375	89.3%
			Unknown	359	399	90.0%	758	800	94.8%
			White	2,461	2,696	91.3%	4,924	5,221	94.3%
		2012		4,382	4,820	90.9%	11,364	12,006	94.7%
			Asian-Pacific Is	331	372	89.0%	923	1,001	92.2%
			Black	513	547	93.8%	2,669	2,797	95.4%
			Hispanic	497	527	94.3%	1,697	1,761	96.4%
			Native American	68	74	91.9%	425	455	93.4%
			Unknown	336	363	92.6%	677	697	97.1%
			White	2,637	2,937	89.8%	4,973	5,295	93.9%
		2011		4,754	5,196	91.5%	11,568	12,167	95.1%
			Asian-Pacific Is	340	390	87.2%	889	952	93.4%
			Black	550	596	92.3%	2,709	2,832	95.7%
			Hispanic	599	629	95.2%	1,871	1,918	97.5%
			Native American	112	122	91.8%	437	461	94.8%
			Unknown	274	288	95.1%	510	549	92.9%
			White	2,879	3,171	90.8%	5,152	5,455	94.4%
		2010		4,876	5,359	91.0%	11,977	12,624	94.9%
			Asian-Pacific Is	359	405	88.6%	812	881	92.2%
			Black	568	615	92.4%	2,706	2,814	96.2%
			Hispanic	678	706	96.0%	2,110	2,162	97.6%
			Native American	88	93	94.6%	525	546	96.2%
			Unknown	261	292	89.4%	443	470	94.3%
			White	2,922	3,248	90.0%	5,381	5,751	93.6%

2009		**4,584**	**5,082**	**90.2%**	**12,463**	**13,160**	**94.7%**
	Asian-Pacific Is	287	336	85.4%	829	898	92.3%
	Black	473	528	89.6%	2,680	2,786	96.2%
	Hispanic	581	605	96.0%	2,247	2,321	96.8%
	Native American	87	95	91.6%	576	617	93.4%
	Unknown	303	323	93.8%	468	487	96.1%
	White	2,853	3,195	89.3%	5,663	6,051	93.6%
Grand Total		**22,899**	**25,123**	**91.1%**	**58,661**	**61,894**	**94.8%**

Table 26: Well-child visits, first 15 months

Waiver population: MA Children 12-24 months. 133 - 275% FPG (DHS program/eligibility codes: MA/CB)

Comparison population: MA Children 12-24 months. Less than 133% FPG (DHS program/eligibility codes: MA/CB)

			MA - 133 to 275% FPG			MA - less than 133% FPG		
Measu	Age Grp	Year / Race	Num	Den	Rate	Num	Den	Rate
	12-24 mths							
		2013	**1,819**	**3,687**	**49.3%**	**5,159**	**9,961**	**51.8%**
		Asian-Pacific Is	146	312	46.8%	408	826	49.4%
		Black	234	456	51.3%	1,246	2,537	49.1%
		Hispanic	282	445	63.4%	872	1,360	64.1%
		Native American	28	62	45.2%	114	313	36.4%
		Unknown	186	322	57.8%	365	631	57.8%
		White	943	2,090	45.1%	2,154	4,294	50.2%
		2012	**1,773**	**3,749**	**47.3%**	**4,958**	**9,852**	**50.3%**
		Asian-Pacific Is	144	300	48.0%	367	825	44.5%
		Black	221	434	50.9%	1,134	2,410	47.1%
		Hispanic	251	424	59.2%	891	1,466	60.8%
		Native American	42	60	70.0%	129	366	35.2%
		Unknown	133	279	47.7%	333	562	59.3%
		White	982	2,252	43.6%	2,104	4,223	49.8%
		2011	**2,059**	**4,112**	**50.1%**	**5,354**	**10,029**	**53.4%**
		Asian-Pacific Is	129	300	43.0%	358	783	45.7%
		Black	241	472	51.1%	1,247	2,429	51.3%
		Hispanic	319	518	61.6%	1,054	1,593	66.2%
		Native American	40	93	43.0%	147	377	39.0%
		Unknown	151	238	63.4%	244	437	55.8%
		White	1,179	2,491	47.3%	2,304	4,410	52.2%
		2010	**1,907**	**4,150**	**46.0%**	**5,079**	**10,386**	**48.9%**
		Asian-Pacific Is	125	313	39.9%	297	728	40.8%
		Black	236	480	49.2%	1,141	2,391	47.7%
		Hispanic	361	568	63.6%	1,093	1,794	60.9%
		Native American	25	68	36.8%	152	461	33.0%
		Unknown	109	224	48.7%	191	373	51.2%
		White	1,051	2,497	42.1%	2,205	4,639	47.5%

2009		**1,644**	**3,949**	**41.6%**	**4,848**	**10,665**	**45.5%**
	Asian-Pacific Is	82	258	31.8%	261	730	35.8%
	Black	193	411	47.0%	1,067	2,303	46.3%
	Hispanic	282	488	57.8%	1,098	1,906	57.6%
	Native American	36	73	49.3%	160	513	31.2%
	Unknown	110	250	44.0%	204	400	51.0%
	White	941	2,469	38.1%	2,058	4,813	42.8%
Grand Total		**9,202**	**19,647**	**46.8%**	**25,398**	**50,893**	**49.9%**

Evaluation for PMAP+ Section 1115 Demonstration Waiver

Notes

1) The adjacent tables provide HEDIS metrics for specific subpopulations identified by Major Program (MP) and Eligibility Type (ET).

2) The MP and ET are associated with an individual as of December of the reporting year.

3) Individuals must be enrolled in a health plan for at least 11 months in the reporting year (including December) to be included in the denominator.

4) All measures were calculated according to the HEDIS specifications for the reporting year.

5) The HEDIS programs were run in the 12/30/2014 warrant cycle.

6) The FPL for the MA children 12-24 months group could not be established for about a quarter of the covered population. These children are excluded from the three reports for this group (orange tabs).

7) The measures are provided for measurement years 2009 to 2013, where available. The Adults w/o children expansion began in 2011. This is reflected in the reports for this group (purple tabs).

8) See adjacent Table Log for table details.

Program Run Date: Dec 30, 2014 warrant cycle

Code and Report Data: HRQ: JDB_2015_R355: /AA_Projects/Req 355 - PMAP Waiver Demo

Attachment G

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

Evaluation Plan 2015 to 2018

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 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, 2018

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, 2018. 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 Medical Assistance 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+ 2015-2018 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 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% 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 Medical Assistance 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

Hypothesis: The number of children from age 12 months through 23 months, with incomes above 275% and at or below 283% of the FPL who qualify for Medicaid each year as a result of the MA one-year-old provision under the PMAP+ waiver will be maintained during the demonstration.

To evaluate the impact of the provision allowing Medical Assistance coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medical Assistance with incomes above 275% and at or below 283% of the FP, the following questions will be addressed.

- How many individuals qualify for Medical Assistance each year due to the MA One-Year-Old provision?
- Of those, how many would not have qualified for Medical Assistance under the approved state plan or under CHIP?
- What coverage would these children qualify for if not covered under this category?

Research Question	Metrics	Data Source
How many individuals qualify for Medical Assistance each year due to the MA One-Year-Old provision?	Number of children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medicaid program in calendar year 2015 through 2018.	MNsure, MMIS and MAXIS via DHS Data Warehouse
Of those, how many would not have qualified for Medicaid under the approved state plan or under CHIP?	Number of children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medicaid program in calendar year 2015 through 2018	MNsure, MMIS and MAXIS via DHS Data Warehouse

What coverage would these children qualify for if not covered under this category?	Children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medical Assistance program in calendar year 2015 through 2018.	MNsure, MMIS and MAXIS via DHS Data Warehouse

5.2 Medicaid Caretaker Adults with 18 –Year- Old

Hypothesis: The provision under the PMAP+ waiver covering caretaker adults with an 18 year old will result in administrative savings during the demonstration.

To evaluate the impact of the provision allowing Minnesota to waive the requirement to track the full-time student status of children age 18 living with a caretaker, the following questions will be addressed:

- What is the estimated number of individuals who qualify for medical assistance each year due to the provision covering caretaker adults with an 18 year old?
- What is the nature of the administrative savings resulting from this provision?

Research Question	Metrics	Data Source
What is the estimated number of individuals who qualify for Medical Assistance each year due to the provision covering caretaker adults with an 18 year old?	Number of caregiver adults enrolled in Minnesota's Medicaid program in calendar year 2105 through 2018. Estimate percentage of caregiver adults enrolled in Minnesota's Medicaid program with a youngest or only child age18 in calendar year 2015 through 2018.	MMIS claims and enrollment data
What is the nature of the administrative savings resulting from this provision?	Case worker average hourly compensation in calendar year 2015 through 2018. Case worker average time saved per case as a result of simplified procedures in calendar year 2015 through 2018.	MMIS claims and enrollment data Minnesota Social Services Information System (SSIS)

5.3 Medical Education and Research Costs (MERC) Trust Fund

Hypothesis: The ratio of primary providers in rural Minnesota as compared to providers in urban areas will be maintained during the demonstration.

Hypothesis: The number of training slots supported through MERC will be maintained during the demonstration.

To evaluate the impact of the provision allowing alternative funding and payment approaches to support graduate medical education through the MERC fund, the following questions will be addressed:

- How do the recipients of payments issued through the MERC fund use those monies?
- How many graduate medical training slots are supported through MERC?
- What is the impact of MERC on the number of providers available to serve the needs of the Medicaid eligible population?
- Did the number of primary providers increase in rural Minnesota as compared to provides in urban counties?
- What is the advantage of distributing payments from a medical education trust fund, compared to making GME subsidy payments directly to providers?

Research Question	Metrics	Data Source
How do the recipients of payments issued through the MERC fund use those monies?	Aggregate level data on the use of MERC funds by recipients in calendar year 2015 through 2018.	MERC Expenditure reporting data
How many graduate medical training slots are supported through MERC?	Aggregate level data on the number of training slots in each eligible profession in calendar year 2015 through 2018.	MERC program data
What is the impact of MERC on the number of providers available to serve the needs of the Medicaid eligible population?	Providers in MERC- eligible professions enrolled in Medicaid Percent of medical residents whose training occurs in MERC-supported facilities Comparing of physician and primary care provider supply with other states.	MERC and Medicaid data MERC and Association of American Medical Colleges Annual report on resident numbers and location. Minnesota Department of Health and HRSA Bureau of Health Professions

	Change in number of MERC supported trainees over time Percent of MERC trainees who remain in Minnesota to practice upon completing training (where available)	MERC annual and historical program data MERC program data; sponsoring institution data on alumnae
Did the number of primary providers increase in rural Minnesota as compared to provides in urban counties?	Number and location of primary care providers.	Minnesota Department of Health Health Professional Shortage Area data - Minnesota Department of Health and HRSA

The evaluation will include a discussion of the advantages of distributing payments from a medical education trust fund compared to making graduate medical education subsidy payments directly to providers.

5.4 Pregnant Women in a Presumptive Eligibility Period

Hypothesis: Pregnant women will receive services in addition to ambulatory prenatal care during a hospital presumptive eligibility period during the demonstration.

To evaluate the impact of the provision allowing pregnant women to receive the full MA benefit during their presumptive eligibility period, the following questions will be addressed:

- What covered services do pregnant women receive during a hospital presumptive eligibility period with the full Medicaid benefit?
- What services would not be covered during a hospital presumptive eligibility period if the benefit was limited to ambulatory prenatal care?
- What is the cost of any additional services?
- What is the impact of providing full Medicaid benefits on access to care and quality of care?

Research Question	Metrics	Data Source
What services did pregnant women receive during an HPE period with the full MA benefit?	Number of services received by pregnant women during a presumptive eligibility span in calendar year 2015 through 2018.	MMIS claims and enrollment data

	Cost of services received by pregnant women during an HPE eligibility span in calendar year 2015 through 2018.	MMIS claims and enrollment data
Of the services received by pregnant women during an HPE period, what services would have been covered if the benefit was limited to ambulatory prenatal care?	Number of services received by pregnant women during a presumptive eligibility span that were not ambulatory prenatal care in calendar year 2015 through 2018. Cost of services received by pregnant women during an HPE eligibility span, that were not ambulatory prenatal care in calendar year 2015 through 2018.	MMIS claims and enrollment data MMIS claims and enrollment data

The evaluation will include a discussion of the impact of providing full Medicaid benefits on access to care and quality of care for pregnant women during a hospital presumptive eligibility period. MMIS data will be accessed via the DHS data warehouse to assess demographic characteristics of enrollees, as well as to measure utilization and changes in enrollment status, for this evaluation.

Evaluation data will be drawn from the following sources

Medicaid Management Information System (MMIS) is the electronic claims processing and information retrieval system used by DHS. MMIS contains recipient, eligibility, and claims payment data. MAXIS is the legacy eligibility system for Medical Assistance and other public assistance. SSIS is Minnesota's case management and data collection system for all county social services programs. The DHS Data Warehouse allows DHS employees to access data sets from MAXIS, MMIS and other systems in order to customize reports and answer specific questions rather than relying on the routine reports generated from the larger statewide systems.

6. Evaluation Implementation Strategy and Timeline

DHS will conduct the waiver evaluation and review results over the first half of calendar years 2016, 2017, 2018 and 2019 with an interim report submitted to CMS at the end of 2016, 2017 and 2018 and a final report submitted to CMS by the end of 2019.

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.

On December 30, 2014 the Centers for Medicare & Medicaid Services (CMS) approved a temporary extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. The PMAP+ waiver provides federal authority for the following:

- Medical Assistance for groups not included in Minnesota's Medicaid state plan; specifically, children ages 12 through 23 months with incomes above 275 percent of poverty and at or below 283 percent of poverty, and parents and caretaker adults with incomes at or below 133 percent of poverty who assume responsibility for and live with an 18-year-old child who is not a full-time secondary school student;
- Full Medical Assistance benefits for pregnant women during the period of presumptive eligibility;
- Mandatory enrollment of certain groups into prepaid managed care; and
- Payments for graduate medical education costs through the MERC fund.

The current waiver ends December 31, 2015.

DHS invites public comment on the PMAP+ waiver renewal request. Comments received will be posted on the DHS website. 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 June 24, 2015.

Marie Zimmerman
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, Minnesota 55164-0983

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 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 locations 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: Tuesday, June 9, 2015
Time: 10:00 a.m.
Location: Department of Human Services, Elmer L. Andersen Human Services Building, 540 Cedar St., St. Paul, MN 55101. Room 2223

(This hearing will be held in conjunction with the previously scheduled post-award public forum on the PMAP waiver)

Public Hearing #2
Date: Thursday, June 11, 2015
Time: 9:00 a.m.
Location: Department of Human Services, 444 Lafayette Rd., St. Paul, MN 55155. Room 6146

Attachment I

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 30 days prior to the anticipated submission date. When a 30-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 J

May 26, 2015

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

Dear Tribal Leader,

This letter is to inform you that DHS is announcing a 30-day comment period on a request to extend the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver.

In calendar year 2014, federal approval of a one-year extension of the PMAP+ waiver was secured to implement modifications to Minnesota's Medical Assistance program and changes to MinnesotaCare to align the program with the requirements for a Basic Health Plan (BHP) under the Affordable Care Act. The 2014 extension allowed the PMAP+ waiver to serve as a bridge to a BHP in 2015 and to coordinate with the expanded Medicaid state plan and MNsure.

On January 1, 2015 the Minnesota Care program transitioned to a BHP. Even though the PMAP+ waiver is no longer necessary to continue the MinnesotaCare program, several aspects of the PMAP+ waiver continue to be necessary. On December 30, 2014 a one-year extension of the PMAP+ waiver was approved by the Centers for Medicare & Medicaid Services for the period January 1, 2015 through December 31, 2015.

The current PMAP+ waiver provides federal authority for the following:

- Medical Assistance for groups not included in Minnesota's Medicaid state plan; specifically, children ages 12 through 23 months with incomes above 275 percent FPL and at or below 283 percent of the FPL, and parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18-year-old child who is not a full time secondary school student;
- Full Medical Assistance benefits for pregnant women during the period of presumptive eligibility;
- Mandatory enrollment of certain groups into prepaid managed care; and
- Payments for graduate medical education through the MERC fund.

We invite you to comment on the proposed waiver extension. For additional information on the PMAP+ waiver and the public input process please refer to the PMAP+ waiver web page. If you have questions about the waiver, please contact me at (651) 431-2188 or jan.kooistra@state.mn.us. Thank you.

Sincerely,

Jan Kooistra

Department of Human Services

Health Care Administration

Post-Award Public Forum on the Prepaid Medical Assistance Project Plus Section 1115 Medicaid Waiver

On December 30, 2014 the Centers for Medicare & Medicaid Services (CMS) approved a one-year extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver through December 31, 2015. The Department of Human Services has secured CMS 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 Minnesota Care program, several aspects of the PMAP+ waiver are still necessary. The PMAP+ waiver extension effective January 1, 2015 through December 31, 2015 provides federal authority for the following:

- Medical Assistance for groups not included in Minnesota's Medicaid state plan; specifically, children ages 12 through 23 months with incomes above 275 percent of poverty and at or below 283 percent of poverty, and parents and caretaker adults with incomes at or below 133 percent of poverty who assume responsibility for and live with an 18-year-old child who is not a full-time secondary school student;
- Full Medical Assistance benefits for pregnant women during the period of presumptive eligibility;
- Mandatory enrollment of certain groups into prepaid managed care; and

- Payments for graduate medical education costs through the MERC fund.

A copy of the waiver can be found on the Department of Human Services' web site at http://www.dhs.state.mn.us/dhs16_171635.

Under the terms of the waiver the Department of Human Services must hold a public forum within six months of the demonstration's implementation, and annually thereafter, to afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. The next public forum is scheduled as follows:

PMAP Waiver Public Forum

Date: June 9, 2015

Time: 11:00 am - Noon

Location: Department of Human Services, Elmer L. Andersen Human Services Building, 540 Cedar St., St. Paul, MN 55164. Room 2223

You may attend the forum 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.

Attachment L

Minnesota Department of Human Services
2013 External Quality Review Annual Technical Report
Issued December 15, 2014

An independent external quality review of Minnesota publicly funded managed care programs in accordance with the Balanced Budget Act of 1997 (Subpart E, 42 Code of Federal Regulations Section 438.64)

IPRO
Improving Healthcare for the Common Good

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1002
(516) 326-7767
www.ipro.org

2013 External Quality Review
Annual Technical Report

Issued: December 15, 2014

Prepared by:
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1979 Marcus Avenue
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IPRO website

For More Information:
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Performance Measurement and Quality Improvement Minnesota
Department of Human Services
P.O. Box 64986
St. Paul, MN 55164-0986
Telephone: (651) 431-2613
Fax: (651) 431-7422
E-mail: Robert Lloyd email address

This information is available in accessible formats for individuals with disabilities by calling (651) 431-2636 or by using your preferred relay service. For other information regarding disability rights and protections, contact the agency's ADA Coordinator.

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Acronyms Used in This Report

(in alphabetical order)

ACA:	Affordable Care Act
ACT:	Assertive Community Treatment
ATR:	Annual Technical Report
BBA:	Federal Balanced Budget Act of 1997
CAHPS®:	Consumer Assessment of Healthcare Providers and Systems
CBP:	County-Based Purchasing
CFR:	Code of Federal Regulation
CMS:	Centers for Medicare and Medicaid Services
C&TC:	Child and Teen Checkups
DBA:	Doing Business As
DHS:	Department of Human Services
ED:	Emergency Department
EHR:	Electronic Health Records
EPSDT:	Early and Periodic Screening, Diagnosis and Treatment
EQR:	External Quality Review
EQRO:	External Quality Review Organization
ER:	Emergency Room
F&C-MA:	Families and Children Medical Assistance
FFS:	Fee-For-Service
FPL:	Federal Poverty Level
FTE:	Full Time Equivalent
GAMC:	General Assistance Medical Care
HEDIS®:	Health Effectiveness Data and Information Set
HMO:	Health Maintenance Organization
IMCare:	Itasca Medical Care
MA:	Medical Assistance
MCO:	Managed Care Organization
MDH:	Minnesota Department of Health
MDH-QA:	Minnesota Department of Health Quality Assurance
MNCare:	MinnesotaCare
MHCP:	Minnesota Health Care Programs
MSHO:	Minnesota Senior Health Options
MSC+:	Minnesota Senior Care Plus
N/A:	Not Available
NCQA:	National Committee for Quality Assurance
OB/GYN:	Obstetrician/Gynecologist
PCP:	Primary Care Practitioner/Provider
PIP:	Performance Improvement Project
QA:	Quality Assurance
QHP:	Qualified Health Plan
QRS:	Quality Rating System
SNBC:	Special Needs Basic Care
SS:	Small Sample (Less than 30)
SWA:	Statewide Average
TCA:	Triennial Compliance Assessment
UR:	Utilization Review

Executive Summary

The Centers for Medicare and Medicaid Services (CMS) require that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCO). In order to comply with these requirements, the Department of Human Services (DHS) contracted with IPRO to assess and report the impact of its Minnesota Health Care Programs (MHCP) and each of the participating Health Plans on the accessibility, timeliness and quality of services. In accordance with Federal requirements, as set forth in the Balanced Budget Act (BBA) of 1997, this report summarizes the results of the 2013 External Quality Review (EQR).

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as State requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation and compliance audits. Results of the most current HEDIS® and CAHPS® surveys are presented and are evaluated in comparison to the NCQA's 2014 *Quality Compass*® benchmarks. Measures performing at or above the 75th percentile are considered strengths, while measures performing at or below the 50th percentile are identified as opportunities for improvement. IPRO's assessment also included a review of the PIPs that concluded during the measurement year and PIPs that are currently in progress, the most current Quality Assurance Examination and Triennial Compliance Assessment findings and MCO achievements under the Financial Withhold Program.

In 2013, overall MCO performance in the areas of quality, access and timeliness was mixed. The MCOs demonstrated strong performance in the areas of adult access to primary care, child and adolescent access to primary care for certain age groups, asthma-related care among adults and one area of diabetes-related care. Related HEDIS® rates met or exceeded the 75th percentile. The MCOs demonstrated opportunities for improvement in regard to overall child and adolescent care. Related HEDIS® rates were below the 50th percentile. Statewide CAHPS® performance suggests that members are generally satisfied with their personal doctors; however, there are opportunities for improvement in regard to member satisfaction with access to care, how well doctors communicate and MCO customer service.

Chapter 1: Introduction

The Minnesota Department of Human Services (DHS) purchases medical care coverage through contracts with eight managed care organizations (MCOs) that receive a fixed, prospective monthly payment for each enrollee. The Minnesota Department of Health (MDH) licenses five of the entities as MCOs (Blue Plus, HealthPartners, Medica, Metropolitan Health Plan (MHP)/Hennepin Health and UCare). The remaining three entities – Itasca Medical Care (IMCare), PrimeWest Health and South Country Health Alliance (SCHA) – are licensed as County-Based Purchasing (CBP) organizations. Minnesota's publicly funded managed care programs include:

- **Families & Children Medical Assistance (F&C-MA):** A State-administered program for low-income people who are blind or disabled, low-income families with children and children who are needy.
- **MinnesotaCare:** A State-funded program for working families and people who do not have access to affordable health care coverage and meet certain income, asset and residency requirements.
- **Minnesota Senior Health Options (MSHO):** A DHS program that combines Medicare and Medicaid financing and acute and long-term care service delivery systems for persons over age 65 years who are dually eligible for both Medicare and Medicaid.
- **Minnesota Senior Care Plus (MSC+):** A Federal- and State-funded mandatory program for individuals age 65 years and older who qualify for Medical Assistance (Medicaid).
- **Special Needs Basic Care (SNBC):** A voluntary program for individuals age 18 – 64 years who are certified disabled and qualify for Medical Assistance (Medicaid).

Table 1: MCO Participation by Program

MCO	Managed Care Program				
	F&C-MA	Minnesota Care	MSHO	MSC+	SNBC
Blue Plus	●	●	●	●	
HealthPartners	●	●	●	●	
Hennepin Health	●				
IMCare	●	●	●	●	
Medica	●	●	●	●	●
MHP			●	●	●
PrimeWest Health	●	●	●	●	●
SCHA	●	●	●	●	●
UCare	●	●	●	●	●

The DHS/MCO Contract specifies the relationships between the purchaser and the MCOs and explicitly states compliance requirements for finances, service delivery and quality of care terms and conditions. DHS and the MCOs meet throughout the year to ensure ongoing communication between the purchaser and the MCOs and to discuss Contract issues.

DHS contracts with IPRO to serve as its External Quality Review Organization (EQRO). As part of the agreement, IPRO performs an independent analysis of MCO performance relative to quality, access and timeliness of health care services. This report is the result of IPRO's 2013 evaluation and review.

The purpose of the 2013 ATR is to present the results of the quality evaluations performed in accordance with the Balanced Budget Act (BBA) of 1997[1], review the strengths and weaknesses of each MCO, provide recommendations for improvement and provide technical assistance to the MCOs. This report provides insight into the performance of the MCOs on key indicators of health care quality for enrollees in publicly funded programs.

Forming the foundation for improving care for the populations served by DHS is the Quality Strategy. The Centers for Medicare & Medicaid Services (CMS) require that each State Medicaid agency has a written strategy for evaluating the quality of care of its publicly funded managed care programs. The DHS Quality Strategy operationalizes the theories and precepts influencing the purchase of managed health care services for publicly funded programs. The strategy is designed to assess the quality and appropriateness of care and service provided by MCOs for all managed care contracts, programs and enrollees. It is aimed at achieving seven essential outcomes:

1. Purchasing quality health care services
2. Protecting the health care interests of managed care enrollees through monitoring
3. Assisting in the development of affordable health care
4. Reviewing and realigning DHS policy and procedures that act as unintended barriers to the effective and efficient delivery of health care services
5. Focusing on health care prevention and chronic disease improvements consistent with enrollee demographics and cultural needs
6. Improving the health care delivery system's capacity to deliver desired medical care outcomes though process standardization, improvement and innovation
7. Strengthening the relationship between the patients and health care providers

[1.] Subpart E, 42 Code of Federal Regulations (CFR), Section 438.364

Purchasing quality health care services is the primary outcome of the Quality Strategy. To achieve this outcome, there must be measurement of improvement in enrollee health status and satisfaction. DHS' Quality Strategy is framed on the key standards in Subpart D of the Medicaid Managed Care Regulation (*Quality Assessment and Performance Improvement)*: Access, Structure and Operations, and Measurement and Improvement.

To facilitate and promote achievement of the Quality Strategy goals, DHS conducts yearly activities, including three mandatory EQR-related activities for each contracted MCO pursuant to the BBA, CFR §438.358. IPRO, as the EQRO, provides analysis of the results. Mandatory EQR activities for each contracted MCO include the following:

- **Validate Performance Measures:** DHS contracts with MetaStar, a certified Healthcare Effectiveness Data and Information Set (HEDIS®)[2] vendor, to evaluate the DHS information system's ability to collect, analyze, integrate and report data. The evaluation includes extensive examinations of DHS's ability to monitor data for accuracy and completeness.
- **Validate Performance Improvement Projects (PIPs):** DHS validates that each MCO develops its proposed PIPs in a manner designed to achieve significant improvement that is sustainable over time and consistent with Federal protocols.
- **Review MCO Compliance with Federal and State Standards Established by DHS:** DHS uses Minnesota Department of Health Quality Assurance examinations (MDH-QA) and Triennial Compliance Assessment (TCA) audits to determine whether MCOs meet requirements relating to access to care, structure and operations and quality measurement and improvement.

Minnesota Health Care Programs help people who live in Minnesota pay for all, or some, medical bills. The programs are generally for people who cannot get or afford health insurance elsewhere. Some people who already have insurance may also be eligible for help. To obtain coverage, there are rules about income, assets, insurance coverage and other factors. Some rules vary for different people; for example, the income limit depends on age, living situation and pregnancy or disability status.

Within the State of Minnesota, publicly funded medical assistance is available for:

- Pregnant women
- Families and children
- Adults with disabilities
- Children with disabilities
- People 65 years or older
- Adults without children

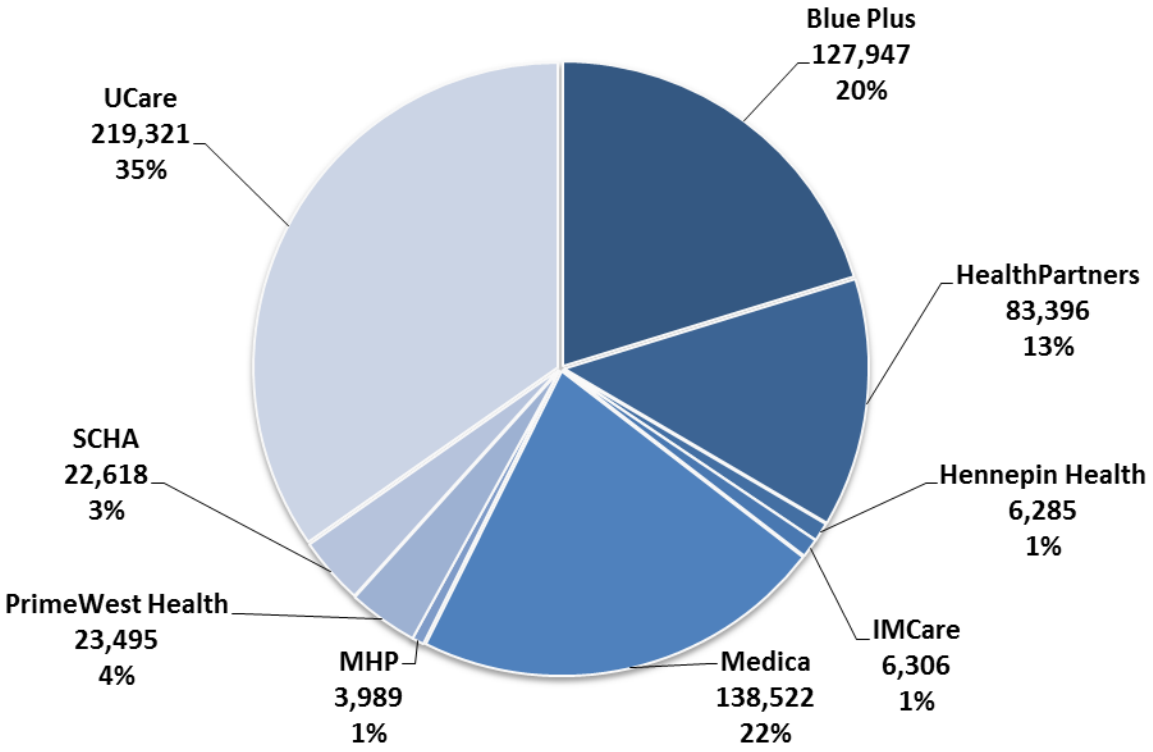
2. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Coverage is also available for the following people who meet certain eligibility criteria:

- People who need nursing home care or home care
- Employed persons with disabilities
- People who want only family planning coverage
- People who have breast or cervical cancer and have been screened by the Sage Program[3]

As of December 2013, total enrollment for the Minnesota Health Care Programs (MHCP) was 631,879; a 2.0% increase since December 2012. Figure 1 displays December 2013 MHCP enrollment by MCO.

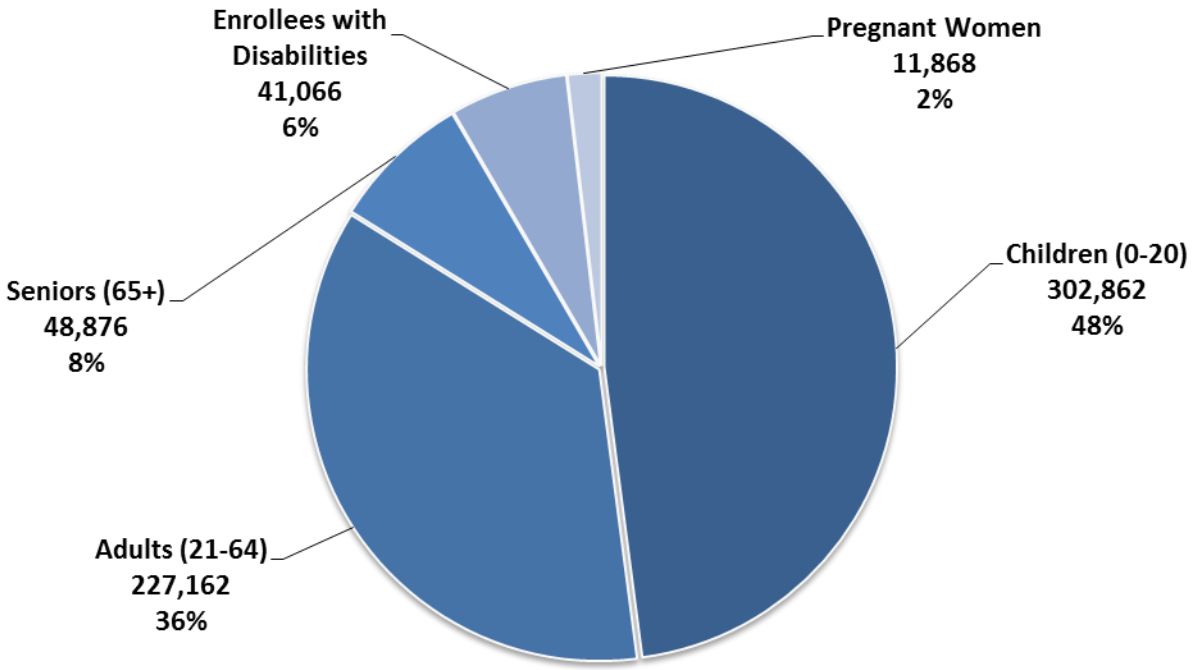
Figure 1: MHCP Enrollment by MCO - December 2013



3. Please visit the Minnesota Department of Health SAGE Screening Program.
Minnesota Department of Health SAGE Screening Program website

As displayed in Figure 2, children continue to be the largest population served by the MHCPs, with almost half of the total enrollees younger than 21 years of age. The December 2013 population breakdown is similar to that observed in December 2012.

Figure 2: Enrollment by Population Type - December 2013



Chapter 2: Summary of DHS Activities

CMS Adult Medicaid Quality Grant

In 2012, Minnesota was one (1) of twenty-three (23) states selected by CMS to participate in the Adult Medicaid Quality Grant Program: Measuring and Improving the Quality of Care in Medicaid. The three (3) main goals of the two-year grant are:

1. Testing and evaluating methods for collection and reporting of the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid in varying delivery care settings.
2. Developing staff capacity to report the data, analyze and use the data for monitoring and improving access and the quality of care in Medicaid.
3. Conducting at least two (2) Medicaid quality improvement projects related to the Initial Core Set Measures.

The semi-annual progress report submitted to CMS in July 2014 by the DHS indicates that the following successes have been achieved:

- Completion of *Task 1: Assessment of Non-Reported Initial Core Set*
- Completion of *Task 2: Enhancement of Birth Certificate Data*
- Completion of Phase One of *Task 3: Core Measurement Risk Adjustment Methodology*
- Initiation of two (2) quality improvement projects: a *Post-Partum Depression Screening QIP* and a *Mental Health QIP*

2013 Health Care Disparities Report

In 2013, DHS contributed to the production of the MN Community Measurement© *2013 Health Care Disparities Report for Minnesota Health Care Programs (MHCP)*. The report provides health care performance rates for patients enrolled in managed care, as well as explores the difference in performance rates between patients enrolled in MHCP and patients enrolled in managed care programs of other purchasers (private, employer-based health care insurance or Medicare managed care programs) at a statewide and medical group level. The full report, as well as key findings, can be accessed *here*.

Evaluation of HEDIS® Performance Data Stratified by Race and Ethnicity

In August 2014, DHS concluded an evaluation of access to care and utilization of services by race and ethnicity of enrollees in the Families & Children Medical Assistance (F&C-MA) and MinnesotaCare programs. The performance of eighteen (18) HEDIS® measures was analyzed for calendar years 2009 through 2012. Key findings suggest that there are differences in access and utilization of health care services between F&C-MA and MinnesotaCare enrollees; and, when stratified by race and ethnicity, sub-populations of these programs also access and utilize health care services differently.

Chapter 3: Evaluation of MCO Strengths and Opportunities

A. Evaluation Process

In order to assess the impact of the Minnesota Health Care Program (MHCP) on access, timeliness and quality of health care services, IPRO reviewed pertinent MCO-specific information from a variety of sources including accreditation survey findings, member satisfaction surveys, performance measures and State monitoring reports. Specifically, IPRO considered the following elements during the 2013 External Quality Review:

- HEDIS® 2014 and 2014 CAHPS® 5.0H Adult Medicaid Survey
- Performance Improvement Projects
- Minnesota Department of Health (MDH) Quality Assurance Examination and Triennial Compliance Assessment
- 2013 Financial Withhold

HEDIS® and CAHPS® Performance

HEDIS® allows for the standardized measurement of care received, while CAHPS® allows for the standardized measurement of member satisfaction with this care. All of the performance measures reported herein are derived from HEDIS® or CAHPS®. For these measures, comparisons to national Medicaid benchmarks have been provided. Unless otherwise noted, the benchmarks originate from the National Committee for Quality Assurance (NCQA) *Quality Compass*®[4] 2014 for Medicaid and represent the performance of all Health Plans that reported HEDIS® and CAHPS® data to the NCQA for HEDIS® 2014 (Measurement Year (MY) 2013). Rates performing at or above the 75th percentile are considered strengths, while rates performing at or below the 50th percentile are identified as opportunities for improvement.

It is important to note that this is the first year that DHS has chosen to report a combination of DHS-produced (administrative) and MCO-produced (hybrid) HEDIS® rates in the ATR. DHS contracted directly with MetaStar, an NCQA-certified HEDIS® auditor, to conduct an independent audit of the administrative rates calculated by DHS, which are based on encounter data submitted by the MCOs to the State. MCO-produced hybrid rates were also validated by certified-HEDIS® vendors and were reported to the NCQA. In 2014, DHS contracted with DataStat to conduct the 2014 CAHPS® 5.0H Adult Medicaid Survey on behalf of the participating MCOs.

Performance Improvement Projects (PIPs)

MCOs are contractually required to conduct, annually, a Performance Improvement Project (PIP) designed to achieve, through ongoing measurements and interventions, significant improvement,

4. Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

sustained over time, in clinical and non-clinical areas that are expected to have improved enrollee health outcomes and satisfaction. The MCO must submit a new PIP for DHS validation, annually. The measurement process includes a baseline, generally a three-year average of the measurement selected, and explicit and precisely defined goals. PIPs are considered completed when the goal has been reached and two more consecutive measurements sustain the improvement. PIPs reported in the ATR were validated by the DHS Health Program Quality Team to ensure MCO compliance with Federal protocols. DHS's assessments of the PIPs were considered during IPRO's evaluation of the Health Plan. Concluded PIPs that demonstrated improvement were considered strengths.

Starting with the 2015-2017 PIPs, the DHS PIP reporting requirements will be modified to resemble the Medicare format. PIPs will run for three (3) years and will follow BBA guidelines for PIP protocols. As DHS has identified disparities in care for enrollees with mental health conditions, DHS has selected the following overarching PIP topic for 2015-2017 period, *Reduction of Race and Ethnic Disparities in the Management of Depression*. Descriptions of MCO-specific PIP topics, contractual start and end dates, and PIP goals are reported in Section B: MCO Evaluations. Please note that reported PIP status is as of 12/31/13.

Quality Assurance Examination and Triennial Compliance Assessment

Federal regulations require DHS to conduct triennial, on-site contract compliance validation assessments of each contracted MCO. DHS uses MDH Quality Assurance examinations (MDH-QA) and Triennial Compliance Assessment (TCA) audits to determine whether MCOs meet requirements relating to access to care, structure and operations and quality measurement and improvement.

While the Quality Assurance examinations and Triennial Compliance Assessments are conducted every three (3) years, the process is staggered and is conducted at different times for each MCO. A summary of recommendations, mandatory improvements and deficiencies from the *most recent* exam is presented for each MCO and was considered during IPRO's evaluation of the MCO. Recommendations are areas where, although compliant with law, opportunities for improvement were identified. Mandatory improvements are required corrections that must be made to non-compliant policies, documents or procedures where evidence of actual compliance is not found or where the file sample did not include any instances of the specific issue of concern. Deficiencies are violations of law. *(The most recent Quality Assurance and Triennial Compliance Assessment reports can be accessed here.)*

2013 Financial Withhold

The overall purpose of the Financial Withhold is to emphasize and focus MCO and health care provider improvement efforts in the areas of prevention or early detection and screening of essential health care services. MCO performance in the 2013 Financial Withhold was considered during IPRO's evaluation.

2014 MCO Transparency and Accountability Reports

Each MCO submits an annual summary of how their Quality Improvement Program identifies, monitors and works to improve service and clinical quality issues relevant to the Minnesota Health Care Program (MHCP) enrollees. The summary highlights what the MCO considers to be significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement. IPRO has chosen to pilot in this ATR, reviews of the 2014 Transparency and Accountability Reports submitted by PrimeWest Health and South Country Health Alliance. *(All 2014 MCO Transparency and Accountability Reports can be accessed here.)* Summaries of all MCO Transparency and Accountability Reports will be included in future ATRs; however, these reports will not be evaluated as part of the EQR process.

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B. MCO Evaluations

This section presents MCO-specific performance, as well as strengths, opportunities for improvement and recommendations identified by IPRO during the external quality review process.

In regard to the HEDIS® performance measures, please note the following:

- As the MCOs were not required to report HEDIS® for the MSC+ program, there are no hybrid performance measures presented for the MSC+ program in this section of the report. However, a total of four (4) DHS administrative measures are presented.
- For the F&C-MA and MinnesotaCare programs, a total of six (6) MCO produced rates are presented, while thirteen (13) DHS produced rates are presented.
- For the MSHO program, a total of three (3) MCO produced rates are presented, while two (2) DHS produced rates are presented. *(Counts may vary if the MCO chose not to report the HEDIS® Adult BMI Assessment measure.)*
- For the SNBC program, a total of four (4) MCO produced rates are presented, while seven (7) DHS produced rates are presented. *(Counts may vary if the MCO produced SNP and Non SNP rates.)*

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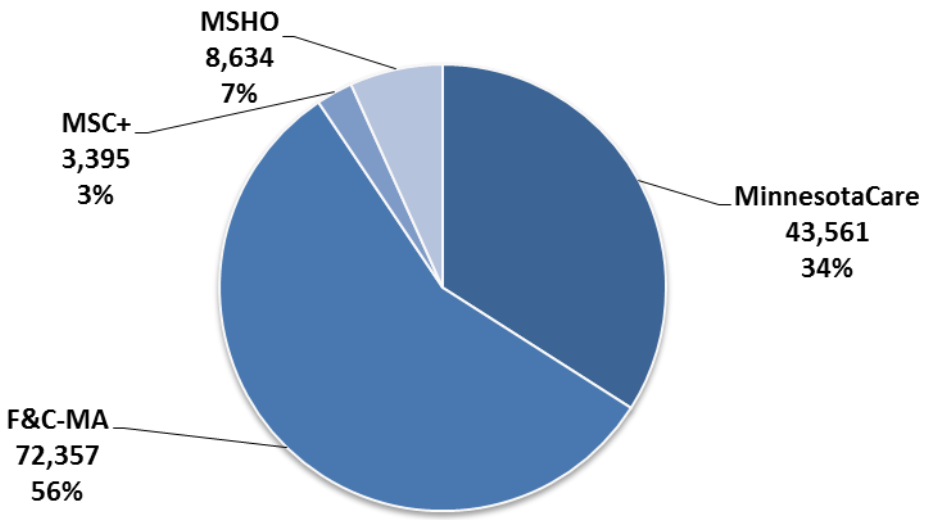
Blue Plus

Corporate Profile

Blue Plus, a wholly owned subsidiary of BlueCross BlueShield of Minnesota, is a licensed HMO. In addition to offering a range of commercial products, Blue Plus contracts with DHS to deliver and administer Families and Children Medical Assistance (F&C-MA), MinnesotaCare, Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO). Blue Plus has provided Minnesota Health Care Programs Managed Care coverage since 1993. The MCO achieved "Commendable" accreditation status from the NCQA for its Medicaid line of business. Blue Plus operates statewide and, as of December 2013, enrollment totaled 127,947, accounting for 20% of the entire MHCP population.

Figure 3: Blue Plus Enrollment by Program - December 2013



Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent compliance audit between June 17, 2013 and June 21, 2013. The examination period covered May 1, 2010 to March 31, 2013, while the file review period covered April 1, 2012 to March 31, 2013. Blue Plus received a total of three (3) recommendations, three (3) mandatory improvements and one (1) deficiency for the Quality Assurance Examination, and one (1) "Not Met" of the Triennial Compliance Assessment.

Performance Improvement Projects

The Health Plan successfully concluded the following PIPs in 2013:

- *Reducing Asthma Related ED Visits in the Public Programs Population* (2009) – The overall goal of the PIP was to decrease the rate of asthma-related emergency department visits through an improved member-centered disease management program, "Whole Person Health Support". BluePlus has integrated PIP interventions into the Asthma Program to maintain the improvements achieved.
- *Blood Pressure Control for Members with Diabetes* (2010) – The overall PIP goal was to increase the proportion of members with diabetes who have blood pressure under control as measured by the HEDIS® *Comprehensive Diabetes Care* (140/90 blood pressure adults 18-75 years) measure.

The following PIPs have been initiated and are currently in progress:

- *Colorectal Cancer Screening* (2011) – The goal of this PIP is to increase the colorectal cancer screening rate in the study population in targeted clinics through clinic-specific interventions.
- *Transitions of Care: Improved Post-Discharge Follow-Up Care* (2011) – The goal of this PIP is to increase the proportion of MSHO and MSC+ members, ages 18 years and older, that complete a scheduled follow-up appointment post-hospital discharge.
- *Reducing Non-Urgent Emergency Department Use in the F&C-MA/MinnesotaCare Populations: A Partnership with the Minnesota Head Start Association* (2012) – The goal of this PIP is to decrease non-urgent ED use among F&C-MA and MinnesotaCare members ages 0-5 who receive the health literacy intervention delivered by Minnesota Head Start and Early Head Start program staff when compared to a non-intervention comparison group.
- *Increasing Use of Spirometry Testing for Diagnosis of COPD in the MSHO/MSC+/SNBC Populations* (2012) – The goal of this clinical PIP is to increase the proportion of members with a new or newly active diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who have had spirometry testing completed as measured by the HEDIS® *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure.
- *Chlamydia Screening in Women* (2013) – The goal of this PIP is to increase Chlamydia screening in women as measured by the HEDIS® *Chlamydia Screening in Women (16-24 Years)* measure among F&C-MA and MinnesotaCare members through multimodal, targeted interventions.
- *Reducing Race and Ethnic Disparities in the Management of Depression* (2015) – The goal of this PIP is to reduce the disparity in antidepressant medication adherence between non-Hispanic

White members and non-White members by an absolute 4% by the end of the three-year project, increasing the rate for the non-White population to 36%.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO and MSC+ Contracts.
- The MCO earned 53.37 of 55 points for the F&C-MA Contract. Blue Plus lost a total of 1.63 points for failing to achieve an annual 10% reduction in its emergency department utilization.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 2 and 3, respectively.

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Table 2: Blue Plus HEDIS® Performance - 2014

HEDIS® Measures	Blue Plus HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adolescent Well-Care Visit (12-21 Years)[1]	45.4%	25th	42.2%
Adult BMI Assessment[1]	83.6%	50th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	90.4%	95th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	89.4%	50th	89.4%
Breast Cancer Screening (50-64 Years)[2]	60.5%	50th	61.2%
Cervical Cancer Screening (24-64 Years)[2]	71.1%	NA	71.0%
Childhood Immunization Status: Combo 3 (2 Years)[1]	78.2%	75th	75.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	98.5%	75th	98.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	90.9%	50th	91.0%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	92.6%	50th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	92.9%	75th	91.8%
Chlamydia Screening in Women (16-24 Years)[2]	51.3%	25th	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	89.9%	75th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	81.7%	75th	81.3%
Controlling High Blood Pressure[1]	67.0%	75th	65.2%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	94.1%	25th	90.4%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	86.7%	25th	89.3%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	79.4%	50th	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	79.7%	75th	81.6%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	63.4%	50th	62.5%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	62.1%	10th	65.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 2: Blue Plus HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	Blue Plus HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MinnesotaCare		
Adolescent Well-Care Visit (12-21 Years)[1]	37.7%	10th	40.8%
Adult BMI Assessment[1]	77.6%	25th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	87.4%	75th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	91.0%	75th	91.4%
Breast Cancer Screening (50-64 Years)[2]	65.8%	75th	67.0%
Cervical Cancer Screening (24-64 Years)[2]	64.9%	NA	66.7%
Childhood Immunization Status: Combo 3 (2 Years)[1]	72.3%	50th	69.6%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	95.2%	10th	96.9%
Chlamydia Screening in Women (16-24 Years)[2]	42.0%	10th	49.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	94.5%	95th	94.6%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	84.8%	90th	88.6%
Controlling High Blood Pressure[1]	69.4%	75th	70.5%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	96.9%	95th	97.3%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	92.9%	75th	88.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	86.9%	95th	85.5%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	77.7%	75th	80.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	66.0%	50th	66.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	60.7%	10th	65.7%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NA: Not available.

Table 2: Blue Plus HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	Blue Plus HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	NR	-	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	98.5%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	57.3%	25th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	92.4%	90th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	85.1%	90th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	91.9%	75th	93.1%
Breast Cancer Screening (65-74 Years)[2]	51.9%	25th	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	88.6%	75th	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	79.1%	50th	70.5%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NR: Not required for MSHO.

Table 3: Blue Plus CAHPS® Performance - 2014

CAHPS® Measures	Blue Plus CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	49%	<10th	50%
Getting Care Quickly[1]	65%	<10th	55%
How Well Doctors Communicate[1]	79%	<10th	77%
Customer Service[1]	73%	<10th	65%
Shared Decision Making[1]	55%	90th	52%
Rating of All Health Care[2]	56%	75th	48%
Rating of Personal Doctor[2]	71%	95th	67%
Rating of Specialist Seen Most Often[2]	54%	<10th	61%
Rating of Health Plan[2]	59%	50th	56%
	MinnesotaCare		
Getting Needed Care[1]	54%	<10th	56%
Getting Care Quickly[1]	63%	<10th	61%
How Well Doctors Communicate[1]	82%	<10th	80%
Customer Service[1]	69%	<10th	63%
Shared Decision Making[1]	52%	50th	50%
Rating of All Health Care[2]	51%	25th	51%
Rating of Personal Doctor[2]	71%	95th	70%
Rating of Specialist Seen Most Often[2]	63%	25th	63%
Rating of Health Plan[2]	57%	25th	58%
	MSC+		
Getting Needed Care[1]	67%	<10th	60%
Getting Care Quickly[1]	64%	<10th	61%
How Well Doctors Communicate[1]	76%	<10th	76%
Customer Service[1]	75%	<10th	63%
Shared Decision Making[1]	48%	10th	48%
Rating of All Health Care[2]	61%	95th	60%
Rating of Personal Doctor[2]	76%	95th	75%
Rating of Specialist Seen Most Often[2]	73%	95th	72%
Rating of Health Plan[2]	69%	95th	66%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Table 3: Blue Plus CAHPS® Performance - 2014 (Continued)

CAHPS® Measures	Blue Plus CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Getting Needed Care[1]	68%	<10th	61%
Getting Care Quickly[1]	75%	10th	69%
How Well Doctors Communicate[1]	79%	<10th	76%
Customer Service[1]	67%	<10th	69%
Shared Decision Making[1]	51%	50th	49%
Rating of All Health Care[2]	62%	95th	62%
Rating of Personal Doctor[2]	76%	95th	75%
Rating of Specialist Seen Most Often[2]	76%	95th	72%
Rating of Health Plan[2]	71%	95th	72%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- Blue Plus achieved "*Commendable*" status on the NCQA Accreditation Survey.
- The Health Plan concluded two (2) PIPs in 2013, demonstrating continued improvement in the areas of asthma and diabetes care. In addition, Blue Plus reported diabetes-related HEDIS® rates at or above the 75th percentile for the F&C-MA, MinnesotaCare and MSHO programs. The Health Plan also met or exceeded the 75th percentile for all age groups of the HEDIS® *Use of Appropriate Medications for People With Asthma* measure for the MinnesotaCare program.
- In regard to the Financial Withhold, the Health Plan earned all possible points for the MSHO and MSC+ programs.
- The Health Plan demonstrated strong performance in regard to hypertensive care. Blue Plus met or exceeded the 75th percentile for HEDIS® *Controlling High Blood Pressure* measure for F&C-MA and MinnesotaCare programs.
- The Health Plan reported adult access rates at or above the 75th percentile for the MinnesotaCare and MSHO populations. Blue Plus also reported a rate above the 75th percentile for members aged 20-44 years in the F&C-MA population.
- The Health Plan performed well in regard to some aspects of child and adolescent care. Blue Plus met or exceeded the 75th percentile for the HEDIS® *Childhood Immunization Status – Combo 3* measure for the F&C-MA program and reported access to care rates at or above the 75th percentile for the 12-24 Months and 12-19 Years groups in the F&C-MA program.
- The Health Plan performed well in regard to some areas of member satisfaction. Blue Plus met or exceeded the 75th percentile across all programs for the *Rating of Personal Doctor* measure. The Health Plan met or exceeded the 75th percentile for the following measures: *Shared Decision Making* for the F&C-MA program, *Rating of All Health Care* for the F&C-MA, MSC+ and MSHO

programs, *Rating of Specialist Seen Most Often* and *Rating of Health Plan* for the MSC+ and MSHO programs.

Opportunities for Improvement

- The Health Plan demonstrates an opportunity for improvement in regard to the Financial Withhold. Blue Plus failed to earn full points for the F&C-MA Contract.
- The Health Plan demonstrates an opportunity for improvement in regard to child and adolescent care. Blue Plus's performance for both the F&C-MA and MinnesotaCare programs was at or below the 50th percentile for the following HEDIS® measures: *Adolescent Well-Care Visit, Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*, *Well-Child Visits in the First 15 Months of Life (6+ Visits)*. The Health Plan also reported rates at or below the 50th percentile for the HEDIS® *Childhood Immunization Status: Combo 3* and *Children and Adolescents' Access to PCPs* (*12-24 Months*) measures for the MinnesotaCare program, and for the *Children and Adolescents' Access to PCPs (25 Months-6 Years, 7-11 Years)* measure for the F&C-MA program.
- The Health Plan demonstrates an opportunity for improvement as it reported rates at or below the 50th percentile for the HEDIS® *Adult BMI Assessment* measure for the F&C-MA and MinnesotaCare populations, as well as for the HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)* measure for the F&C-MA program.
- The Health Plan demonstrates an opportunity for improvement in regard to women's health. Blue Plus performed below the 50th percentile for the HEDIS® *Chlamydia Screening in Women* measure for the F&C-MA and MinnesotaCare programs. The Health Plan also performed at or below the 50th percentile for the HEDIS® *Breast Cancer Screening* measure for the F&C-MA and MSHO programs.
- Although the Health Plan performed well in regard to asthma treatment for MinnesotaCare members, there remains an opportunity for improvement for the F&C-MA program as its performance for the HEDIS® *Use of Appropriate Medications for People With Asthma (5-11 Years, 12-18 Years* and *19-50 Years)* measure was below the 75th percentile.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. Blue Plus performed at or below the 10th percentile across all programs for the following CAHPS® measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service*. The Health Plan also reported rates below the 75th percentile for the *Rating of Specialist Seen Most Often* and *Rating of Health Plan* measures for the F&C-MA and MinnesotaCare programs, for the *Shared Decision Making* measure for the MinnesotaCare, MSC+ and MSHO programs, and for the *Rating of All Health Care* measure for the MinnesotaCare program.

Recommendations

- The Health Plan should conduct root cause analyses, at the program level, for HEDIS® and CAHPS® measures that performed below the 75th percentile and implement interventions to address identified barriers. The Health Plan should consider conducting a future focused study aimed at improving child and adolescent care, specifically targeting well child visits, as well as a focused study aiming to improve preventive screenings for women.
- As this is the second year that the Health Plan lost points under the Financial Withhold for the Emergency Department Rate measure, the Health Plan should evaluate the effectiveness of the interventions implemented under the related PIP and modify them as needed.
- In regard to PIPs, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.

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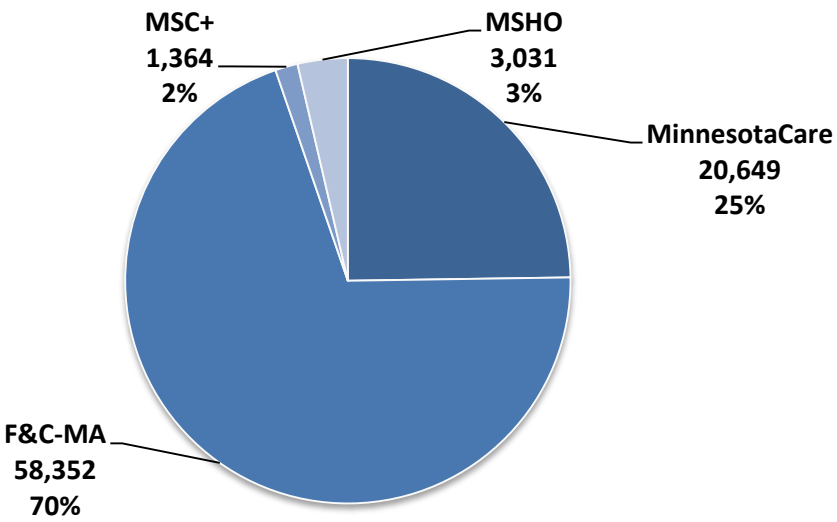
HealthPartners

Corporate Profile

HealthPartners became a managed care entity in 1992, with the affiliation of two MCOs – Group Health, Inc. and MedCenters. HealthPartners provides services to enrollees in the Families & Children Medical Assistance (F&C-MA), MinnesotaCare, Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs in the following counties: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, McLeod, Meeker, Ramsey, Scott, Sherburne, Stearns, Washington and Wright. As of December 2013, enrollment totaled 83,396, accounting for 13% of the entire MHCP population.

Figure 4: HealthPartners Enrollment by Program - December 2013



Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent compliance audit between June 11, 2012 and June 15, 2012. The evaluation period covered December 1, 2008 to March 31, 2012, while the file review period covered April 1, 2011 to March 31, 2012. The Health Plan received a total of three (3) recommendations, four (4) mandatory improvements and one (1) deficiency. During the mid-cycle review in 2013, it was determined that Health Partners met its corrective action plan with the exception of one (1) issue related to 42 CFR 438.404(b), (Contract Section 8.3.1 (B)).

Performance Improvement Projects

The Health Plan concluded the following PIP in 2013:

- *Blood Pressure Control for Members with Diabetes* (2010) – The overall PIP goal was to increase the proportion of members with diabetes who have blood pressure under control as measured by the HEDIS® *Comprehensive Diabetes Care* (140/90 blood pressure adults 18-75 years) measure.
- *Increasing Use of Spirometry Testing for Diagnosis of COPD in the MSHO/MSC+/SNBC Populations* (2012) – The goal of this clinical PIP is to increase the proportion of members with a new or newly active diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who have had spirometry testing completed as measured by the HEDIS® *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure.
- *Colorectal Cancer Screening* (2011) – The goal of this PIP is to increase the colorectal cancer screening rate in the study population in targeted clinics through clinic-specific interventions.
- *Chlamydia Screening in Women* (2013) – The goal of this PIP is to increase Chlamydia screening in women as measured by the HEDIS® *Chlamydia Screening in Women (16-24 Years)* measure among F&C-MA and MinnesotaCare members through multimodal, targeted interventions.

The following PIPs have been initiated and are currently in progress:

- *Transitions of Care: Improved Post-Discharge Follow-Up Care* (2011) - The goal of this PIP is to increase the proportion of MSHO, MSC+ and SNBC members, ages 18 years and older, that complete a scheduled follow-up appointment post-hospital discharge.
- *Reducing Non-Urgent Emergency Department Use in the F&C-MA/MinnesotaCare Populations: A Partnership with the Minnesota Head Start Association* (2012) – The goal of this PIP is to decrease non-urgent ED use among F&C-MA and MinnesotaCare members ages 0-5 who receive the health literacy intervention delivered by Minnesota Head Start and Early Head Start program staff when compared to a non-intervention comparison group.
- *Reducing Race Disparities in the Management of Depression* (2015) – The goal of this PIP is to reduce the racial disparity for the related HEDIS® measure between White members and members in other racial/ethnic groups within the Health Plan by a 20% relative improvement rate.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO and MSC+ Contracts.
- The MCO earned 48.95 of 55 points for the F&C-MA Contract. HealthPartners lost 1.05 points for failing to achieve an annual 10% reduction in its emergency department utilization and lost 5.0 points for failing to achieve an annual 5% reduction in its 30 day hospital readmission percentage.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 4 and 5, respectively.

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Table 4: HealthPartners HEDIS® Performance - 2014

HEDIS® Measures	HealthPartners HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adolescent Well-Care Visit (12-21 Years)[1]	44.0%	25th	42.2%
Adult BMI Assessment[1]	93.2%	90th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	87.9%	75th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	87.9%	25th	89.4%
Breast Cancer Screening (50-64 Years)[2]	64.7%	50th	61.2%
Cervical Cancer Screening (24-64 Years)[2]	73.2%	NA	71.0%
Childhood Immunization Status: Combo 3 (2 Years)[1]	77.9%	75th	75.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	98.3%	75th	98.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	90.7%	50th	91.0%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	90.6%	25th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	91.1%	50th	91.8%
Chlamydia Screening in Women (16-24 Years)[2]	68.4%	90th	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	95.3%	95th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	86.1%	90th	81.3%
Controlling High Blood Pressure[1]	73.7%	90th	65.2%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	89.1%	25th	90.4%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	89.1%	50th	89.3%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	80.2%	50th	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	84.8%	95th	81.6%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	65.7%	50th	62.5%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	68.4%	25th	65.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 4: HealthPartners HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	HealthPartners HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MinnesotaCare		
Adolescent Well-Care Visit (12-21 Years)[1]	47.7%	25th	40.8%
Adult BMI Assessment[1]	95.9%	95th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	88.2%	75th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	91.9%	75th	91.4%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	SS	-	92.1%
Breast Cancer Screening (50-64 Years)[2]	71.6%	90th	67.0%
Cervical Cancer Screening (24-64 Years)[2]	69.6%	NA	66.7%
Childhood Immunization Status: Combo 3 (2 Years)[1]	77.8%	75th	69.6%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	98.5%	90th	96.9%
Chlamydia Screening in Women (16-24 Years)[2]	63.5%	75th	49.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	94.9%	95th	94.6%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	92.3%	95th	88.6%
Controlling High Blood Pressure[1]	70.1%	90th	70.5%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	96.4%	95th	97.3%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	89.3%	50th	88.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	84.5%	90th	85.5%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	74.4%	50th	80.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	73.2%	75th	66.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	73.0%	50th	65.7%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 4: HealthPartners HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	HealthPartners HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	95.8%	95th	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	98.3%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	68.1%	75th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	97.0%	95th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	89.5%	95th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	91.4%	75th	93.1%
Breast Cancer Screening (65-74 Years)[2]	38.8%	<10th	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	68.1%	<10th	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	61.9%	<10th	70.5%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

Table 5: HealthPartners CAHPS® Performance - 2014

CAHPS® Measures	HealthPartners CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	54%	<10th	50%
Getting Care Quickly[1]	60%	<10th	55%
How Well Doctors Communicate[1]	81%	<10th	77%
Customer Service[1]	66%	<10th	65%
Shared Decision Making[1]	56%	95th	52%
Rating of All Health Care[2]	56%	75th	48%
Rating of Personal Doctor[2]	70%	95th	67%
Rating of Specialist Seen Most Often[2]	61%	10th	61%
Rating of Health Plan[2]	60%	50th	56%
	MinnesotaCare		
Getting Needed Care[1]	56%	<10th	56%
Getting Care Quickly[1]	62%	<10th	61%
How Well Doctors Communicate[1]	81%	<10th	80%
Customer Service[1]	70%	<10th	63%
Shared Decision Making[1]	49%	25th	50%
Rating of All Health Care[2]	53%	50th	51%
Rating of Personal Doctor[2]	75%	95th	70%
Rating of Specialist Seen Most Often[2]	69%	75th	63%
Rating of Health Plan[2]	61%	50th	58%
	MSC+		
Getting Needed Care[1]	61%	<10th	60%
Getting Care Quickly[1]	60%	<10th	61%
How Well Doctors Communicate[1]	77%	<10th	76%
Customer Service[1]	62%	<10th	63%
Shared Decision Making[1]	46%	<10th	48%
Rating of All Health Care[2]	64%	95th	60%
Rating of Personal Doctor[2]	74%	95th	75%
Rating of Specialist Seen Most Often[2]	72%	90th	72%
Rating of Health Plan[2]	66%	90th	66%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Table 5: HealthPartners CAHPS® Performance - 2014 (Continued)

CAHPS® Measures	HealthPartners CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Getting Needed Care[1]	64%	<10th	61%
Getting Care Quickly[1]	65%	<10th	69%
How Well Doctors Communicate[1]	73%	<10th	76%
Customer Service[1]	69%	<10th	69%
Shared Decision Making[1]	43%	<10th	49%
Rating of All Health Care[2]	62%	95th	62%
Rating of Personal Doctor[2]	72%	95th	75%
Rating of Specialist Seen Most Often[2]	72%	90th	72%
Rating of Health Plan[2]	66%	90th	72%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- The Health Plan concluded one (1) PIP in 2013, demonstrating continued improvement in the area of diabetes care. In addition, HealthPartners reported diabetes-related HEDIS® rates above the 75th percentile for the F&C-MA, MinnesotaCare and MSHO programs.
- In regard to the Financial Withhold, the Health Plan earned all possible points for the MSHO and MSC+ programs.
- The Health Plan demonstrated strong performance in regard to hypertensive care. HealthPartners performed above the 75th percentile for related HEDIS® measures for the F&C-MA and MinnesotaCare programs.
- In addition, the Health Plan reported HEDIS® *Adult BMI Assessment* rates at or above the 90th percentile across all programs.
- The Health Plan performed well in regard to asthma care for certain age groups. HealthPartners reported HEDIS® *Use of Appropriate Medications for People With Asthma* rates at or above the 75th percentile for the 5-11 Years and 19-50 Years groups in the MinnesotaCare program, and for the 51-64 Years group in the F&C-MA program.
- The Health Plan performed well in regard to women's health. The Health Plan reported rates at or above the 75th percentile for the HEDIS® *Chlamydia Screening in Women* for the F&C-MA and MinnesotaCare programs and for the *Breast Cancer Screening* measure for the MinnesotaCare and MSHO programs
- The Health Plan performed well in regard to some aspects of child and adolescent care. HealthPartners reported rates at or above the 75th percentile for the HEDIS® *Childhood Immunization Status: Combo 3* and for the *Children and Adolescents' Access to PCPs (12-24 Months)* measures for the F&C-MA and MinnesotaCare programs. The Health Plan also reported

a rate at or above the 75th percentile for the HEDIS® *Well-Child Visits in the First 15 Months of Life* measure for the MinnesotaCare program.

- Adult access rates were at or above the 75th percentile for the 20-44 Years group for the F&C-MA and MinnesotaCare programs, for the 45-64 Years group for the MinnesotaCare program and for the 65+ Years group for the MSHO program.
- The Health Plan performed well in regard to some areas of member satisfaction. HealthPartners met or exceeded the 75th percentile across all programs for the *Rating of Personal Doctor* measure. The Health Plan also reported rates at or above the 75th percentile for the *Shared Decision Making* measure for the F&C-MA program, for the *Rating of All Health Care* measure for the F&C-MA, MSC+ and MSHO programs, for the *Rating of Specialist Seen Most Often* measure for the MinnesotaCare, MSC+ and MSHO programs and for the *Rating of Health Plan* measure for the MSC+ and MSHO programs.

Opportunities for Improvement

- The Health Plan demonstrates an opportunity for improvement in regard to the Financial Withhold. HealthPartners failed to earn full points for the F&C-MA Contract.
- The Health Plan demonstrates an opportunity for improvement in regard to child and adolescent care. Although access rates for the 12-24 Month group were at or above the 75th percentile, access rates for the 25 Months-6 Years, 7-11 Years and 12-19 Years age groups of the F&C-MA program were below the 75th percentile. HealthPartners also reported rates below the 75th percentile for the HEDIS® *Adolescent Well-Care Visit* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* measures for the F&C-MA and MinnesotaCare programs and for the *Well-Child Visits in the First 15 Months of Life (6+ Visits)* measure for the F&C-MA program.
- HealthPartners demonstrates an opportunity for improvement in regard to adult access to care for F&C-MA members aged 45-64 years. The Health Plan's performance for the HEDIS® *Adults' Access to Preventive/Ambulatory Health Services* measure for this age group was below the 50th percentile.
- The Health Plan demonstrates an opportunity for improvement in regard to asthma care as HealthPartners reported rates below the 75th percentile for the HEDIS® *Use of Appropriate Medications for People With Asthma* measure for the 5-11 Years, 12-18 Years and 19-50 Years groups in the F&C-MA program and for the 12-18 Years and 51-64 Years groups in the MinnesotaCare program.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. HealthPartners reported CAHPS® rates below the 10th percentile for the *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service* measures across all programs. The Health Plan also reported rates below the 75th percentile for the *Rating of Health Plan* measure for the F&C-MA and MinnesotaCare program, for the *Shared Decision Making* measure for the MinnesotaCare, MSC+ and MSHO programs, for *Rating of Specialist Seen Most Often* measure for the F&C-MA program and for the *Rating of All Health Care* measure for the MinnesotaCare program.

Recommendations

- As this is the second year that the Health Plan lost points under the Financial Withhold for the Emergency Department (ED) Rate measure and the 30-Day Readmission Rate measure, the Health Plan should evaluate the effectiveness of the current interventions and modify them as needed. Interventions conducted under the ED-related PIP should also be evaluated and modified.
- The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers. The Health Plan should consider conducting a future focused study aimed at improving adolescent care, specifically targeting well-care visits.
- As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.
- In regard to PIPs, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.

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Hennepin Health

Corporate Profile

Hennepin Health is a county-based program that began on January 1, 2012. Hennepin County contracts with DHS to offer the Families & Children Medical Assistance (F&C-MA) program to county residents age 18-64 years. The Hennepin Health service model is unique in its approach as it combines a social service approach with behavioral health and medical services. While the county holds the license, it delegates services for health care to Metropolitan Health Plan (MHP). As of December 2013, enrollment totaled 6,285, accounting for 1% of the entire MHCP population.

Quality Assurance Examination and Triennial Compliance Assessment

See Metropolitan Health Plan (MHP).

Performance Improvement Projects

There were no PIPs concluded in 2013; however, the following PIP has been initiated and is currently in progress:

- *Reducing Emergency Department Utilization in Adults through a Collaborative Healthcare Model* (2013) – The goal of this PIP is to reduce emergency department utilization within the adult Metropolitan Health Plan (MHP)/Hennepin Health population as measured through emergency department administrative claims visits per 1000 member months for dates of service during the measurement period.
- *Reduction of Race Disparities in the Management of Depression* (2015) – The goal of this PIP is to reduce the gaps between the White to Black and the White to Native American populations for the HEDIS® *Antidepressant Medication Management* measure by 20% by the end of the three-year measurement period.

2013 Financial Withhold

- The MCO achieved 55 of 70 points for the F&C-MA Contract. Hennepin Health lost a total of 5.0 points for failing to achieve an annual increase in the percentage of enrollees with an annual dental visit, lost a total of 5.0 points for failing to achieve an annual 5% reduction in hospital admissions and lost a total 5.0 points for failing to achieve an annual 5% reduction in its 30-day hospital readmission percentage.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 6 and 7, respectively.

Table 6: Hennepin Health HEDIS® Performance - 2014

HEDIS® Measures	Hennepin Health HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adult BMI Assessment[1]	95.1%	95th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	77.1%	10th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	85.7%	10th	89.4%
Cervical Cancer Screening (24-64 Years)[2]	48.5%	NA	71.0%
Chlamydia Screening in Women (16-24 Years)[2]	SS	-	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	91.4%	75th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	78.7%	50th	81.3%
Controlling High Blood Pressure[1]	58.6%	50th	65.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	SS	-	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	SS	-	81.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 7: Hennepin Health CAHPS® Performance - 2014

CAHPS® Measures	Hennepin CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	49%	<10th	50%
Getting Care Quickly[1]	55%	<10th	55%
How Well Doctors Communicate[1]	74%	<10th	77%
Customer Service[1]	67%	<10th	65%
Shared Decision Making[1]	52%	50th	52%
Rating of All Health Care[2]	46%	10th	48%
Rating of Personal Doctor[2]	62%	25th	67%
Rating of Specialist Seen Most Often[2]	63%	25th	61%
Rating of Health Plan[2]	50%	10th	56%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- The Health Plan met or exceeded the 75th percentile for the following two (2) HEDIS® measures: *Adult BMI Assessment* and *Comprehensive Diabetes Care: HbA1c Testing*.
- The Health Plan met or exceeded the 75th percentile for three (3) of eight (8) CAHPS® measures.

Opportunities for Improvement

- The Health Plan demonstrates an opportunity for improvement in regard to adult care. Hennepin Health performed below the 50th percentile for the HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (20-44 Years* and *45-64 Years*), *Comprehensive Diabetes Care: LDL-C Screening* and *Controlling High Blood Pressure* measures.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. Hennepin Health did not meet the 75th percentile for any CAHPS® measure.
- The Health Plan demonstrates an opportunity for improvement in regard to the Financial Withhold. Hennepin Health failed to earn full points for the F&C-MA Contract.

Recommendations

- The Health Plan should conduct root cause analysis for HEDIS® and CAHPS® measures that performed below the 75th percentile and implement interventions to address identified barriers. As all CAHPS® measures were below the 50th percentile, Hennepin Health should consider conducting a future study aimed at improving member satisfaction.
- The Health Plan should implement interventions to improve its annual dental visit rate to ensure members are receiving appropriate care and to ensure it earns all available points under the Financial Withhold.

- In regard to the "*Reducing Emergency Department Utilization in Adults through a Collaborative Healthcare Model*" PIP, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.

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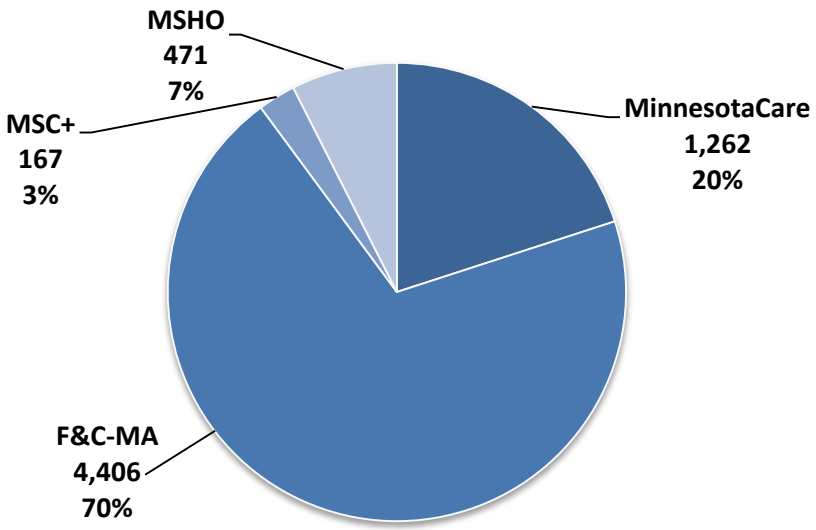
Itasca Medical Care (IMCare)

Corporate Profile

Itasca County Health and Human Services administers Itasca Medical Care (IMCare), a County-Based purchasing organization. Itasca County contracts with DHS to provide medical benefits through the IMCare program to the Families & Children Medical Assistance (F&C-MA), MinnesotaCare, Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) programs. As of December 2013, enrollment totaled 6,306 accounting for 1% of the entire MHCP population.

Figure 5: IMCare Enrollment by Program - December 2013



Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent Quality Assurance Exam between October 1, 2012 and October 4, 2012. The examination period covered July 1, 2009 to July 31, 2012, while the file review period covered August 1, 2011 to July 31, 2012. The Health Plan received a total of six (6) recommendations, eight (8) mandatory improvements and two (2) deficiencies.

Performance Improvement Projects

The Health Plan successfully concluded the following PIP in 2013:

- *Blood Pressure Control for Members with Diabetes* (2010) – The goal for this PIP was to increase the proportion of members with diabetes whose blood pressure is under control (i.e., less than 130/80 mm Hg), across all three MCOs in the collaborative.

The following PIPs have been initiated and are currently in progress:

- *Collaboration to Improve the Quality of Life of Members with Asthma/Chronic Obstructive Pulmonary Disease (COPD)* (2011) – The goal is to improve the care and quality of life of our members diagnosed with asthma/COPD.
- *Colorectal Cancer Screening* (2011) – The goal of the PIP is to increase, by a relative 15%, the proportion of members who have had a colorectal cancer screening and sustain this improvement for two measurement periods.
- *Human Papillomavirus Vaccination for Males* (2013) – The goal of this PIP is to promote administration of the HPV vaccination to males enrolled in the Minnesota Health Care Programs (MHCP) population for the purpose of preventing the spread of HPV strains.
- *Elimination of Race and Ethnic Disparities in the Management of Depression* (2015) – The goal of this PIP is to improve the HEDIS® *Antidepressant Medication Management Effective Continuation Phase Treatment* rate for the study population by an absolute 8% by HEDIS® 2017 and sustain this improvement for HEDIS® 2018.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO and MSC+ Contracts.
- The MCO earned 50 of 50 points for the F&C-MA Contract.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 8 and 9, respectively.

Table 8: IMCare HEDIS® Performance - 2014

HEDIS® Measures	IMCare HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adolescent Well-Care Visit (12-21 Years)[1]	45.7%	25th	42.2%
Adult BMI Assessment[1]	95.6%	95th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	89.3%	90th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	89.9%	50th	89.4%
Breast Cancer Screening (50-64 Years)[2]	58.2%	50th	61.2%
Cervical Cancer Screening (24-64 Years)[2]	69.2%	NA	71.0%
Childhood Immunization Status: Combo 3 (2 Years)[1]	62.5%	10th	75.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	100.0%	95th	98.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	87.0%	25th	91.0%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	94.7%	75th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	93.8%	75th	91.8%
Chlamydia Screening in Women (16-24 Years)[2]	43.3%	10th	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	89.7%	75th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	80.9%	75th	81.3%
Controlling High Blood Pressure[1]	62.8%	50th	65.2%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	SS	-	90.4%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	SS	-	89.3%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	SS	-	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	SS	-	81.6%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	57.1%	25th	62.5%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	62.8%	10th	65.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 8: IMCare HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	IMCare HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MinnesotaCare		
Adolescent Well-Care Visit (12-21 Years)[1]	42.1%	25th	40.8%
Adult BMI Assessment[1]	93.4%	90th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	83.2%	50th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	90.0%	50th	91.4%
Breast Cancer Screening (50-64 Years)[2]	74.4%	90th	67.0%
Cervical Cancer Screening (24-64 Years)[2]	65.5%	NA	66.7%
Childhood Immunization Status: Combo 3 (2 Years)[1]	SS	-	69.6%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	SS	-	96.9%
Chlamydia Screening in Women (16-24 Years)[2]	38.3%	10th	49.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	92.2%	90th	94.6%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	82.4%	75th	88.6%
Controlling High Blood Pressure[1]	68.9%	75th	70.5%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	SS	-	97.3%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	SS	-	88.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	SS	-	85.5%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	SS	-	80.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	SS	-	66.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	63.6%	10th	65.7%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 8: IMCare HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	IMCare HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	NR	-	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	96.6%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	61.5%	50th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	91.7%	90th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	80.0%	50th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	81.0%	10%	93.1%
Breast Cancer Screening (65-74 Years)[2]	14.7%	<10%	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	SS	-	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	SS	-	70.5%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NR: Not required for MSHO

Table 9: IMCare CAHPS® Performance - 2014

CAHPS® Measures	IMCare CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	48%	<10th	50%
Getting Care Quickly[1]	48%	<10th	55%
How Well Doctors Communicate[1]	74%	<10th	77%
Customer Service[1]	78%	<10th	65%
Shared Decision Making[1]	47%	10th	52%
Rating of All Health Care[2]	42%	<10th	48%
Rating of Personal Doctor[2]	60%	10th	67%
Rating of Specialist Seen Most Often[2]	55%	<10th	61%
Rating of Health Plan[2]	50%	10th	56%
	MinnesotaCare		
Getting Needed Care[1]	59%	<10th	56%
Getting Care Quickly[1]	65%	<10th	61%
How Well Doctors Communicate[1]	85%	<10th	80%
Customer Service[1]	58%	<10th	63%
Shared Decision Making[1]	55%	90th	50%
Rating of All Health Care[2]	50%	25th	51%
Rating of Personal Doctor[2]	74%	95th	70%
Rating of Specialist Seen Most Often[2]	62%	25th	63%
Rating of Health Plan[2]	52%	25th	58%
	MSC+		
Getting Needed Care[1]	58%	<10th	60%
Getting Care Quickly[1]	58%	<10th	61%
How Well Doctors Communicate[1]	76%	<10th	76%
Customer Service[1]	59%	<10th	63%
Shared Decision Making[1]	42%	<10th	48%
Rating of All Health Care[2]	61%	95th	60%
Rating of Personal Doctor[2]	73%	95th	75%
Rating of Specialist Seen Most Often[2]	64%	25th	72%
Rating of Health Plan[2]	65%	90th	66%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Table 9: IMCare CAHPS® Performance - 2014 (Continued)

CAHPS® Measures	IMCare CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Getting Needed Care[1]	60%	<10th	61%
Getting Care Quickly[1]	68%	<10th	69%
How Well Doctors Communicate[1]	79%	<10th	76%
Customer Service[1]	70%	<10th	69%
Shared Decision Making[1]	52%	50th	49%
Rating of All Health Care[2]	61%	95th	62%
Rating of Personal Doctor[2]	79%	95th	75%
Rating of Specialist Seen Most Often[2]	73%	95th	72%
Rating of Health Plan[2]	74%	95th	72%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- The Health Plan concluded one (1) PIP in 2013, demonstrating continued improvement in the area of diabetes care. In addition, IMCare reported all but one diabetes-related HEDIS® measure at or above the 75th percentile.
- In regard to the Financial Withhold, the Health Plan earned all possible points for the F&C-MA, MSHO and MSC+ Contracts.
- The Health Plan reported adult access to primary care rates above the 75th percentile for the 20-44 Years group for the F&C-MA program and for the 65+ Years group for the MSHO program. IMCare also reported child and adolescent access to primary care rates at or above the 75th percentile for the 12-24 Months, 7-11 Years and 12-19 Years groups for the F&C-MA program.
- The Health Plan performed better than the 75th percentile for the HEDIS® *Adult BMI Assessment* measure for the F&C-MA and MinnesotaCare programs and for the HEDIS® *Breast Cancer Screening* measure for the MinnesotaCare measure.
- The Health Plan performed well in regard to some aspects of member satisfaction. IMCare reported CAHPS® rates at or above the 75th percentile for the following measures: *Shared Decision Making* for the MinnesotaCare program, *Rating of Personal Doctor* for the MinnesotaCare, MSC+ and MSHO programs, *Rating of All Health Care* and *Rating of Health Plan* for the MSC+ and MSHO programs, and *Rating of Specialist Seen Most Often* for the MSHO program.

Opportunities for Improvement

- The Health Plan also demonstrates an opportunity for improvement in regard to child and adolescent care. IMCare performed below the 50th percentile for the following HEDIS® measures: *Adolescent Well-Care Visit* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* for the F&C-MA and MinnesotaCare programs, *Well-Child Visits in the First 15 Months of Life (6+ Visits)* for the F&C-MA program and *Childhood Immunization Status: Combo 3* for the F&C-MA program. The Health Plan also reported access rates below the 50th percentile for the 25 Months-6 Years group for the F&C-MA program.
- The Health Plan demonstrates an opportunity for improvement in regard to women's health. IMCare reported rates below the 50th percentile for the HEDIS® *Chlamydia Screening in Women* measure for the F&C-MA and MinnesotaCare programs and reported rates below the 75th percentile for the HEDIS® *Breast Cancer Screening* measure for the F&C-MA and MSHO programs.
- The Health Plan demonstrates an opportunity for improvement in regard to chronic conditions. IMCare reported rates below the 75th percentile for the following HEDIS® measures: *Controlling High Blood Pressure* for the F&C-MA program and *Comprehensive Diabetes Care: LDL-C Screening* for the MSHO program.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. IMCare reported CAHPS® rates below the 10th percentile across all programs for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service*. The Health Plan also reported rates below the 75th percentile for the *Shared Decision Making* measure for the F&C-MA, MSC+ and MSHO programs, for the *Rating of All Health Care* for the F&C-MA and MinnesotaCare, *Rating of Health Plan* measure for the F&C-MA, MinnesotaCare and SNBC programs, for the *Rating of Personal Doctor* measure for the F&C-MA program, for the *Rating of Specialist Seen Most Often* measure for the F&C-MA, MinnesotaCare and MSC+ programs, and for the *Rating of Health Plan* measure for the F&C-MA and MinnesotaCare programs.

Recommendations

- In regard to PIPs, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.
- The Health Plan should conduct root cause analyses, at the program level, for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers. The Health Plan should consider conducting a future focused study aimed at improving child and adolescent care, specifically targeting well-child visits, as well as a focused study aiming to improve preventive screenings for women.
- As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members.

The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.

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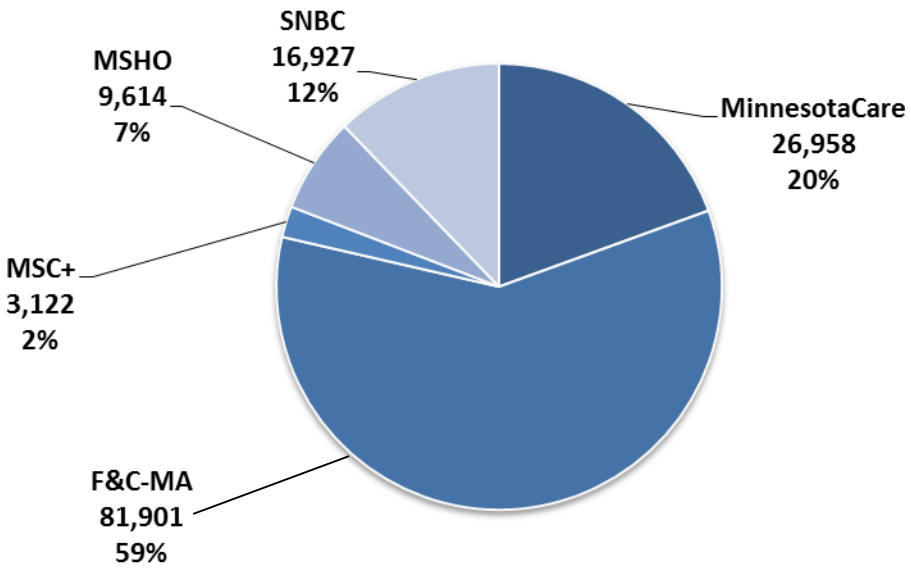
Medica

Corporate Profile

Medica is one of Minnesota's largest MCOs and Preferred Provider Organizations (PPO). The MCO achieved "Excellent" accreditation status from the NCQA for its Medicaid line of business and ranked 11th in the NCQA's *2013-2014 Health Plan Rankings*[5]. Medica provides services to enrollees in the Families & Children Medical Assistance (F&C-MA), MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) programs. As of December 2013, enrollment totaled 138,522, accounting for 22% of the entire MHCP population.

Figure 6: Medica Enrollment by Program - December 2013



5. NCQA 2013-2014 Medicaid Health Insurance Plan Rankings

Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent Quality Assurance Exam between March 12, 2012 and March 19, 2012. The examination period covered June 1, 2009 to December 31, 2011, while the file review period covered January 1, 2011 to December 31, 2011. The Health Plan received a total of two (2) recommendations, five (5) mandatory improvements and six (6) deficiencies.

Performance Improvement Projects

The Health Plan concluded the following PIP in 2013:

- *Blood Pressure Control for Members with Diabetes* (2010) – The overall PIP goal was to increase the proportion of members with diabetes who have blood pressure under control as measured by the HEDIS® *Comprehensive Diabetes Care* (140/90 blood pressure adults 18-75 years) measure. Although the project goal was met for the F&C-MA/MinnesotaCare and MSHO/MSC+ populations, it was not met for the SNBC population.

The following PIPs have been initiated and are currently in progress:

- *Colorectal Cancer Screening* (2011) – The goal of this PIP is to increase the colorectal cancer screening rate in the study population in targeted clinics through clinic-specific interventions.
- *Transitions of Care: Improved Post-Discharge Follow-Up Care* (2011) – The goal of this PIP is to increase the proportion of MSHO, MSC+ and SNBC members, ages 18 years and older, that complete a scheduled follow-up appointment post-hospital discharge.
- *Reducing Non-Urgent Emergency Department Use in the F&C-MA/MinnesotaCare Populations: A Partnership with the Minnesota Head Start Association* (2012) – The goal of this PIP is to decrease non-urgent ED use among F&C-MA and MinnesotaCare members ages 0-5 years who receive the health literacy intervention delivered by Minnesota Head Start and Early Head Start program staff when compared to a non-intervention comparison group.
- *Increasing Use of Spirometry Testing for Diagnosis of COPD in the MSHO/MSC+/SNBC Populations* (2012) – The goal of this clinical PIP is to increase the proportion of members with a new or newly active diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who have had spirometry testing completed as measured by the HEDIS® *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure.
- *Chlamydia Screening in Women* (2013) – The goal of this PIP is to increase Chlamydia screening in women as measured by the HEDIS® *Chlamydia Screening in Women* (ages 16-24) measure among F&C-MA and MinnesotaCare members through multimodal, targeted interventions.
- *Improving Transitions Post-Hospitalization in the Special Needs Basic Care Population* (2013) – The goal of this PIP is to reduce hospital readmissions by improving member support for the transition from hospital to home or another health care setting for SNBC members as measured by the HEDIS® *Plan All-cause Readmissions* measure.
- *Racial and Ethnic Disparities in the Management of Depression* (2015) – The goal of this PIP is to reduce the disparity of antidepressant medication management between White and non-White members in the F&C-MA and MinnesotaCare populations by an absolute rate of 5.38 percentage points.

- *Follow-Up After Hospitalization for Mental Illness* (2015) – The goal of this PIP is to increase follow-up after hospitalization for the SNBC population by 5.40% for 7 days and 4.50% for 30 days after three (3) years.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO and MSC+ Contracts.
- The MCO earned 50 of 50 points for the SNBC Contract.
- The MCO earned 43.93 of 55 points for the F&C-MA Contract. Medica lost 1.07 points for failing to achieve an annual 10% reduction in its emergency department utilization, lost a total of 5.0 points for failing to achieve an annual 5% reduction in hospital admissions and lost a total 5.0 points for failing to achieve an annual 5% reduction in its 30-day hospital readmission percentage.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 10 and 11, respectively.

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Table 10: Medica HEDIS® Performance - 2014

HEDIS® Measures	Medica HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adolescent Well-Care Visit (12-21 Years)[1]	40.2%	10th	42.2%
Adult BMI Assessment[1]	90.5%	75th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	89.6%	90th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	90.1%	50th	89.4%
Breast Cancer Screening (50-64 Years)[2]	60.0%	50th	61.2%
Cervical Cancer Screening (24-64 Years) [2]	70.7%	NA	71.0%
Childhood Immunization Status: Combo 3 (2 Years) [1]	80.1%	75th	75.7%
Children and Adolescents' Access to PCPs (12-24 Months) [2]	98.2%	75th	98.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) [2]	91.1%	50th	91.0%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	93.1%	50th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	92.5%	75th	91.8%
Chlamydia Screening in Women (16-24 Years)[2]	61.9%	50th	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	90.7%	75th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	81.6%	75th	81.3%
Controlling High Blood Pressure[1]	66.7%	75th	65.2%
Use of Appropriate Medications for People With Asthma (5-11 Years) [2]	91.2%	50th	90.4%
Use of Appropriate Medications for People With Asthma (12-18 Years) [2]	92.5%	75th	89.3%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	74.4%	25th	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	82.1%	90th	81.6%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	61.5%	25th	62.5%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	66.8%	25th	65.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 10: Medica HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	Medica HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MinnesotaCare		
Adolescent Well-Care Visit (12-21 Years)[1]	39.2%	10th	40.8%
Adult BMI Assessment[1]	91.0%	90th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	87.8%	75th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	91.6%	75th	91.4%
Breast Cancer Screening (50-64 Years)[2]	63.7%	50th	67.0%
Cervical Cancer Screening (24-64 Years)[2]	66.8%	NA	66.7%
Childhood Immunization Status: Combo 3 (2 Years)[1]	67.4%	25th	69.6%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	96.7%	25th	96.9%
Chlamydia Screening in Women (16-24 Years)[2]	52.1%	25th	49.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	95.6%	95th	94.6%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	88.7%	90th	88.6%
Controlling High Blood Pressure[1]	74.2%	95th	70.5%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	100.0%	95th	97.3%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	88.9%	50th	88.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	80.2%	50th	85.5%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	83.1%	90th	80.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	62.8%	25th	66.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	66.9%	25th	65.7%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NA: Not available.

Table 10: Medica HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	Medica HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	93.9%	95th	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	97.9%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	57.5%	50th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	94.7%	95th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	85.6%	90th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	95.1%	95th	93.1%
Breast Cancer Screening (65-74 Years)[2]	31.7%	<10th	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	69.8%	<10th	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	49.3%	<10th	70.5%
	SNBC		
Adult BMI Assessment[1] *(Non-SNP)*	91.7%	90th	86.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	94.3%	95th	93.2%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	96.5%	95th	96.2%
Breast Cancer Screening (50-64 Years)[2]	44.1%	<10th	59.1%
Cervical Cancer Screening (24-64 Years)[2]	46.2%	NA	50.3%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(Non-SNP)*	92.9%	90th	90.5%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(Non-SNP)*	84.7%	90th	82.2%
Controlling High Blood Pressure[1] *(Non-SNP)*	75.2%	95th	67.9%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NA: Not available.

Table 11: Medica CAHPS® Performance - 2014

CAHPS® Measures	Medica CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	59%	<10th	50%
Getting Care Quickly[1]	53%	<10th	55%
How Well Doctors Communicate[1]	76%	<10th	77%
Customer Service[1]	63%	<10th	65%
Shared Decision Making[1]	53%	50th	52%
Rating of All Health Care[2]	51%	25th	48%
Rating of Personal Doctor[2]	68%	75th	67%
Rating of Specialist Seen Most Often[2]	72%	90th	61%
Rating of Health Plan[2]	61%	50th	56%
	MinnesotaCare		
Getting Needed Care[1]	53%	<10th	56%
Getting Care Quickly[1]	58%	<10th	61%
How Well Doctors Communicate[1]	78%	<10th	80%
Customer Service[1]	63%	<10th	63%
Shared Decision Making[1]	50%	25th	50%
Rating of All Health Care[2]	52%	50th	51%
Rating of Personal Doctor[2]	65%	50th	70%
Rating of Specialist Seen Most Often[2]	62%	25th	63%
Rating of Health Plan[2]	61%	50th	58%
	MSC+		
Getting Needed Care[1]	49%	<10th	60%
Getting Care Quickly[1]	57%	<10th	61%
How Well Doctors Communicate[1]	76%	<10th	76%
Customer Service[1]	59%	<10th	63%
Shared Decision Making[1]	56%	95th	48%
Rating of All Health Care[2]	54%	75th	60%
Rating of Personal Doctor[2]	74%	95th	75%
Rating of Specialist Seen Most Often[2]	74%	95th	72%
Rating of Health Plan[2]	62%	75th	66%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Table 11: Medica CAHPS® Performance - 2014 (Continued)

CAHPS® Measures	Medica CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Getting Needed Care[1]	55%	<10th	61%
Getting Care Quickly[1]	64%	<10th	69%
How Well Doctors Communicate[1]	73%	<10th	76%
Customer Service[1]	66%	<10th	69%
Shared Decision Making[1]	46%	<10th	49%
Rating of All Health Care[2]	54%	75th	62%
Rating of Personal Doctor[2]	69%	90th	75%
Rating of Specialist Seen Most Often[2]	70%	75th	72%
Rating of Health Plan[2]	68%	95th	72%
	SNBC		
Getting Needed Care[1]	52%	<10th	57%
Getting Care Quickly[1]	57%	<10th	61%
How Well Doctors Communicate[1]	73%	<10th	75%
Customer Service[1]	65%	<10th	68%
Shared Decision Making[1]	49%	25th	52%
Rating of All Health Care[2]	50%	25th	52%
Rating of Personal Doctor[2]	70%	95th	70%
Rating of Specialist Seen Most Often[2]	63%	25th	65%
Rating of Health Plan[2]	59%	50th	59%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- Medica achieved "*Excellent*" status on the NCQA Accreditation Survey and was ranked 11th in the NCQA's 2013-2014 *Health Plan Rankings.*
- In regard to the Financial Withhold, the Health Plan earned all possible points for the MSHO, MSC+ and SNBC Contracts.
- The Health Plan concluded one (1) PIP in 2013, demonstrating continued improvement in the area of diabetes care.
- The Health Plan demonstrated strong performance in regard to care for chronic conditions. Medica reported rates at or above the 75th percentile for diabetes- and hypertension-related HEDIS® measures across the F&C-MA, MinnesotaCare, MSHO and SNBC programs. The Health Plan also reported rates at or above the 75th percentile for the HEDIS® *Use of Appropriate Medications for People With Asthma* measure for the 12-18 Years and 51-64 Years groups for the F&C-MA program, for the 5-11 Years and 51-64 Years groups for the MinnesotaCare program.

- The Health Plan performed at or above the 75th percentile for the HEDIS® *Adult BMI Assessment* measure across the F&C-MA, MinnesotaCare, MSHO and SNBC programs.
- The Health Plan reported adult access to primary care rates above the 75th percentile for all age groups of the MSHO and SNBC programs. Medica also reported rates at or above the 75th percentile for the 20-44 Years age group for the F&C-MA program and for the 20-44 Years and 45-64 Years age groups for the MinnesotaCare program. In addition, the Health Plan reported child and adolescent access rates at or above the 75th percentile for the 12-24 Months and 12-19 Years groups for the F&C-MA program. The HEDIS® *Childhood Immunization Status: Combo 3* measure also performed at the 75th percentile for the F&C-MA program.
- The Health Plan performed well in regard to some aspects of member satisfaction. Medica reported rates at or above the 75th percentile for the following CAHPS® measures: *Rating of Personal Doctor* for the F&C-MA, MSC+, MSHO and SNBC programs, *Rating of Specialist Seen Most Often* for the F&C-MA, MSC+ and MSHO programs, *Shared Decision Making* for the MSC+ program, and *Rating of All Health Care* and *Rating of Health Plan* for the MSC+ and MSHO programs.

Opportunities for Improvement

- Although the Health Plan concluded the "*Blood Pressure Control for Members with Diabetes*" PIP, Medica demonstrates an opportunity for improvement as the goal was not met for the SNBC population.
- The Health Plan demonstrates an opportunity for improvement in regard to the Financial Withhold. Medica failed to earn full points for the F&C-MA Contract.
- The Health Plan demonstrates an opportunity for improvement in regard to women's health. Medica reported rates below the 75th percentile for the HEDIS® *Chlamydia Screening in Women* measure for the F&C-MA and MinnesotaCare programs. The Health Plan also reported rates for the HEDIS® *Breast Cancer Screening* measure below the 75th percentile for the F&C-MA, MinnesotaCare, MSHO and SNBC programs.
- The Health Plan also demonstrates an opportunity for improvement in regard to child and adolescent care. Medica performed at or below the 50th percentile for the following HEDIS® measures: *Adolescent Well-Care Visit, Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* for the F&C-MA and MinnesotaCare programs and *Childhood Immunization Status: Combo 3* for the MinnesotaCare program. The Health Plan also reported access to primary care rates below the 75th percentile for the 12-24 Months group for the MinnesotaCare program, and for the 25 Months-6 Years and 7-11 Years groups for the F&C-MA program.
- The Health Plan also demonstrates an opportunity for improvement in regard to the HEDIS® *Adults' Access to Preventive/Ambulatory Health Services* measure for the 45-64 Years group for the F&C-MA program as the rate was below the 75th percentile.
- The Health Plan demonstrates an opportunity for improvement in regard to asthma care. Although HEDIS® *Use of Appropriate Medications for People with Asthma* rates for certain age

groups met or exceeded the 75th percentile, Medica reported rates below the 75th percentile for the 5-11 Years and 19-50 Years groups for the F&C-MA program and for the 12-18 Years and 19-50 Years groups for the MinnesotaCare program.

- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. Medica reported CAHPS® rates below the 10th percentile across all programs for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service*. The Health Plan also reported rates below the 75th percentile for the *Shared Decision Making* measure for the F&C-MA, MinnesotaCare, MSHO and SNBC programs, for the *Rating of All Health Care* and *Rating of Health Plan* measures for the F&C-MA, MinnesotaCare and SNBC programs, for the *Rating of Personal Doctor* measure for the MinnesotaCare program and for the *Rating of Specialist Seen Most Often* measure for the MinnesotaCare and SNBC programs.

Recommendations

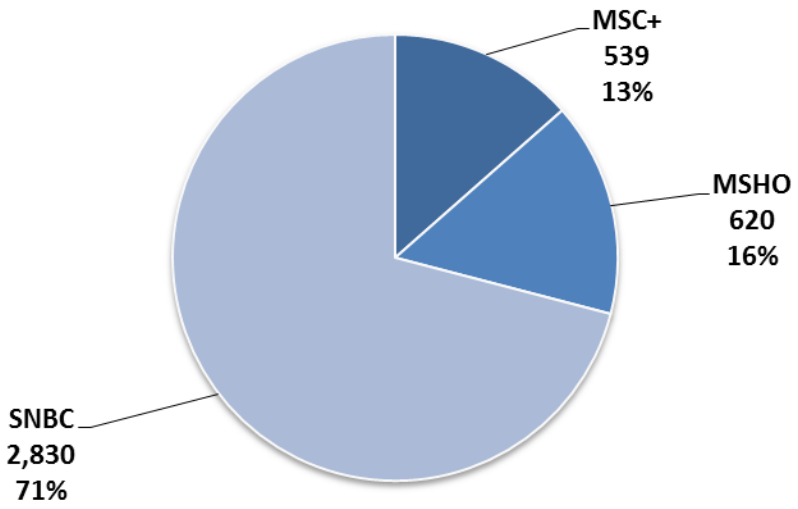
- As this is the second year that the Health Plan lost points under the Financial Withhold for the Emergency Department (ED) Rate measure and the 30-Day Readmission Rate measure, the Health Plan should evaluate the effectiveness of the current interventions and modify them as needed. Interventions conducted under the ED-related PIP should also be evaluated and modified.
- The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers. The Health Plan should consider conducting future focused studies aimed at improving child and adolescent care, specifically targeting well-care visits.
- As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.
- In regard to PIPs, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.

Metropolitan Health Plan (MHP)

Corporate Profile

Metropolitan Health Plan (MHP) has been a licensed HMO since 1983 and has provided medical assistance benefits to public program enrollees since 1984. MHP operates under the sponsorship of Hennepin County and serves enrollees in the Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) programs. The MCO ended its participation in the Families & Children Medical Assistance (F&C-MA) and MinnesotaCare programs in 2011. As of December 2013, enrollment totaled 3,989, accounting for 1% of the entire MHCP population.

Figure 7: MHP Enrollment by Program - December 2013



Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent Quality Assurance Exam between May 23, 2011 and May 26, 2011. The examination period covered May 1, 2008 to April 30, 2011, while the file review period covered March 1, 2010 to February 28, 2011. The Health Plan received a total of five (5) recommendations, six (6) mandatory improvements and five (5) deficiencies.

Performance Improvement Projects

The Health Plan concluded the following PIP in 2013:

- *Blood Pressure Control for Members with Diabetes* (2010) – The overall PIP goal was to increase the proportion of members with diabetes who have blood pressure under control as measured by the HEDIS® *Comprehensive Diabetes Care* (140/90 blood pressure adults 18-75 years). Although the project goal was met for the F&C-MA/MinnesotaCare and MSHO/MSC+ populations, it was not met for the SNBC population.

The following PIPs have been initiated and are currently in progress:

- *Transitions of Care: Improved Post-Discharge Follow-Up Care* (2011) – The goal of this PIP is to increase the proportion of MSHO, MSC+ and SNBC members, ages 18 years and older, that complete a scheduled follow-up appointment post-hospital discharge.
- *Increasing Annual Preventive and Diagnostic Dental Services* (2012) – The goal of this PIP is to increase the proportion of study population members who have received an annual preventive and/or diagnostic dental service as measured through administrative claims for dates of service during the measurement period.
- *Elimination of Race and Ethnic Disparities in the Management of Depression* (2015) – The goal of this PIP is to reduce the gaps between the White to Black SNBC populations for the HEDIS® *Antidepressant Medication Management* rate by 20% by the end of the three-year measurement period.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO and MSC+ Contracts.
- The MCO earned 50 of 50 points for the SNBC Contract.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 12 and 13, respectively.

Table 12: MHP HEDIS® Performance - 2014

HEDIS® Measures	MHP HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	NR	-	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	97.0%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	60.5%	50th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	93.9%	95th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	88.8%	90th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	94.9%	95th	93.1%
Breast Cancer Screening (65-74 Years)[2]	56.5%	25th	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	93.3%	90th	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	83.7%	90th	70.5%
	SNBC		
Adult BMI Assessment[1] *(SNP)*	97.2%	95th	92.2%
Adult BMI Assessment[1] *(Non-SNP)*	98.8%	95th	86.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	90.4%	95th	93.2%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	95.3%	95th	96.2%
Breast Cancer Screening (50-64 Years)[2]	75.3%	95th	59.1%
Cervical Cancer Screening (24-64 Years)[2]	54.8%	NA	50.3%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(SNP)*	90.0%	75th	91.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(Non-SNP)*	90.5%	75th	90.5%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(SNP)*	82.5%	75th	84.9%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(Non-SNP)*	80.1%	75th	82.2%
Controlling High Blood Pressure[1] *(SNP)*	65.6%	75th	70.4%
Controlling High Blood Pressure[1] *(Non-SNP)*	65.2%	75th	67.9%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NR: Not reported.
NA: Not available.

Table 13: MHP CAHPS® Performance - 2014

CAHPS® Measures	MHP CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSC+		
Getting Needed Care[1]	58%	<10th	60%
Getting Care Quickly[1]	58%	<10th	61%
How Well Doctors Communicate[1]	76%	<10th	76%
Customer Service[1]	59%	<10th	63%
Shared Decision Making[1]	42%	<10th	48%
Rating of All Health Care[2]	61%	95th	60%
Rating of Personal Doctor[2]	73%	95th	75%
Rating of Specialist Seen Most Often[2]	64%	25th	72%
Rating of Health Plan[2]	65%	90th	66%
	MSHO		
Getting Needed Care[1]	60%	<10th	61%
Getting Care Quickly[1]	68%	<10th	69%
How Well Doctors Communicate[1]	79%	<10th	76%
Customer Service[1]	70%	<10th	69%
Shared Decision Making[1]	52%	50th	49%
Rating of All Health Care[2]	61%	95th	62%
Rating of Personal Doctor[2]	79%	95th	75%
Rating of Specialist Seen Most Often[2]	73%	95th	72%
Rating of Health Plan[2]	74%	95th	72%
	SNBC		
Getting Needed Care[1]	56%	<10th	57%
Getting Care Quickly[1]	53%	<10th	61%
How Well Doctors Communicate[1]	78%	<10th	75%
Customer Service[1]	67%	<10th	68%
Shared Decision Making[1]	53%	50th	52%
Rating of All Health Care[2]	50%	25th	52%
Rating of Personal Doctor[2]	72%	95th	70%
Rating of Specialist Seen Most Often[2]	65%	50th	65%
Rating of Health Plan[2]	59%	50th	59%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- The Health Plan concluded one (1) PIP in 2013, demonstrating continued improvement in the area of diabetes care. In addition, MHP reported all diabetes-related HEDIS® measures at or above the 75th percentile.
- In regard to the Financial Withhold, the Health Plan earned all possible points for the MSHO, MSC+ and SNBC Contracts.
- The Health Plan reported adult access to primary care rates above the 75th percentile for all programs.
- The Health Plan performed at or above the 75th percentile for the HEDIS® *Adult BMI Assessment* and *Controlling High Blood Pressure* measures for both the SNP and Non-SNP groups in the SNBC program.
- The Health Plan demonstrated strong performance in regard to some aspects of member satisfaction. MHP performed better than the 75th percentile for the following CAHPS® measures: *Rating of All Health Care* for the MSC+ and MSHO programs, *Rating of Personal Doctor* for all programs, *Rating of Health Plan* for the MSC+ and MSHO programs and *Rating of Specialist Seen Most Often* for the MSHO program.

Opportunities for Improvement

- Although the Health Plan concluded the "*Blood Pressure Control for Members with Diabetes*" PIP, MHP demonstrates an opportunity for improvement as the goal was not met for the SNBC population.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. MHP reported CAHPS® rates below the 10th percentile across all programs for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service*. The Health Plan also reported rates below the 75th percentile for the *Shared Decision Making* measure across all programs, for the *Rating of Specialist Seen Most Often* measure for the MSC+ and SNBC programs, for the *Rating of All Health Care* and *Rating of Health Plan* measures for the SNBC program.

Recommendations

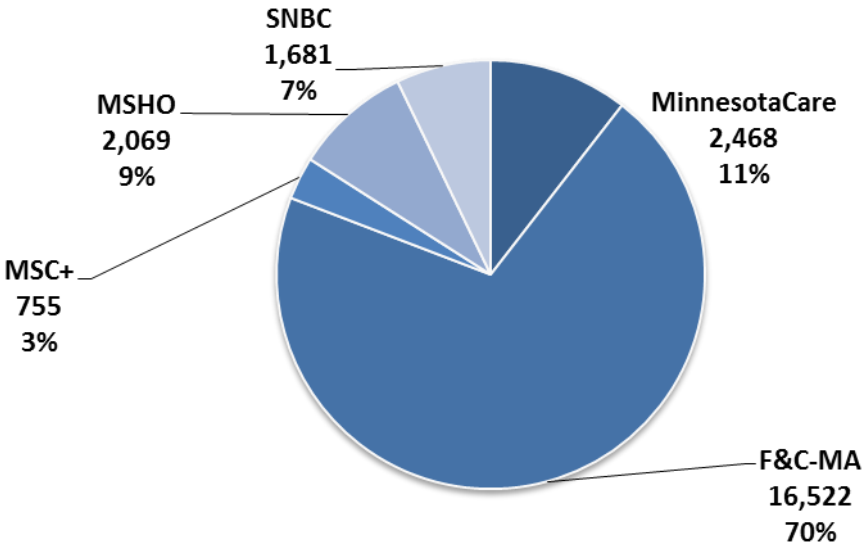
- The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers.
- As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.
- In regard to PIPs, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.

PrimeWest Health

Corporate Profile

Organized through a Joint Powers Board of thirteen (13) local county governments as a County-Based Purchaser, PrimeWest is a publicly funded MCO serving the rural counties of western Minnesota, including Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse counties. The MCO began enrollment in July 2013 for the Families & Children Medical Assistance (F&C-MA), MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) programs. As of December 2013, enrollment totaled 23,495, accounting for 4% of the entire MHCP population.

Figure 8: PrimeWest Health Enrollment by Program - December 2013



Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent Quality Assurance Exam between September 12, 2011 and September 15, 2011. The examination period covered July 1, 2008 to May 31, 2011, while the file review period covered June 1, 2010 to May 31, 2011. The Health Plan received a total of two (2) mandatory improvements and four (4) deficiencies.

Performance Improvement Projects

The Health Plan concluded the following PIP in 2013:

- *Blood Pressure Control for Members with Diabetes* (2010) – The goal for this PIP was to increase the proportion of members with diabetes whose blood pressure is under control (i.e., less than 130/80 mm Hg), across all three MCOs in the collaborative. *Note: Goal was not achieved for the SNBC population and, therefore, the PIP will continue for this population only.*

The following PIPs have been initiated and are currently in progress:

- *Blood Pressure Control for Members with Diabetes* (2010) – The goal for this PIP is to increase the proportion of SNBC members with diabetes whose blood pressure is under control (i.e., less than 130/80 mm Hg), across all three MCOs in the collaborative.
- *Colorectal Cancer Screening* (2012) – The goal for this PIP is to increase, by a relative 15%, the proportion of members who have had a colorectal cancer screening and sustain this improvement for two measurement periods.
- *Human Papillomavirus Vaccination for Males* (2013) – The goal of this PIP is to promote administration of the HPV vaccination to males enrolled in the Minnesota Health Care Programs (MHCP) population for the purpose of preventing the spread of HPV strains.
- *Post-Discharge Member Follow-Up* (2011) – The goal of this PIP is to decrease the aggregate 30-day readmission rate for members discharged from the three (3) contracted focus hospitals by a relative 10.8% and sustain that improvement for two measurement periods.
- *Cholesterol Screening Among Members with Diabetes* (2011) – The goal of this PIP is to increase the current percentage of SNBC members with diabetes who receive an LDL-C screening as reflected by the HEDIS® *Comprehensive Diabetes Care* measure to 85.0% or above and sustain this improvement for two measurement periods.
- *Antidepressant Medication Management with a Special Focus on Racial/Ethnic Disparities* (2015) – The goal of this PIP is to improve the HEDIS® *Antidepressant Medication Management Continuation Phase* rate by 6%.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO/MSC+ Contracts.
- The MCO earned 50 of 50 points for the SNBC Contract.
- The MCO earned 49.05 of 50 points for the F&C-MA Contract. PrimeWest Health lost 0.95 points for failing to achieve an annual 10% reduction in its emergency department utilization.

2014 MCO Transparency and Accountability Report

Prime West Health identified *Dental Access and Utilization* as a topic that provided an opportunity to improve dental access for Minnesota Health Care Programs (MHCP) enrollees who face barriers to obtaining needed dental services. Through aggressive, unique and hands-on initiatives, the MCO showed year-end dental utilization data for 2013 as a 42% increase in unique members served and a 45% increase in dental office visits and an increase of 33% for members who received preventive, diagnostic or restorative dental visits per 1,000 member months (MM) as compared to 2004 data. The MCO anticipates sustainability will be achieved by continuing to identify opportunities to use non-traditional dental providers to increase access to dental services and facilitate member accountability for oral health through education and promotion. IPRO considers the MCO's use and support of allied oral health professionals integrated into rural underserved areas as a strength and it should be expanded. Prime West Health identified the second project as *Increasing Timely Renewal of Needed Formulary Exceptions* to show a reduction in the number of medication denials due to expired formulary exceptions. Through the addition of steps to the formulary exception process, Prime West Health realized a 9.56% of expired formulary exceptions rate in 2013 as compared to 18.00% in 2012. The MCO anticipates sustained performance because the pharmacy denial process is less burdensome for parties responsible to reach resolution. IPRO considers the internal review of the formulary exception process that led to modifications in procedures that resulted in positive outcomes as a strength and should be continued.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 14 and 15, respectively.

Table 14: PrimeWest Health HEDIS® Performance - 2014

HEDIS® Measures	PrimeWest Health HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adolescent Well-Care Visit (12-21 Years)[1]	40.6%	10th	42.2%
Adult BMI Assessment[1]	77.9%	25th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	91.5%	95th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	90.4%	50th	89.4%
Breast Cancer Screening (50-64 Years)[2]	50.0%	10th	61.2%
Cervical Cancer Screening (24-64 Years) [2]	66.8%	NA	71.0%
Childhood Immunization Status: Combo 3 (2 Years)[1]	73.6%	50th	75.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	98.4%	75th	98.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	89.9%	50th	91.0%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	93.2%	50th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	93.9%	75th	91.8%
Chlamydia Screening in Women (16-24 Years)[2]	32.6%	<10th	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	84.6%	50th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	70.1%	10th	81.3%
Controlling High Blood Pressure[1]	58.9%	50th	65.2%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	SS	-	90.4%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	SS	-	89.3%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	82.2%	75th	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	SS	-	81.6%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	60.5%	10th	62.5%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	55.1%	<10th	65.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NA: Not available.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.

Table 14: PrimeWest Health HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	PrimeWest Health HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MinnesotaCare		
Adolescent Well-Care Visit (12-21 Years)[1]	36.7%	<10th	40.8%
Adult BMI Assessment[1]	77.4%	25th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) [2]	88.4%	75th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) [2]	91.4%	75th	91.4%
Breast Cancer Screening (50-64 Years) [2]	58.8%	50th	67.0%
Cervical Cancer Screening (24-64 Years) [2]	63.7%	NA	66.7%
Childhood Immunization Status: Combo 3 (2 Years) [1]	SS	-	69.6%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	SS	-	96.9%
Chlamydia Screening in Women (16-24 Years)[2]	28.6%	<10th	49.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	92.8%	90th	94.6%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	84.5%	90th	88.6%
Controlling High Blood Pressure[1]	61.2%	50th	70.5%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	SS	-	97.3%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	SS	-	88.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	SS	-	85.5%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	SS	-	80.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	SS	-	66.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	55.6%	<10th	65.7%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 14: PrimeWest Health HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	PrimeWest Health HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	NR	-	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	98.0%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	58.1%	50th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	92.5%	90th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	82.0%	75th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	87.4%	25th	93.1%
Breast Cancer Screening (65-74 Years)[2]	54.6%	25th	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	82.2%	25th	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	72.9%	25th	70.5%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NR: Not required for MSHO.

Table 14: PrimeWest Health HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	PrimeWest Health HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	SNBC		
Adult BMI Assessment[1] *(SNP)*	88.7%	75th	92.2%
Adult BMI Assessment[1] *(Non-SNP)*	74.5%	25th	86.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	92.5%	95th	93.2%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	96.4%	95th	96.2%
Breast Cancer Screening (50-64 Years)[2]	77.6%	95th	59.1%
Cervical Cancer Screening (24-64 Years)[2]	50.9%	NA	50.3%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(SNP)*	90.4%	75th	91.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(Non-SNP)*	84.0%	50th	90.5%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(SNP)*	73.1%	25th	84.9%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(Non-SNP)*	74.7%	25th	82.2%
Controlling High Blood Pressure[1] *(SNP)*	77.1%	95th	70.4%
Controlling High Blood Pressure[1] *(Non-SNP)*	63.1%	50th	67.9%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NA: Not available.

Table 15: PrimeWest Health CAHPS® Performance - 2014

CAHPS® Measures	PrimeWest Health CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	51%	<10th	50%
Getting Care Quickly[1]	55%	<10th	55%
How Well Doctors Communicate[1]	76%	<10th	77%
Customer Service[1]	63%	<10th	65%
Shared Decision Making[1]	51%	50th	52%
Rating of All Health Care[2]	42%	<10th	48%
Rating of Personal Doctor[2]	65%	50th	67%
Rating of Specialist Seen Most Often[2]	64%	25th	61%
Rating of Health Plan[2]	54%	25th	56%
	MinnesotaCare		
Getting Needed Care[1]	58%	<10th	56%
Getting Care Quickly[1]	56%	<10th	61%
How Well Doctors Communicate[1]	79%	<10th	80%
Customer Service[1]	64%	<10th	63%
Shared Decision Making[1]	45%	<10th	50%
Rating of All Health Care[2]	52%	50th	51%
Rating of Personal Doctor[2]	66%	75h	70%
Rating of Specialist Seen Most Often[2]	63%	25th	63%
Rating of Health Plan[2]	62%	75th	58%
	MSC+		
Getting Needed Care[1]	65%	<10th	60%
Getting Care Quickly[1]	69%	<10th	61%
How Well Doctors Communicate[1]	77%	<10th	76%
Customer Service[1]	71%	<10th	63%
Shared Decision Making[1]	42%	<10th	48%
Rating of All Health Care[2]	63%	95th	60%
Rating of Personal Doctor[2]	76%	95th	75%
Rating of Specialist Seen Most Often[2]	71%	90th	72%
Rating of Health Plan[2]	69%	95th	66%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Table 15: PrimeWest Health CAHPS® Performance - 2014 (Continued)

CAHPS® Measures	PrimeWest Health CAHPS® 2014	*Quality Compass® 2013* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Getting Needed Care[1]	64%	<10th	61%
Getting Care Quickly[1]	77%	10th	69%
How Well Doctors Communicate[1]	75%	<10th	76%
Customer Service[1]	71%	<10th	69%
Shared Decision Making[1]	46%	<10th	49%
Rating of All Health Care[2]	66%	95th	62%
Rating of Personal Doctor[2]	76%	95th	75%
Rating of Specialist Seen Most Often[2]	74%	95th	72%
Rating of Health Plan[2]	77%	95th	72%
	SNBC		
Getting Needed Care[1]	59%	<10th	57%
Getting Care Quickly[1]	66%	<10th	61%
How Well Doctors Communicate[1]	74%	<10th	75%
Customer Service[1]	72%	<10th	68%
Shared Decision Making[1]	52%	50th	52%
Rating of All Health Care[2]	55%	75th	52%
Rating of Personal Doctor[2]	68%	75th	70%
Rating of Specialist Seen Most Often[2]	61%	10th	65%
Rating of Health Plan[2]	56%	25th	59%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- The Health Plan concluded one (1) PIP in 2013, demonstrating continued improvement in the area of diabetes care for the F&C-MA, MSC+ and MSHO populations.
- In regard to the Financial Withhold, the Health Plan earned all possible points for the MSHO, MSC+ and SNBC Contracts.
- The Health Plan performed well in regard to diabetes-related care for the MinnesotaCare and MSHO programs. PrimeWest Health reported HEDIS® *Comprehensive Diabetes Care: HbA1c Testing* and *LDL-C Screening* rates at or above the 75th percentile for these programs. The Health Plan also met or exceeded the 75th percentile for the HEDIS® *Comprehensive Diabetes Care: HbA1c Testing* for the SNBC SNP program.
- The Health Plan reported adult access to primary care rates at or above 75th percentile for all age groups in the MinnesotaCare, MSHO and SNBC programs. PrimeWest also performed better than the 75th percentile for the 20-44 Years group in the F&C-MA program. Child and adolescent

access to primary care rates were at or above the 75th percentile for the 12-24 Months and 12-19 Years groups for the F&C-MA program.

- The Health Plan performed well in regard to one aspect of asthma care. PrimeWest performed at or above the 75th percentile for the HEDIS® *Use of Appropriate Medications for People With Asthma* measure for the 19-50 Years group in the F&C-MA program.
- The Health Plan performed well in regard to some aspects of member satisfaction. PrimeWest Health reported CAHPS® rates at or above the 75th percentile for the *Rating of Personal Doctor* measure for the MinnesotaCare, MSC+, MSHO and SNBC programs, for the *Rating of Health Plan* measure for the MinnesotaCare, MSC+ and MSHO programs, for the *Rating of All Health Care* measure for the MSC+, MSHO and SNBC programs and for the *Rating of Specialist Seen Most Often* measure for the MSC+ and MSHO programs.

Opportunities for Improvement

- Although the Health Plan concluded the "*Blood Pressure Control for Members with Diabetes"* PIP, PrimeWest Health demonstrates an opportunity for improvement as the goal was not met for the SNBC population. In addition, PrimeWest Health reported the following SNBC HEDIS® rates below the 75th percentile: *Comprehensive Diabetes Care: HbA1c Testing* (Non-SNP) and *Comprehensive Diabetes Care: LDL-C Screening* (SNP and Non-SNP). There also remains an opportunity for improvement for the F&C-MA program as related HEDIS® rates were below the 75th percentile.
- The Health Plan demonstrates an opportunity for improvement in regard to the Financial Withhold. PrimeWest Health failed to earn full points for the F&C-MA Contract.
- The Health Plan also demonstrates an opportunity for improvement in regard to child and adolescent care. PrimeWest Health performed below the 75th percentile for the following HEDIS® measures: *Adolescent Well-Care Visit* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* for the F&C-MA and MinnesotaCare programs, and *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Childhood Immunization Status: Combo 3* for the F&C-MA program. The Health Plan also reported access rates below the 75th percentile for the 25 Months-6 Years and 7-11 Years groups for the F&C-MA program.
- The Health Plan demonstrates an opportunity for improvement in regard to one area of women's health. PrimeWest Health reported HEDIS® *Chlamydia Screening in Women* rates below the 10th percentile for the F&C-MA and MinnesotaCare programs.
- Other HEDIS® measures demonstrating an opportunity for improvement include: *Adult BMI Assessment* for the F&C-MA and MinnesotaCare programs and *Controlling High Blood Pressure* for the F&C-MA, MinnesotaCare and SNBC Non-SNP programs.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. PrimeWest Health reported CAHPS® rates below the 10th percentile across all programs for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service*. The Health Plan also reported rates below the 75th percentile for the *Getting Care Quickly* and *Shared Decision Making* measures across all

programs, for the *Rating of All Health Care* measure for the F&C-MA and MinnesotaCare programs, for the *Rating of Personal Doctor* measure for the F&C-MA program, for the *Rating of Specialist Seen Most Often* measure for the F&C-MA, MinnesotaCare and SNBC programs and for the *Rating of Health Plan* measure for the F&C-MA and SNBC programs.

Recommendations

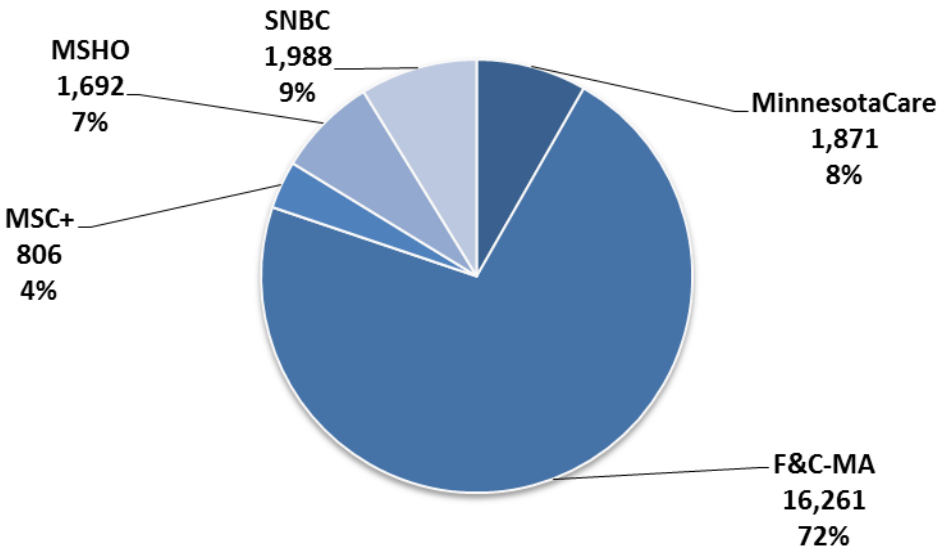
- In regard to the PIP, "*Blood Pressure Control for Members with Diabetes"*, the Health Plan should evaluate the effectiveness of implemented interventions and modify them to meet the specific needs of the SNBC population.
- As this is the second year that the Health Plan lost points under the Financial Withhold for the Emergency Department Rate measure, the Health Plan should evaluate the effectiveness of the current interventions and modify them as needed.
- The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers. As overall improvement is needed in the quality of care for members in the F&C-MA and MinnesotaCare programs, PrimeWest should consider conducting future focused studies aimed at improving care, specifically for its child/adolescent and female populations.
- As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.

South Country Health Alliance (SCHA)

Corporate Profile

South Country Health Alliance (SCHA) is a partnership of eleven (11) Minnesota counties formed in 2001 as a County-Based Purchaser. The MCO participates in the Families & Children Medical Assistance (F&C-MA), MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC) programs in the following counties: Brown, Dodge, Goodhue, Kanabec, Morrison, Sibley, Steele, Todd, Wabasha, Wadena and Waseca. SCHA also administers MSHO, MSC+ and SNBC in Freeborn County. As of December 2013, enrollment totaled 22,618, accounting for 4% of the entire MHCP population.

Figure 9: SCHA Health Enrollment by Program - December 2013



Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent Quality Assurance Exam between April 1, 2013 and April 5, 2013. The examination period covered January 1, 2010 to December 31, 2012, while the file review period covered January 1, 2012 to December 31, 2012. The Health Plan received a total of seven (7) recommendations, five (5) mandatory improvements and one (1) deficiency.

Performance Improvement Projects

The Health Plan concluded the following PIP in 2013:

- *Blood Pressure Control for Members with Diabetes* (2010) – The goal for this PIP was to increase the proportion of members with diabetes whose blood pressure is under control (i.e., less than 130/80 mm Hg), across all three MCOs in the collaborative. *Note: Goal was not achieved for the SNBC population and, therefore, the PIP will continue for this population only.*

The following PIPs have been initiated and are currently in progress:

- *Blood Pressure Control for Members with Diabetes* (2010) – The goal for this PIP is to increase the proportion of SNBC members with diabetes whose blood pressure is under control (i.e., less than 130/80 mm Hg), across all three MCOs in the collaborative.
- *Improvement of Mammogram Screening Through Multiple Reminders* (2011) – The goal of this PIP is to meet the national Medicaid HEDIS® 90th percentile rate.
- *Improvement of Influenza Vaccination* (2011) – The goal for this PIP is to meet the 2010 CMS national 5-Star Rating threshold rate of 80.8%.
- *Colorectal Cancer Screening* (2012) – The goal for this PIP is to increase by a relative 15% the proportion of members who have had a colorectal cancer screening and sustain this improvement for two measurement periods.
- *Human Papillomavirus Vaccination for Males* (2013) – The goal of this PIP is to promote administration of the HPV vaccination to males enrolled in the Minnesota Health Care Programs (MHCP) population for the purpose of preventing the spread of HPV strains.
- *Elimination of Racial and Ethnic Disparities in the Management of Depression* (2015) – The goal of this PIP is to increase the rate of F&C-MA and MinnesotaCare enrollees 18-65 years of age who are newly diagnosed with major depression and treated, remaining on antidepressant medication for at least 180 days, by 4.64% for the first measurement year.
- *Home-Based Medication Reconciliation Post-Hospital Discharge* (2015) – The goal of this PIP is to increase the percentage of target population members having a completed medication reconciliation within 30 days after an acute hospital discharge to home by 6% percent.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO and MSC+ Contracts.
- The MCO earned 50 of 50 points for the SNBC Contract.
- The MCO earned 52.11 of 55 points for the F&C-MA Contract. SCHA lost 2.89 points for failing to achieve an annual 10% reduction in its emergency department utilization.

2014 MCO Transparency and Accountability Report

South Country Health Alliance focused on three quality improvement activities. The Blood Lead Testing Program utilized a multi-faceted approach that included member rewards and P4P program incentives resulting in an overall lead testing rate of 82.83% in 2013 compared to 69.60% in 2008. Sustainability will be achieved as a result of the incorporation of practices both internally and within provider partner practices. The MCO's partnership with public health departments and provider clinics is a strength and IPRO recommends the continuation of these partnerships that have contributed to the increase of blood lead testing rates in Minnesota.

The MCO conducted a satisfaction survey of their SeniorCare Complete and AbilityCare members to determine *Member Satisfaction with Care Coordination Services.* Survey results indicated that 99% of SeniorCare Complete members were satisfied with South Country and 98% were satisfied with the services provided by the Care Coordinators. Additionally, 90% of respondents stated they would comply with services recommended by their Care Coordinator, a slight increase from previous years. Survey results for AbilityCare members exceeded 90% in all areas and 87% of members indicated they would follow recommendations from their Care Coordinator. The favorable outcomes of both surveys are supported by results of the Consumer Assessment of Health Providers and Systems (CAHPS®), where South Country was a top performing plan in Minnesota for member satisfaction. Sustainability will be achieved due to support and commitment of the Quality Assurance Committee to evaluate and improve member satisfaction with services. IPRO recommends the expansion of the member satisfaction survey to include all plan members and continued monitoring and further development of their care coordination training program.

The Provider P4P Program was designed to meet the health care needs of members through enhanced payments to primary care partners for preventive care services and to increase access to care. Performance was determined for key preventive care services, lead testing and Chlamydia screening, and increased access to care by reducing emergency department visits and avoiding unnecessary hospital re-admissions. 2013 results showed that the provider groups met or exceeded 85% of the targets collectively and, in total, over 90% of the dollars allocated to the program were paid to providers. The MCO identified the early and continued success of the Provider P4P program and will ensure its sustainability. The MCO identified the opportunity to incorporate a Health Information Exchange (HIE) initiative into the P4P program that will improve efficiencies for the Health Plan and providers as a positive impact for members. IPRO recommends that South County Health Alliance and

their primary care network actively pursue the integration and expansion of an HIE initiative within the Provider P4P program.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 16 and 17, respectively.

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Table 16: SCHA HEDIS® Performance - 2014

HEDIS® Measures	SCHA HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adolescent Well-Care Visit (12-21 Years)[1]	41.7%	25th	42.2%
Adult BMI Assessment[1]	85.0%	75th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	90.5%	95th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	89.0%	50th	89.4%
Breast Cancer Screening (50-64 Years)[2]	65.6%	75th	61.2%
Cervical Cancer Screening (24-64 Years)[2]	71.5%	NA	71.0%
Childhood Immunization Status: Combo 3 (2 Years)[1]	76.4%	50th	75.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	95.9%	25th	98.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	86.9%	25th	91.0%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	88.2%	25th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	89.8%	25th	91.8%
Chlamydia Screening in Women (16-24 Years)[2]	47.8%	10th	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	91.7%	90th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	82.4%	75th	81.3%
Controlling High Blood Pressure[1]	67.7%	75th	65.2%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	83.9%	10th	90.4%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	SS	-	89.3%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	79.6%	50th	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	SS	-	81.6%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	65.1%	50th	62.5%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	54.6%	<10th	65.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 16: SCHA HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	SCHA HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MinnesotaCare		
Adolescent Well-Care Visit (12-21 Years)[1]	40.0%	10th	40.8%
Adult BMI Assessment[1]	82.8%	50th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	85.8%	50th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	92.5%	90th	91.4%
Breast Cancer Screening (50-64 Years)[2]	63.4%	50th	67.0%
Cervical Cancer Screening (24-64 Years)[2]	65.5%	NA	66.7%
Childhood Immunization Status: Combo 3 (2 Years)[1]	SS	-	69.6%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	SS	-	96.9%
Chlamydia Screening in Women (16-24 Years)[2]	34.0%	<10th	49.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	89.8%	75th	94.6%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	89.8%	95th	88.6%
Controlling High Blood Pressure[1]	67.2%	75th	70.5%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	SS	-	97.3%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	SS	-	88.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	SS	-	85.5%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	SS	-	80.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	SS	-	66.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	61.5%	10th	65.7%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 16: SCHA HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	SCHA HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	NR	-	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	98.4%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	61.8%	50th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	93.9%	95th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	82.8%	75th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	91.3%	75th	93.1%
Breast Cancer Screening (65-74 Years)[2]	47.6%	10th	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	88.3%	75th	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	77.5%	50th	70.5%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NR: Not required for MSHO.

Table 16: SCHA HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	SCHA HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	SNBC		
Adult BMI Assessment[1] *(SNP)*	91.2%	90th	92.2%
Adult BMI Assessment[1] *(Non-SNP)*	83.1%	50th	86.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	95.1%	95th	93.2%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	96.0%	95th	96.2%
Breast Cancer Screening (50-64 Years)[2]	79.4%	95th	59.1%
Cervical Cancer Screening (24-64 Years)[2]	52.9%	NA	50.3%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(SNP)*	93.6%	90th	91.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(Non-SNP)*	93.9%	95th	90.5%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(SNP)*	90.7%	95th	84.9%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(Non-SNP)*	86.2%	90th	82.2%
Controlling High Blood Pressure[1] *(SNP)*	72.6%	90th	70.4%
Controlling High Blood Pressure[1] *(Non-SNP)*	75.2%	95th	67.9%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
NA: Not available.

Table 17: SCHA CAHPS® Performance - 2014

CAHPS® Measures	SCHA CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	46%	<10th	50%
Getting Care Quickly[1]	58%	<10th	55%
How Well Doctors Communicate[1]	79%	<10th	77%
Customer Service[1]	61%	<10th	65%
Shared Decision Making[1]	52%	50th	52%
Rating of All Health Care[2]	45%	10th	48%
Rating of Personal Doctor[2]	73%	95th	67%
Rating of Specialist Seen Most Often[2]	61%	10th	61%
Rating of Health Plan[2]	51%	10th	56%
	MinnesotaCare		
Getting Needed Care[1]	59%	<10th	56%
Getting Care Quickly[1]	65%	<10th	61%
How Well Doctors Communicate[1]	85%	<10th	80%
Customer Service[1]	58%	<10th	63%
Shared Decision Making[1]	55%	90th	50%
Rating of All Health Care[2]	50%	25th	51%
Rating of Personal Doctor[2]	74%	95th	70%
Rating of Specialist Seen Most Often[2]	62%	25th	63%
Rating of Health Plan[2]	52%	25th	58%
	MSC+		
Getting Needed Care[1]	65%	<10th	60%
Getting Care Quickly[1]	69%	<10th	61%
How Well Doctors Communicate[1]	77%	<10th	76%
Customer Service[1]	71%	<10th	63%
Shared Decision Making[1]	42%	<10th	48%
Rating of All Health Care[2]	63%	95th	60%
Rating of Personal Doctor[2]	76%	95th	75%
Rating of Specialist Seen Most Often[2]	71%	90th	72%
Rating of Health Plan[2]	69%	95th	66%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Table 17: SCHA CAHPS® Performance - 2014 (Continued)

CAHPS® Measures	SCHA CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Getting Needed Care[1]	66%	<10th	61%
Getting Care Quickly[1]	72%	<10th	69%
How Well Doctors Communicate[1]	80%	<10th	76%
Customer Service[1]	76%	<10th	69%
Shared Decision Making[1]	51%	50th	49%
Rating of All Health Care[2]	65%	95th	62%
Rating of Personal Doctor[2]	76%	95th	75%
Rating of Specialist Seen Most Often[2]	74%	95th	72%
Rating of Health Plan[2]	73%	95th	72%
	SNBC		
Getting Needed Care[1]	56%	<10th	57%
Getting Care Quickly[1]	66%	<10th	61%
How Well Doctors Communicate[1]	73%	<10th	75%
Customer Service[1]	75%	<10th	68%
Shared Decision Making[1]	55%	90th	52%
Rating of All Health Care[2]	51%	25th	52%
Rating of Personal Doctor[2]	67%	75th	70%
Rating of Specialist Seen Most Often[2]	70%	75th	65%
Rating of Health Plan[2]	63%	75th	59%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- The Health Plan concluded one (1) PIP in 2013, demonstrating continued improvement in the area of diabetes care for the F&C-MA, MSC+ and MSHO populations. In addition, SCHA reported diabetes-related HEDIS® rates at or above the 75th percentile across all programs.
- In regard to the Financial Withhold, the Health Plan earned all possible points for the MSHO, MSC+ and SNBC Contracts.
- The Health Plan reported adult access to primary care rates for all age groups at or above the 75th percentile for the MSHO and SNBC programs. SCHA also reported rates above the 75th percentile for the 20-44 Years group in the F&C-MA program and for the 45-64 Years group in the MinnesotaCare program.

- The Health Plan performed at or above the 75th percentile for the following HEDIS® measures: *Controlling High Blood Pressure* for all programs and *Adult BMI Assessment* for the F&C-MA and SNBC SNP programs.
- The Health Plan performed well in regard to some aspects of member satisfaction. SCHA reported rates at or above the 75th percentile for the following CAHPS® measures: *Rating of Personal Doctor* across all programs, *Shared Decision Making* for the MinnesotaCare and SNBC programs, *Rating of All Health Care* for the MSC+ and MSHO programs, *Rating of Specialist Seen Most Often* and *Rating of Health Plan* for the MSC+, MSHO and SNBC programs.

Opportunities for Improvement

- The Health Plan demonstrates an opportunity for improvement in regard to the Financial Withhold. SCHA failed to earn full points for the F&C-MA Contract.
- The Health Plan demonstrates an opportunity for improvement in regard to child and adolescent care. SCHA reported rates below the 75th percentile for the HEDIS® *Adolescent Well-Care Visit* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* measures for the F&C-MA and MinnesotaCare programs, and *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Childhood Immunization Status: Combo 3* measures for the F&C-MA program. In addition, SCHA performed below the 75th percentile for the HEDIS® *Children and Adolescents' Access to PCPs* measure for all age groups in the F&C-MA program.
- The Health Plan demonstrates an opportunity for improvement in regard to women's health. SCHA performed below the 75th percentile for the HEDIS® *Chlamydia Screening in Women* measure for the F&C-MA and MinnesotaCare programs and for the *Breast Cancer Screening* measure for the MinnesotaCare and MSHO programs.
- The Health Plan demonstrates an opportunity for improvement in regard to asthma care as it performed below the 75th percentile for the HEDIS® *Use of Appropriate Medications for People With Asthma* measure for the 5-11 Years and 19-50 Years groups in the F&C-MA program.
- Other HEDIS® measures demonstrating opportunities for improvement include: *Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)* for the F&C-MA program, *Adult BMI Assessment* for the MinnesotaCare and SNBC Non-SNP programs.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. SCHA reported CAHPS® rates below the 10th percentile across all programs for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service*. The Health Plan also reported rates below the 75th percentile for the *Shared Decision Making* measure for the F&C-MA, MSC+ and MSHO programs, for the *Rating of All Health Care* measure for the F&C-MA, MinnesotaCare and SNBC programs, and for the *Rating of Specialist Seen Most Often* and *Rating of Health Plan* measures for the F&C-MA and MinnesotaCare programs.

Recommendations

- In regard to the PIP, "*Blood Pressure Control for Members with Diabetes*", the Health Plan should evaluate the effectiveness of implemented interventions and modify them to meet the specific needs of the SNBC population.
- As this is the second year that the Health Plan lost points under the Financial Withhold for the Emergency Department Rate measure, the Health Plan should evaluate the effectiveness of the current interventions and modify them as needed.
- The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers. As overall improvement is needed in the quality of care for members in the F&C-MA and MinnesotaCare programs, SCHA should consider conducting future clinical studies aimed at improving care, specifically for its child/adolescent and female populations.
- As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.

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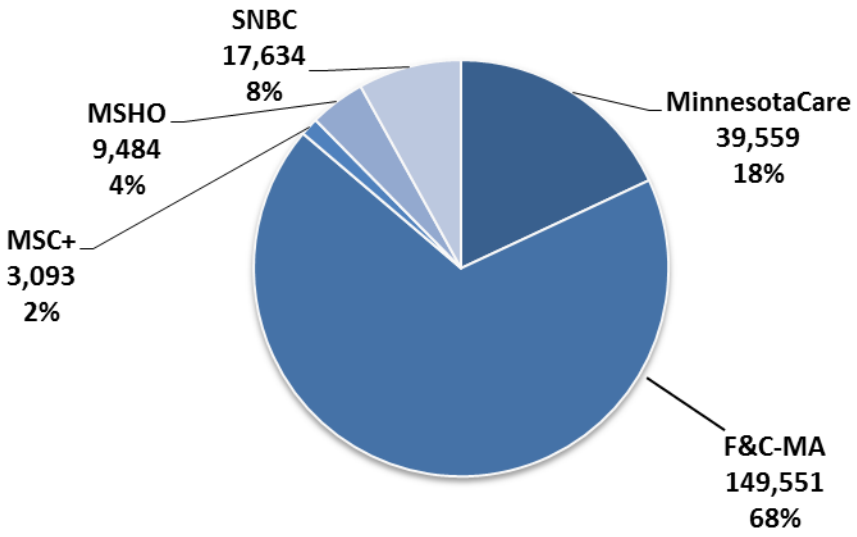
UCare

Corporate Profile

UCare is an independent, nonprofit MCO founded in 1984 by the Department of Family Practice at the University of Minnesota Medical School. UCare serves enrollees in the F&C-MA, MinnesotaCare, MSHO, MSC+ and SNBC programs in all counties except Beltrami, Hubbard, Itasca, Lake of Woods, Mahnomen and Wilkin. As of December 2013, enrollment totaled 219,321, accounting for 35% of the entire MHCP population.

Figure 10: UCare Health Enrollment by Program - December 2013



Quality Assurance Examination and Triennial Compliance Assessment

The Minnesota Department of Health conducted the most recent compliance audit between September 9, 2013 and September 13, 2013. The examination period covered January 1, 2011 to June 30, 2013, while the file review period covered July 1, 2012 to June 30, 2013. The Health Plan received a total of four (4) recommendations, three (3) mandatory improvements and three (3) deficiencies on the Quality Assurance Examination and zero (0) "Not Mets" for the Triennial Compliance Assessment.

Performance Improvement Projects

The Health Plan concluded the following PIP in 2013:

- *Blood Pressure Control for Members with Diabetes* (2010) - The overall PIP goal was to increase the proportion of members with diabetes who have blood pressure under control as measured by the HEDIS® *Comprehensive Diabetes Care* (140/90 blood pressure adults 18-75 years) measure. Although the project goal was met for the F&C-MA/MinnesotaCare and MSHO/MSC+ populations, it was not met for the SNBC population.

The following PIPs have been initiated and are currently in progress:

- *Colorectal Cancer Screening* (2011) – The goal of this PIP is to increase the colorectal cancer screening rate in the study population in targeted clinics through clinic-specific interventions.
- *Breast Cancer Screening* (2012) – The goal of this PIP is to increase the rate of breast cancer screening by mammography in the study population through multimodal, targeted interventions.
- *Reducing Non-Urgent Emergency Department Use in the F&C-MA/MinnesotaCare Populations: A Partnership with the Minnesota Head Start Association* (2012) – The goal of this PIP is to decrease non-urgent ED use among F&C-MA and MinnesotaCare members ages 0-5 years who receive the health literacy intervention delivered by Minnesota Head Start and Early Head Start program staff when compared to a non-intervention comparison group.
- *Chlamydia Screening in Women* (2013) – The goal of this PIP is to increase Chlamydia screening in women as measured by the HEDIS® *Chlamydia Screening in Women (16-24 Years)* among F&C-MA and MinnesotaCare members through multimodal, targeted interventions.
- *Improving Transitions Post-Hospitalization in the Special Needs Basic Care Population* (2013) – The goal of this PIP is to reduce hospital readmissions by improving member support for the transition from hospital to home or another health care setting for SNBC members as measured by the HEDIS® *Plan All-cause Readmissions* measure.
- *Elimination of Race and Ethnic Disparities in the Management of Depression* (2015) – The goal of this PIP is to increase antidepressant medication adherence of the non-White population in the F&C-MA and MinnesotaCare programs by six (6) percentage points after three years.
- *Follow-Up After Hospitalization Rates* (2015) – The goal of this PIP is to increase follow-up after hospitalization for the SNBC population by seven (7) percentage points for 7 days and six (6) percentage points for 30 days after three years.

2013 Financial Withhold

- The MCO earned 60 of 60 points for the MSHO and MSC+ Contracts.
- The MCO earned 50 of 50 points for the SNBC Contract.
- The MCO earned 46.6 of 55 points for the F&C-MA Contract. UCare lost 3.4 points for failing to achieve an annual 10% reduction in its emergency department utilization and lost 5.0 points for failing to achieve an annual 5% reduction in its 30-day hospital readmission percentage.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 18 and 19, respectively.

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Table 18: UCare HEDIS® Performance - 2014

HEDIS® Measures	UCare HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Adolescent Well-Care Visit (12-21 Years)[1]	37.7%	10th	42.2%
Adult BMI Assessment[1]	85.4%	75th	88.2%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	89.8%	95th	89.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	90.3%	50th	89.4%
Breast Cancer Screening (50-74 Years)[2]	62.3%	50th	61.2%
Cervical Cancer Screening (24-64 Years)[2]	71.4%	NA	71.0%
Childhood Immunization Status: Combo 3 (2 Years)[1]	70.8%	25th	75.7%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	97.9%	75th	98.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years)[2]	91.7%	75th	91.0%
Children and Adolescents' Access to PCPs (7-11 Years)[2]	92.7%	50th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years)[2]	91.1%	50th	91.8%
Chlamydia Screening in Women (16-24 Years)[2]	61.7%	50th	58.6%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	88.7%	75th	90.7%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	80.8%	75th	81.3%
Controlling High Blood Pressure[1]	62.5%	50th	65.2%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	89.1%	25th	90.4%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	87.6%	50th	89.3%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	80.6%	75th	79.0%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	86.0%	95th	81.6%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	61.8%	25th	62.5%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	67.8%	25th	65.6%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NA: Not available.

Table 18: UCare HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	UCare HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MinnesotaCare		
Adolescent Well-Care Visit (12-21 Years)[1]	40.9%	10th	40.8%
Adult BMI Assessment[1]	86.6%	75th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) [2]	86.8%	75th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) [2]	91.6%	75th	91.4%
Breast Cancer Screening (50-64 Years) [2]	70.3%	75th	67.0%
Cervical Cancer Screening (24-64 Years) [2]	67.3%	NA	66.7%
Childhood Immunization Status: Combo 3 (2 Years) [1]	63.4%	10th	69.6%
Children and Adolescents' Access to PCPs (12-24 Months)[2]	97.6%	50th	96.9%
Chlamydia Screening in Women (16-24 Years)[2]	52.1%	25th	49.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1]	94.5%	95th	94.6%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1]	89.2%	95th	88.6%
Controlling High Blood Pressure[1]	71.5%	90th	70.5%
Use of Appropriate Medications for People With Asthma (5-11 Years)[2]	95.7%	90th	97.3%
Use of Appropriate Medications for People With Asthma (12-18 Years)[2]	80.3%	90th	88.2%
Use of Appropriate Medications for People With Asthma (19-50 Years)[2]	89.5%	95th	85.5%
Use of Appropriate Medications for People With Asthma (51-64 Years)[2]	83.0%	90th	80.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits)[2]	66.3%	50th	66.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life[2]	68.1%	25th	65.7%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NA: Not available.

Table 18: UCare HEDIS® Performance - 2014 (Continued)

HEDIS® Measures	UCare HEDIS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Adult BMI Assessment[1]	NR	-	86.8%
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	98.1%	95th	98.1%
Breast Cancer Screening (65-74 Years)[2]	58.7%	50th	59.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[1]	94.2%	95th	94.0%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[1]	89.5%	95th	86.3%
	MSC+		
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)[2]	95.5%	95th	93.1%
Breast Cancer Screening (65-74 Years)[2]	45.1%	<10th	43.8%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years)[2]	87.0%	50th	81.7%
Comprehensive Diabetes Care: LDL-C Screening (65-75 Years)[2]	79.4%	50th	70.5%
	SNBC		
Adult BMI Assessment[1] *(Non-SNP)*	84.7%	50th	86.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)[2]	92.6%	95th	93.2%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)[2]	96.1%	95th	96.2%
Breast Cancer Screening (50-64 Years)[2]	61.1%	50th	59.1%
Cervical Cancer Screening (24-64 Years)[2]	53.4%	NA	50.3%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years)[1] *(Non-SNP)*	89.4%	75th	90.5%
Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)[1] *(Non-SNP)*	82.9%	75th	82.2%
Controlling High Blood Pressure[1] *(Non-SNP)*	62.5%	50th	67.9%

1. Rate calculated by the MCO using the hybrid methodology.
2. Rate calculated by DHS using the administrative methodology.

NR: Not required for MSHO.
NA: Not available.

Table 19: UCare CAHPS® Performance - 2014

CAHPS® Measures	UCare CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	F&C-MA		
Getting Needed Care[1]	40%	<10th	50%
Getting Care Quickly[1]	51%	<10th	55%
How Well Doctors Communicate[1]	77%	<10th	77%
Customer Service[1]	58%	<10th	65%
Shared Decision Making[1]	52%	50th	52%
Rating of All Health Care[2]	48%	25th	48%
Rating of Personal Doctor[2]	68%	75th	67%
Rating of Specialist Seen Most Often[2]	58%	<10th	61%
Rating of Health Plan[2]	57%	25th	56%
	MinnesotaCare		
Getting Needed Care[1]	55%	<10th	56%
Getting Care Quickly[1]	62%	<10th	61%
How Well Doctors Communicate[1]	78%	<10th	80%
Customer Service[1]	54%	<10th	63%
Shared Decision Making[1]	50%	25th	50%
Rating of All Health Care[2]	47%	10th	51%
Rating of Personal Doctor[2]	68%	75th	70%
Rating of Specialist Seen Most Often[2]	59%	10th	63%
Rating of Health Plan[2]	56%	25th	58%
	MSC+		
Getting Needed Care[1]	51%	<10th	60%
Getting Care Quickly[1]	53%	<10th	61%
How Well Doctors Communicate[1]	70%	<10th	76%
Customer Service[1]	51%	<10th	63%
Shared Decision Making[1]	52%	50th	48%
Rating of All Health Care[2]	55%	75th	60%
Rating of Personal Doctor[2]	72%	95th	75%
Rating of Specialist Seen Most Often[2]	71%	90th	72%
Rating of Health Plan[2]	59%	50th	66%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Table 19: UCare CAHPS® Performance - 2014 (Continued)

CAHPS® Measures	UCare CAHPS® 2014	*Quality Compass® 2014* National Medicaid Benchmark Met/Exceeded	2014 Statewide Average
	MSHO		
Getting Needed Care[1]	52%	<10th	61%
Getting Care Quickly[1]	64%	<10th	69%
How Well Doctors Communicate[1]	76%	<10th	76%
Customer Service[1]	66%	<10th	69%
Shared Decision Making[1]	53%	50th	49%
Rating of All Health Care[2]	63%	95th	62%
Rating of Personal Doctor[2]	79%	95th	75%
Rating of Specialist Seen Most Often[2]	69%	75th	72%
Rating of Health Plan[2]	73%	95th	72%
	SNBC		
Getting Needed Care[1]	60%	<10th	57%
Getting Care Quickly[1]	60%	<10th	61%
How Well Doctors Communicate[1]	77%	<10th	75%
Customer Service[1]	61%	<10th	68%
Shared Decision Making[1]	49%	25th	52%
Rating of All Health Care[2]	54%	75th	52%
Rating of Personal Doctor[2]	73%	95th	70%
Rating of Specialist Seen Most Often[2]	64%	25th	65%
Rating of Health Plan[2]	56%	25th	59%

1. Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.
2. Scores of 9 and 10 were considered achievements.

Strengths

- The Health Plan concluded one (1) PIP in 2013, demonstrating continued improvement in the area of diabetes care for the F&C-MA, MinnesotaCare, MSC+ and MSHO populations. In addition, UCare reported diabetes-related HEDIS® rates at or above the 75th percentile for the F&C-MA, MinnesotaCare, MSHO and SNBC programs.
- In regard to the Financial Withhold, the Health Plan earned all possible points for the MSHO, MSC+ and SNBC Contracts.
- The Health Plan reported adult access to primary care rates at or above the 75th percentile for all age groups in the MinnesotaCare, MSHO and SNBC programs. UCare also performed above the 75th percentile for the 20-44 Years group in the F&C-MA program.
- The Health Plan also reported rates at or above the 75th percentile for the HEDIS® *Adult BMI Assessment* measure for the F&C-MA and MinnesotaCare programs and for the *Controlling High Blood Pressure* measure for the MinnesotaCare program.

- The Health Plan demonstrated strong performance in regard to asthma care. UCare reported rates above the 75th percentile for the HEDIS® *Use of Appropriate Medications for People With Asthma* measure for all age groups in the MinnesotaCare program. The Health Plan also reported at or above the 75th percentile for the 19-50 Years and 51-64 Years groups in the F&C-MA program.
- The Health Plan reported child and adolescent access to primary care rates at or above the 75th percentile for the 12-24 Months and 25 Months-6 Years groups in the F&C-MA program.
- The Health Plan performed well in regard to some aspects of member satisfaction. UCare reported rates at or above the 75th percentile for the following CAHPS® measures: *Rating of Personal Doctor* across all programs, *Rating of All Health Care* for the MSC+, MSHO and SNBC programs, *Rating of Specialist Seen Most Often* for the MSC+ and MSHO programs and *Rating of Health Plan* for the MSHO program.

Opportunities for Improvement

- Although the Health Plan concluded the "*Blood Pressure Control for Members with Diabetes"* PIP and reported diabetes-related HEDIS® rates were at or above the 75th percentile, UCare demonstrates an opportunity for improvement as the PIP goal was not met for the SNBC population.
- The Health Plan demonstrates an opportunity for improvement in regard to the Financial Withhold. UCare failed to earn full points for the F&C-MA Contract.
- The Health Plan demonstrates an opportunity for improvement in regard to child and adolescent care. UCare reported rates below the 75th percentile for the HEDIS® *Adolescent Well-Care Visit*, *Well-Child Visits in the First 15 Months of Life (6+ Visits)*, *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* and *Childhood Immunization Status: Combo* 3 measures for the F&C-MA and MinnesotaCare programs. The Health Plan also reported child and adolescent access to primary care rates below the 75th percentile for the 7-11 Years and 12-19 Years groups in the F&C-MA program and the 12-24 Months group in the MinnesotaCare program.
- The Health Plan demonstrates an opportunity for improvement in regard women's health. UCare reported rates below the 75th percentile for the HEDIS® *Chlamydia Screening in Women* measure for the F&C-MA and MinnesotaCare programs, and for the HEDIS® *Breast Cancer Screening* measure for the F&C-MA, MSHO and SNBC programs.
- Other HEDIS® measures demonstrating an opportunity for improvement include: *Controlling High Blood Pressure* for the F&C-MA and SNBC Non-SNP programs, *Adult BMI Assessment* for the SNBC Non-SNP program, *Use of Appropriate Medications for People with Asthma* for the 5-11 Years and 12-18 Years groups in the F&C-MA program and *Adults' Access to Preventive/Ambulatory Health Services* for the 45-64 Years group in the F&C-MA program.
- The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction. UCare reported CAHPS® rates below the 10th percentile across all programs for the following measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate* and *Customer Service*. The Health Plan also reported rates below the 75th percentile for the

Shared Decision Making measure across all programs, for the *Rating of All Health Care* measure for the F&C-MA and MinnesotaCare programs, for the *Rating of Specialist Seen Most Often measure* for the F&C-MA, MinnesotaCare and SNBC programs, and for the *Rating of Health Plan* measure for the F&C-MA, MinnesotaCare, MSC+ and SNBC programs.

Recommendations

- As this is the second year that the Health Plan lost points under the Financial Withhold for the Emergency Department Rate measure and the 30 Day Readmission Rate measure, the Health Plan should evaluate the effectiveness of the current interventions and modify them as needed.
- The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers. As overall improvement is needed in the quality of care for members in the F&C-MA and MinnesotaCare programs, UCare should consider conducting future focused studies aimed at improving care, specifically for its child/adolescent and female populations.
- As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.

C. Common Strengths and Opportunities Across MHCP

Annually, the DHS evaluates statewide performance using the HEDIS® administrative methodology for select measures. DHS also contracts with a certified-CAHPS® vendor to annually assess statewide member satisfaction. To determine common strengths and opportunities for improvement across all MCOs participating in the MHCP, IPRO compared these statewide averages to the national Medicaid benchmarks presented in the *Quality Compass®* 2014. Measures performing at or above the 75th percentile were considered strengths, measures performing at the 50th percentile were considered to be average and measures performing below the 50th percentile were identified as opportunities for improvement. Common strengths and opportunities for improvement are discussed below. Statewide HEDIS® and CAHPS® performance, as well as IPRO's assessment, are displayed in Tables 20 and 21, respectively.

MHCP Common Strengths and Opportunities for Improvement

Common strengths among all MCOs participating in the MHCP include access to primary care for adults and certain child/adolescent groups, certain age groups for asthma-related care and member satisfaction with personal doctor. MHCP rates for the following HEDIS® and CAHPS® measures met or exceeded the 75th percentile:

- Adults' Access to Preventive/Ambulatory Health Services (all ages)
- Children and Adolescents' Access to Primary Care Practitioners (12-24 Months and 12-19 Years)
- Comprehensive Diabetes Care: HbA1c Testing (18-75 Years)
- Use of Appropriate Medications for People With Asthma (19-50 and 51-64 Years)
- Rating of Personal Doctor

Common opportunities for improvement include child/adolescent care and member satisfaction with accessing care, provider communication and MCO customer service. MCHP rates for the following HEDIS® and CAHPS® measures were below the 50th percentile:

- Adolescent Well-Care Visit (12-21 Years)
- Childhood Immunization Status: Combo 3 (2 Years)
- Well-Child Visits in the First 15 Months of Life (6+ Visits)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (3-6 Years)
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service

Table 20: MHCP HEDIS® Performance - 2014

HEDIS® Measures	MHCP HEDIS® 2014[1]	Performance Assessment based on *Quality Compass® 2014* National Medicaid Benchmarks
Adolescent Well-Care Visit (12-21 Years)	35.0%	Opportunity
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	89.3%	Strength
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	92.1%	Strength
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	96.9%	Strength
Breast Cancer Screening (50-74 Years)	59.8%	Average
Cervical Cancer Screening (24-64 Years)[2]	66.1%	
Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	98.0%	Strength
Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	91.0%	Average
Children and Adolescents' Access to Primary Care Practitioners (7-11 Years)	92.5%	Average
Children and Adolescents' Access to Primary Care Practitioners (12-19 Years)	92.3%	Strength
Childhood Immunization Status: Combo 3 (2 Years)	66.3%	Opportunity
Chlamydia Screening in Women (16-24 Years)	55.6%	Average
Comprehensive Diabetes Care: HbA1c Testing (18-75 Years)	87.5%	Strength
Comprehensive Diabetes Care: LDL-C Screening (18-75 Years)	77.2%	Average
Use of Appropriate Medications for People With Asthma (5-11 Years)	91.8%	Average
Use of Appropriate Medications for People With Asthma (12-18 Years)	89.0%	Average
Use of Appropriate Medications for People With Asthma (19-50 Years)	80.8%	Strength
Use of Appropriate Medications for People With Asthma (51-64 Years)	80.7%	Strength
Well Child Visits in the First 15 Months of Life (6+ Visits)	62.8%	Opportunity
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (3-6 Years)	65.6%	Opportunity

1. Rates calculated by DHS using the administrative methodology.
2. Benchmarks were not available due to specification changes.

Table 21: MHCP CAHPS® Performance - 2014

CAHPS® Measures	MHCP CAHPS® 2014	Performance Assessment based on *Quality Compass® 2014* National Medicaid Benchmarks
Getting Needed Care[1]	56%	Opportunity
Getting Care Quickly[1]	60%	Opportunity
How Well Doctors Communicate[1]	76%	Opportunity
Customer Service[1]	66%	Opportunity
Shared Decision Making[1]	51%	Average
Rating of All Health Care[2]	53%	Average
Rating of Personal Doctor[2]	70%	Strength
Rating of Specialist Seen Most Often[2]	66%	Average
Rating of Health Plan[2]	60%	Average

[1] Represents a domain. Each domain consists of a collection of survey items that together represent a unique area of member experience.

[2] Scores of 9 and 10 were considered achievements.

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D. EQRO Technical Assistance Statement

IPRO's contract with DHS includes the provision of technical assistance to the MCOs. In its role as EQRO, IPRO provides technical assistance to MCOs on a variety of issues connected to quality performance data collection and validation. The technical assistance IPRO provides is instructional, consultative and/or evaluative in nature and may be delivered informally or formally, one-on-one by phone or email, in group sessions, or via webinar or teleconference.

During this contract period, all MCOs were contacted by IPRO to schedule an introductory one-on-one conference call with IPRO for the purposes of introducing key staff and identifying areas in which the MCOs thought IPRO could provide them with technical assistance. One-on-one calls were held with the Health Plans between June 2014 and July 2014. Discussion topics included Performance Improvement Projects, HEDIS®, CAHPS®, the Annual Technical Report, practice guidelines, special needs populations and disparities in care. Using theses discussion topics, IPRO will work with the DHS and the MCOs to continue to provide technical assistance activities during the next contract period.

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Chapter 4: Follow-Up to 2012 ATR Recommendations

As in the past and in accordance with the BBA, Section 42 CFR §438.364(a)(5), MPRO requested the MCO to describe how they plan to or have addressed the EQR recommendations. This chapter presents the previous EQRO's 2012 improvement recommendations including a discussion on how effectively each MCO addressed the recommendations. Subsection A presents verbatim responses from each MCO, while Subsection B presents the EQRO's response to the MCOs' follow-up.

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A. MCO Follow-Up to 2012 ATR Recommendations

Blue Plus

- ***2012 Recommendation:*** Determine strategies to improve performance in the nine areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

  MCO Response: Blue Plus convened a leadership level Member Satisfaction Workgroup to improve CAHPS® results. The Workgroup met in the fall of 2013 to analyze member grievances, appeals data and CAHPS® results using root cause analysis and trend data. The group developed key strategies to lower grievances and appeals rates and increase CAHPS® scores in weak areas. The Member Satisfaction Committee, met in late November 2013 to prioritize the improvement opportunities, assign resources and develop implementation plans. Action plans were developed and implemented to address the CAHPS® weaknesses of How Well Doctors Communicate, Getting Care When Needed, Health Plan Customer Service, and Getting Care Quickly. The following is a list of current interventions:

  a) Articles for providers focused on health literacy best practices to improve communication in the Blue Cross Provider Press
  b) Added CG-CAHPS® measure in the 2014 Aligned Incentives Contracts
  c) Continued on-going monitoring, coaching and training of customer service staff to improve courtesy and respect. Leveraged improvements made in 2013 to update the assessment process, increase number of assessments and coaching time. Further improve the process with assessments from audit specialists rather than the direct supervisor. Monitoring includes both call assessments and first call's resolution results.
  d) Redesigned the member portal
  e) Improved customer-focused web content to: reduce jargon, lower material's grade level and improve usability
  f) Partnered with Marketing on strategy to increase member education through website as a way to build understanding and increase the likelihood of member experience of visit with physician/specialist meeting expectations of that visit
  g) Developed and launched onboarding kit with BluePrint pilot and measure of benefits throughout year
  h) Performed further root cause analysis on complaints and why rate may have increased for SecureBlue and Platinum Blue

  Blue Plus has formed a HEDIS® Improvement Strategy Committee to evaluate and improve HEDIS® clinical measures. A key focus for this group is the preventive measures for the F&C-MA and MNCare populations, including preventive visits, immunizations and screenings. Blue Cross and Blue Shield's executive leadership team approved initiatives recommended for the Blue Plus population, including the implementation of provider and member incentive programs in 2014 specifically for Well Child

Visits and Immunizations, which were identified as a weakness' in the 2012 ATR report. The health plan has also identified a company goal to increase Preventive Care Visits as a key initiative for all populations served. In addition, Blue Plus has continued collaborative work to increase the Chlamydia screening rate. Blue Plus will continue the interventions that were planned in 2014 for the Chlamydia performance improvement project. The group continues to update and provide resources to providers.

- ***2012 Recommendation:*** Continue careful analysis of PIP progress making mid-course adjustments as necessary. Collaborative efforts provide opportunities for collective learning and the MCO should seek opportunities to identify and promote spread of best practices. Strengthen areas of weakness through mentoring and sharing of lessons learned.

  MCO Response: Our PIPs are collaborative with other health plans. The collaborative process allows for us to continually evaluate our interventions with other plans, identify our weakness and share lessons learned. Changes in the DHS contract allowed health plans to discontinue several PIPs to focus efforts on key initiatives for Reducing Readmissions and improving Antidepressant Management for our Medicaid and Medicare members. Blue Plus will continue to work collaboratively with other health plans to forward this work in 2014 and beyond.

  Blue Plus identified the value in continuing the collaborative projects for Chlamydia Screening for our Medicaid members and Reduction of Use of High Risk Medications for our Senior population. The health plan collaborative influences and promotes best practice throughout the state of Minnesota.

  The PIP titled "Increasing Use of Spirometry Testing for the Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) in the MSHO/MSC+ Populations" met its HEDIS® improvement goal. This project will not be continuing in 2014; however we will monitor the HEDIS® rate.

- ***2012 Recommendation:*** Ascertain causes and strategically identify and implement interventions to address the loss of withhold points in the areas of lead screening, ED utilization, and 30-day readmissions. Consider working collaboratively with other MCOs to identify common barriers, best practices, or other successful strategies.

  MCO Response: Analysis of the causes for missed points in the withholds for Lead Screening, ED Utilization, and 30 day Readmissions indicated that efforts toward improving rates to date needed to be strengthened.

In 2013, the Reducing Non-Urgent Emergency Department Use Performance Improvement Project completed its first year of interventions. This collaborative PIP was designed to reduce ED Utilization by increasing parent knowledge on appropriate utilization of services in the care of infants and young children. The collaborative has continued interventions with Head Start and has seen some positive effects on the target population. Blue Plus will monitor and continue to evaluate the ED Utilization rate and promote hospital efforts to improve utilization.

Blue Plus recently added the All Cause Readmissions measure to the two new ICSP contracts that will start in 2014. A workgroup was developed to identify key measures applicable to our Medicaid and Medicare population. All Cause Readmissions was identified as one of the measures that could be used to focus on and possibly incent additional providers that we contract with.

Blue Plus started interventions for the 2013 CMS required quality improvement project to reduce readmissions for our MSHO and MSC+ members. The main intervention has been to revise the Care Coordinators transitions of care log. Revisions were done to guide the Care Coordinators to help members understand what to do, when they are moving from the hospital to home or other transitions. The collaborative has also started working with local hospitals to improve communication and coordination between hospital staff (e.g., discharge planners) and health plan care coordinators. The CMS required Quality Improvement Project for our Medicare population started in 2014. First quarter member interventions are currently in progress.

The Aligned Incentive Program has included the reducing potentially preventable readmissions measure. This measure is similar to the All Cause Readmission measure. There has been a stronger emphasis on providers to focus on reducing potentially preventable readmissions in 2014.

Activities to improve Lead Screening did not occur in 2013. This is due to changes in the screening recommendations as well as changes outlined in the DHS contract.

- ***2012 Recommendation:*** Perform an in-depth analysis of the four measures demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

MCO Response: As stated above, Blue Plus has an improvement initiative to evaluate and improve HEDIS® clinical measures. The initiative includes performing in-depth analysis and looking at 3-year trend data. A key focus for this group is the preventive measures for the F&C-MA and MNCare populations, including preventive visits, immunizations and screenings. The team has identified top priorities for improvement and has analyzed barriers to success. Work is on-going to identify and implement improvement programs to address gaps. In 2014 member and provider incentives will be implemented to improve preventive visit rates; Chlamydia screening PIP will continue to improve provider and member awareness of this important service; well child and childhood and adolescent

immunizations will be part of the incentive efforts. Quality and Government Programs have joined an external group (Southern Prairie Community Care) to work together on the barriers and interventions related to childhood and adolescent screenings.

- ***2012 Recommendation:*** Determine strategies to improve performance in the nine areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

MCO Response:

Member Satisfaction Results – CAHPS®

HealthPartners is committed to evaluating and acting upon the results of the CAHPS® survey. Each year our Market Research department presents the results to a large, multi-disciplinary group. This is an important part of our review process that facilitates a thorough review of the results, a discussion of identified trends and a plan for next steps.

We have developed a number of initiatives to address the causes for attaining CAHPS® ratings less than the average in Health Plan Customer Service, Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate. We have several work groups and multi-year initiatives in place to improve member experience.

There are a number of factors affecting these CAHPS® performance measures. HealthPartners offers a value-based provider network to achieve high quality outcomes and member-centered care. Our demographic also varies from our competitors in that we are primarily metro-based whereas most health plans have a statewide service area. In addition, our plan demographic includes one of the highest percentages of non-English speaking members and we continue to address our opportunities to meet diverse member and patient expectations.

Ongoing and multi-year HealthPartners CAHPS® strategies include:

- Member Service Representatives deliver health-related messages through our Person Centered System (PCS) visible on our HealthPartners Customer Service System (HCSS). When a representative receives a member call, HCSS displays active messages that can be delivered to members. The purpose of these messages is to help notify or remind members of opportunities to improve their health or safety, and provides an opportunity for Member Services to help schedule any needed appointments. We also have a PCS campaign in place to encourage preventive visits.

- Member Services Representatives complete new member welcome calls to confirm members know how to access services, confirm receipt of materials, and answer questions.

- Member Services Representatives send hand written notes in follow up to inquiries from members. This attention to detail and personal follow up with members demonstrates HealthPartners ongoing commitment in providing an exceptional member experience.
    - We have a variety of initiatives in place to improve access and quality. This includes our HealthPartners Interpreter Services Work Group. The group provides enterprise-wide leadership regarding the provision of spoken and American Sign Language services for limited English proficient, deaf and hard-of-hearing patients and members. In 2012, this group embedded best practices for language services into our HealthPartners Medical Group Care Model Process. In addition, the work group continued to create common expectations across plans and care delivery organizations to provide exceptional Interpreter services.

- The HealthPartners Equitable Care Sponsor Group provides strategic leadership and oversight of initiatives related to language assistance and reducing health disparities. These efforts support provider communication goals. This group is comprised of leaders of our medical clinics, dental clinics, hospitals and health plan. One of the programs engages staff members and providers to receive expert training so they can become advocates and serve as local resources for their colleagues in caring for patients from diverse cultures and those with limited English proficiency.

- We put a number of initiatives in place to enhance the transportation benefit. We provide appointment reminders to members; check for future appointments when confirming appointments; and, connect with transportation vendors quarterly and as needed to discuss concerns, questions and issues to ensure a positive member experience.

- The EBAN Experience is our innovative approach to link quality improvement with the health of the population. This initiative utilizes a collaborative format that incorporates teams of health professionals and community members, working side-by-side to understand cultural barriers to optimal care and improve care design. This initiative has evolved over the years. In 2013, the EBAN 3D Collaborative focuses on decreasing diabetes disparities in African American and Somali populations at five clinic sites across our system of care with an aim of sharing solutions, outcomes and best practices for diabetes care across our organization.
    - Our Experience work plan continues to be reinforced across the organization: training on making great first impressions, appointment wait time communication, promotion of online patient service, and use of after-visit summaries to enhance understanding of next steps in care.

- We have corporate-wide initiatives that address specialty provider access in the HealthPartners Medical Group. Multi-year initiatives include:
    - Specialty appointment schedules are open 13 months into the future, making it easier for patients to schedule their follow-up appointments in advance.

- Adjusting provider capacity to patient demand - through recruitment & moving provider time to different geographic clinics.
- Developing daily minimum provider staffing levels to ensure consistent access throughout the year.
- Schedule changes to accommodate more patients. This includes creating standard start/end times and standardization of appointment lengths within specialties.

- Since 2012, we have implemented several pilot initiatives to improve provider-patient communication. These initiatives include an office visit checklist that outlines actions, key phrases, and behaviors that represent best practice for patient experience. Additionally, care team action plans are created to outline the tactics the teams are implementing to improve patient experience. Finally, a formal program where providers are shadowed in the exam room by a trained observer, or coach, and are given real-time feedback on their patient interactions.

Appropriate Use of Asthma Medications (5-64 yrs)

HealthPartners works with our provider groups to utilize the Asthma registries and encourages providers to reach out to patients to schedule appointments when a gap in care or treatment is identified. HealthPartners provides provider groups with a quarterly patient registry that lists patients assigned to their group who are past due for services.

Adolescent Well-Child Care (12-21 yrs)

HealthPartners does collaborate with our county partners to promote Child & Teen Check-ups for our members and the community at large. In addition, we promote the use of our preventive registry to clinics to identify children who are in need of Child & Teen Check-up visits, as well as the child's HPV immunizations status.

Based on the difference between this HEDIS® measure that requires well child visits beyond Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Well Child visits, our community has an opportunity to review the guidelines.

Childhood Immunizations (Combo#3-2 yrs)

HealthPartners does want to further improve the overall performance of this measure and performed a root cause analysis that identified three main barriers to receiving immunizations:

- Vaccines are deferred when child comes in ill
- Parents are concerned about the safety of the vaccine
- Parents are concerned the vaccine will cause autism.

As a result of these issues, HealthPartners implemented the following interventions to address the barriers:

- Address parental concerns about vaccine safety by educating providers regarding resources available to share clinically accurate information with their patients.
- Log parents reasons for declining vaccine.
- Administer needed immunizations at illness visits.

- Utilize poster “It’s OK to Receive Shots…”
- Promote the preventive registry where clinics are provided lists of 18-23 month old children not up-to-date to clinics on a quarterly basis.
- Utilized “nurse referral” order to prompt parents to schedule return visit for immunizations.
- Promote the two year immunization incentive to encourage patients who were not up-to-date to receive all recommended immunizations by age two.

HealthPartners continues to work with provider groups to identify barriers to immunizations, promote the preventive registry and work to improve our childhood immunization rate.

Well-Child Care in First 15 Months (6+ visits)

HealthPartners does want to improve our overall performance of this measure.

- We work closely with the county Child &Teen Check-up coordinators to promote well-child visits to our members and the community at large.
- We promote the use of our preventive registry with network clinics. This registry identifies children in need of preventive well care and lead screening.
- Beginning in 2014, HPCare members will be eligible for an incentive for completing their well-baby care for the first 15 months. We anticipate this having a positive effect on the measure.

Well-Child Care (3-6 yrs)

HealthPartners does collaborate with our county partners to promote Child & Teen Check-ups for our members and the community at large. In addition, we promote the use of our preventive registry to clinics to identify children who are in need of Child &Teen Check-up visits.

Based on the difference between this HEDIS® measure that requires well child visits beyond Minnesota’s Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Well Child visits, our community has an opportunity to review the guidelines.

- ***2012 Recommendation:*** Continue careful analysis of PIP progress making mid-course adjustments as necessary. Collaborative efforts provide opportunities for collective learning and the MCO should seek opportunities to identify and promote spread of best practices. Strengthen areas of weakness through mentoring and sharing of lessons learned.

MCO Response:

Emergency Room Use Reduction – Head Start PIP

The goal of this project was to support appropriate use of the emergency room and decrease non-urgent emergency room use among F&C-MA and MNCare members who participate in Minnesota Head Start Association programs. PIP interventions centered on a partnership with the Minnesota Head Start Association (MHSA), which coordinates Head Start and Early Head Start programs throughout the state. The project utilized the book What to Do When Your Child Gets Sick. Head Start staff worked with families to understand how to use this book to determine the best course of action when their child is sick.

Education with the Head Start families began in April 2012 and continued through 2013. During the first measurement period, 693 collaborative health plan members received the intervention. The Emergency Room (ER) utilization rate for the participant group during the first measurement year was 0.326 compared to 0.343 for the comparison group. In relative terms, the rate of emergency room usage for non-urgent visits was 4.9% lower for children in the intervention cohort than for children in the comparison cohort, showing the intervention resulted in the desired lowering the rate of utilizing the ER.

Colorectal Cancer Screening PIP

This Performance Improvement Project had a goal of a relative improvement rate (RIR) of 15% in the first measurement year. Actual first year results were a RIR of 13.07%. Despite significant achievements in the colorectal cancer (CRC) screening rate at individual clinics, the CRC project did not achieve the desired goal of 15% RIR compared to the baseline year. Clinics that agreed to participate in this project accepted an immense challenge and took the responsibility to improve their colorectal cancer screening rate very seriously. As such, the clinics and health plan partners did extensive needs assessments to evaluate their internal processes and patient flow, electronic health record practices, patient experience and communication systems. Each clinic and health plan partner identified a variety of barriers and began to address potential solutions. Due to the extensive impact that changes to clinic process flows and other activities can have on the daily work of all levels of the clinic staff, clinics were deliberate about implementation of the clinic-based interventions.

Potential impact of proposed interventions was studied and discussed by clinic staff and health plan partners. Clinics and health plan partners agreed that appropriate implementation took priority over rushed implementation. As a result, many of the clinic-based interventions were not fully implemented until late in the measurement year, and were not able to affect the first measurement period rate at the goal target.

The second measurement year ended 6/30/2013 and bore out the anticipated results. In the second year, the participating clinics showed a CRC screening rate of 58.56%, which is a RIR of 27.87%, comfortably exceeding the 15% RIR goal. This increase shows that a thoughtful approach to clinical systems change, and recognizing the unique needs of diverse service communities can result in significant improvements in preventive screening.

Diabetes Blood Pressure PIP

Complications from diabetes include cardiovascular disease, kidney damage, blindness and amputations of the lower limbs. Patients with type 2 diabetes have twice the risk for coronary heart disease (CHD) and stroke as persons without diabetes. The goal of this clinical PIP is to increase the proportion of members with diabetes who have blood pressure under control as measured by the Healthcare Effectiveness Data and Information Set® (HEDIS®) Comprehensive Diabetes Care (CDC) 130/80 Blood Pressure measure in adults ages 18 through 75 years.

Interventions for this PIP included care coordinator education and outreach, provider interventions, outreach to long term care facilities and member education. As a result of this multi-pronged approach, HealthPartners plan and their partner clinics saw a 32% improvement over baseline. This PIP met the goal and has been retired.

- ***2012 Recommendation:*** Ascertain causes and strategically identify and implement interventions to address the loss of withhold points in the areas of ED utilization, hospitalizations, and 30-day readmissions. Consider working collaboratively with other MCOs to identify common barriers, best practices, or other successful strategies.

MCO Response:

Emergency Department Utilization Initiatives

Since 2009, HealthPartners has had a specialized task force to analyze appropriate places of care and use by all of our members. This task force has implemented a number of ongoing processes, communications and supports to help our members find the care they need, when they need it and in the most appropriate care delivery setting. The aim is to help members access the most appropriate care setting, which will ultimately lead to better health outcomes in the most efficient and effective way possible.

Much of the member outreach efforts are focused on educating our members and the public about the appropriate level of care for various conditions and how to access care and service when they need them. Member information on our seven days a week, 24 hours a day nurse line as well as convenience care and urgent care options, where to go for care and how to access virtuwell® is shared in multiple ways. virtuwell, HealthPartners 24-hour online diagnosis and medical treatment clinic, is available to members with Families & Children Medical Assistance and MinnesotaCare at no cost. Use of virtuwell by public program members has steadily increased since its introduction, increasing ten-fold from 2011 to 2012 with continued growth into 2013. Going forward, HealthPartners plans to further increase the awareness of this resource through targeted mailings and other member promotions.

CareLine, HealthPartners 24-hour nurse line, is promoted heavily as a decision-making tool. Members are encouraged to call CareLine to discuss their situation with a nurse prior to seeking care if they are unsure where to go. CareLine nurses are trained to assess the member's medical situation and, using standard protocols, to recommend the most appropriate course of action.

Members who have an emergency room visit for a non-emergent condition receive a letter in the mail informing them of alternatives to the emergency room. The letter also explains how to use their clinic, urgent care or the emergency room. The letter includes examples of conditions that can be seen at an urgent care or convenience clinic when a clinic is not available. It also includes health plan resources for assistance such as CareLine and virtuwell.

Members who have two emergency room visits in a 6-month period are contacted by a special team of CareLine nurses to discuss alternatives to the emergency room and for assistance establishing a primary care clinic. Members who discuss this issue with the CareLine nurse are sent an incentive for taking the time to learn about options.

HealthPartners participated with three other health plans in a collaborative Performance Improvement Project (PIP) to support care options and reduce non-urgent emergency room use among F&C-MA families and children who are 5-years-old and younger. This project was a collaborative with the Minnesota Head Start Association and included Head Start sites across the state, including Chisago County. The PIP utilized the book *What to Do When Your Child Gets Sick.* Head Start staff worked with families to help them understand how to use the book to answer questions when their child is sick. In addition to understanding how to use the book to make health decisions, Head Start staff worked with the family to ensure they have a primary care provider. Due to the success of the project, many Head Start sites will continue to use the book and other organizations have requested copies as well.

In 2013 we added additional initiatives to expand our intensive and comprehensive approach to reducing emergency department visits. For example, at the HealthPartners St. Paul Clinic, a new "walk-in" nurse practitioner position was developed. Members are able to receive health care services from a dedicated nurse practitioner without an appointment for conditions such as ear infections, fevers, stomach aches and headaches. This is another way we are working to encourage members to access appropriate care at a medical clinic versus at the emergency room. In 2014, we are working to promote this service among members and will expand it to at least one other clinic in St. Paul.

We also have a new process for an automated (IVR) phone based outreach to members with missed appointments, as missed appointments are associated with higher rate of ER visits than those without missed appointments. Also in 2013, Children's Hospital leaders visited Regions Hospital, to learn about and observe the hospital-based case manager position. To facilitate communication with members, electronic transmission of the full ER dictated summaries are sent from Children's Hospital to the HealthPartners Medical Group central inbox within 7-8 hours of ER visit/discharge. In

addition, materials are shared with HealthPartners members that visit the ER to educate them about CareLine, St Paul Walk-in and virtuwell.

Hospital Admissions and Readmissions Initiatives

HealthPartners has implemented a multi-strategy approach to reduce avoidable hospital admissions, reduce avoidable readmissions and improve coordination of care through outreach to members, care delivery changes, and community partnerships.

Initiatives include:

- When a member leaves the hospital, it is important that they understand their medications, how and when to take them, and what side effects to look for. Members who are discharged from Regions to Integrated Home Care are encouraged to work with a Medication Therapy Management Pharmacist who can help them with this.
- Regions Hospital, a high volume hospital for our state public programs members made changes to their after visit summary for patients to enable them to better understand what they are supposed to do following discharge from Regions. This information is also sent to the primary care doctor so they can follow up with the patient as well.
- Regions Hospital is enhancing transition processes including the use of technology to get information from one care setting to the next.
- HealthPartners Medical Group (HPMG) Primary Care Providers developed a standard approach to proactively manage the care and follow-up of patients who have chronic conditions. Patients are identified upon discharge from the hospital or Emergency Room (ER). The Doctor completes an initial assessment of the patient and develops a care plan which is used to teach patients about self care management. Frequent follow-up occurs with the patient and the clinic RN care coordinator.
- Regions Hospital is a collaborative participant sharing what they have learned with other health care organizations in the statewide campaign focused on Reducing Avoidable Readmissions Effectively (RARE).

- ***2012 Recommendation:*** Perform an in-depth analysis of the thirteen measures demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

MCO Response:

Antidepressant Medication Management (Acute) MNCare, MSHO

Antidepressant Medication Management (Continuous) – MSHO

In 2012 to help improve our Antidepressant Medication Management outcomes, HealthPartners health plan behavioral health department leveraged our integration with HealthPartners Medical Group to increase the supports and guidance for state public program members. This new approach integrates HealthPartners health care financing / health care delivery roles and capabilities.

We created an algorithm which identifies gaps in care using claims data. When HealthPartners members who are treated in HealthPartners Medical Group are 3 to 5 days overdue in refilling their antidepressant, the health plan Behavioral Health staff in their role as "Behavioral Health

Centralized Services" reaches out to the member on behalf of the prescriber and functions as part of the prescriber's "extended care team." The Centralized Services staff is licensed for independent clinical practice but are employees of the health plan and function within care support (not care delivery) roles. They also document in EPIC, HealthPartners Medical Group's electronic medical record so that the treatment team can be aware of new information about the patient. Following proprietary workflows and protocols, the Centralized Services staff work to identify and resolve barriers to medication adherence.

In 2012 there were 2,120 instances when a state public programs member treated in HealthPartners Medical Group was overdue in refilling their antidepressant medication. Behavioral Health Centralized Services reached out by phone to each member and had a voice to voice conversation with 43.3% and provided coaching as noted above. A review of claims data shows that within 7 days of the phone call 39.8% of those contacted had refilled their antidepressant medication.

As noted above, this approach appears to be helpful to members who are patients within an integrated health care financing and health care delivery system like HealthPartners. These efforts helped in 365 instances where the antidepressant medication was overdue for being filled by state public programs members and is apparently due to the proactive phone call and discussion since this many members refilled their prescriptions within 7 days of the call.

Chlamydia Screening – F&C-MA

While HealthPartners Chlamydia screening rates have shown a three year downward trend, this reflects the trend seen across the industry. HealthPartners performs better on this measure than the 90th percentile for both Medicaid and Commercial products. That being said, HealthPartners is committed to improving our performance on this measure. It is a priority area for both the health plan and our affiliated medical group. Root cause analysis has shown that provider level of knowledge and comfort with the topic is reflected in this measure. HealthPartners is actively promoting the practice of universal screening for this measure.

- The 2013 Medicaid PIP focused on improving the Chlamydia screening rate for Medicaid members. Interventions included the development of a toolkit for providers with valuable resources and information they could utilize to impact this measure in their practice.

- HealthPartners has sponsored two webinars for clinics to assist in improving their Chlamydia screening practices, and is actively participating with the Minnesota Chlamydia Partnership, focused on the same goal.
- HealthPartners hosted meeting of Quality Improvement staff at major network clinics to share information ideas and strategies around this measure.

HealthPartners is providing quality consultation services to clinics who are struggling with this measure and offering support and technical assistance to improve clinic practices.

Adult Preventive Visits (20-44 yrs) – F&C-MA

HealthPartners does promote the use of our Preventive Registry to clinics to assist them in identifying patients who may be in need of preventive health screenings. This registry includes such screenings as colorectal, breast and cervical cancer screenings, which are common flags for the need for preventive care.

Based on the difference between this HEDIS® measure that requires visits beyond Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Adult Preventive visits, our community has an opportunity to review the guidelines.

Adult Preventive Visits (45-64 yrs) – F&C-MA

HealthPartners does promote the use of our Preventive Registry to clinics to assist them in identifying patients who may be in need of preventive health screenings. This registry includes such screenings as colorectal, breast and cervical cancer screenings, which are common flags for the need for preventive care.

Based on the difference between this HEDIS® measure that requires visits beyond Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Adult Preventive visits, our community has an opportunity to review the guidelines.

Adult Preventive Visits (65+) MSC+

HealthPartners does promote the use of our Preventive Registry to clinics to assist them in identifying patients who may be in need of preventive health screenings. This registry includes such screenings as colorectal, breast and cervical cancer screenings, which are common flags for the need for preventive care.

Based on the difference between this HEDIS® measure that requires visits beyond Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Adult Preventive visits, our community has an opportunity to review the guidelines.

Child PCP Visits (12-24 mos) – F&C-MA

HealthPartners does collaborate with our county partners to promote Child & Teen Check-ups for our members and the community at large. In addition, we promote the use of our preventive registry to clinics to identify children who are in need of Child &Teen Check-up visits.

Based on the difference between this HEDIS® measure that requires child PCP above Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Well Child visits, our community has an opportunity to review the guidelines.

Child PCP Visits (25mos-6 yrs) – F&C-MA, MNCare

HealthPartners does collaborate with our county partners to promote Child & Teen Check-ups for our members and the community at large. In addition, we promote the use of our preventive registry to clinics to identify children who are in need of Child & Teen Check-up visits.

Based on the difference between this HEDIS® measure that requires child PCP above Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Well Child visits, our community has an opportunity to review the guidelines.

Child PCP Visits (7-11 yrs) – F&C-MA

HealthPartners does collaborate with our county partners to promote Child & Teen Check-ups for our members and the community at large. In addition, we promote the use of our preventive registry to clinics to identify children who are in need of Child & Teen Check-up visits.

Based on the difference between this HEDIS® measure that requires child PCP above Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Well Child visits, our community has an opportunity to review the guidelines.

Breast Cancer Screening – MNCare, MSC+, MSHO

Nationally, health plans have seen a decline in breast cancer screenings. Changes in guidelines and recommended screening schedules have resulted in confusion among the public. In an effort to stem this decline, HealthPartners is sending out reminders to members who are behind schedule. This includes mailings to members who are due for preventive screenings, as well as messages delivered by our member services team if the member calls the plan for information.

HealthPartners works with our provider groups to utilize the preventive registries and encourages them to reach out to patients to schedule preventive visits. HealthPartners provides provider groups with a quarterly patient registry that lists patients assigned to their group who are past due for preventive services, including mammograms.

Cervical Cancer Screening – F&C-MA

Nationally, health plans have seen a decline in cervical cancer screenings. Changes in guidelines and recommended screening schedules have resulted in confusion among the public. In an effort to stem this decline, HealthPartners is sending out reminders to members who are behind schedule. This includes mailings to members who are due for preventive screenings, as well as messages delivered by our member services team if the member calls the plan for information.

HealthPartners works with our provider groups to utilize the preventive registries and encourages them to reach out to patients to schedule preventive visits. HealthPartners provides provider groups with a quarterly patient registry that lists patients assigned to their group who are past due for preventive services, including cervical cancer screening.

Well-Child Care in first 15 mos (6+ visits) – MNCare

HealthPartners does want to improve our overall performance of this measure.

- We work closely with the county Child & Teen Check-up coordinators to promote well-child visits to our members and the community at large.
- We promote the use of our preventive registry with network clinics. This registry identifies children in need of preventive well care and lead screening.
- Beginning in 2014, HealthPartners Care members will be eligible for an incentive for completing their well-baby care for the first 15 months. We anticipate this having a positive effect on the measure.

Well-Child Care (3-6 yrs) – F&C-MA

HealthPartners does collaborate with our county partners to promote Child & Teen Check-ups for our members and the community at large. In addition, we promote the use of our preventive registry to clinics to identify children who are in need of Child & Teen Check-up visits.

Based on the difference between this HEDIS® measure that requires child PCP above Minnesota's Institute for Clinical Systems Improvement (ICSI) evidence-based guidelines for Well Child visits, our community has an opportunity to review the guidelines.

- ***2012 Recommendation:*** MPRO recognizes the recent establishment of HH, the uniqueness of the care delivery system, and the time required to ensure processes are well designed to promote desired outcomes. The thirteen weaknesses provide an opportunity to guide future efforts as the plan refines processes and its organizational structure. The plan should determine strategies to improve performance in these areas. In addition, the plan should identify industry best practices and use those best practices to extrapolate methods that appropriately address the root causes for the population served.

MCO Response:

1. Antidepressant Medication Management (Acute)
2. Antidepressant Medication Management (Continuous)
3. CAHPS® How People Rated Their Specialist
4. CAHPS® How People Rated Their Health Care
5. CAHPS® How People Rated Their Health Plan
6. CAHPS® How Well Doctors Communicate
7. Adult Preventive Visits (20-44 yrs)
8. Adult Preventive Visits (45-64 yrs)
9. CAHPS® Getting Needed Care
10. CAHPS® Health Plan Customer Service
11. Cervical Cancer Screening
12. Comprehensive Diabetes Care (LDL-C Screening)
13. CAHPS® Getting Care Quickly

1 & 2. For both measures of Antidepressant Medication Management, Acute and Continuous, MHP d/b/a Hennepin Health cannot validate the results displayed by MPRO. MPRO gave Hennepin Health 16.67% for both acute and continuous metrics. The denominator MPRO cited was only 6 members. MHP's audited HEDIS® results for these measures in calendar year 2012 were vastly different. MHP d/b/a Hennepin Health was able to extract a denominator of 82 for Antidepressant Medication Management Acute and Continuous. MHP d/b/a Hennepin Health calculated 2012 rates for this measure as 45.12% acute and 34.15% continuous. The MCO derived rates fall much closer to the stated Medicaid 50th percentile even though the Hennepin Health risk profile and needs of this sub-population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid.

At this point, it is unclear to MHP d/b/a Hennepin Health how the two denominators can be so significantly different. Based on the data derived by MHP, these measures were not considered weaknesses. Until Hennepin Health has conducted HEDIS® measurement for at least a few more years and can benchmark from itself; it is not clear what trajectory these measures will take.

The Hennepin Health population does have a high need for mental and behavioral health care services. For this reason, MHP is certain that the denominator of six members is not accurate.

Specifically, MHP d/b/a Hennepin Health has been interested in both the screening and treatment of major depression. The MHP Quality Management Committee has had numerous discussions around depression screening tools in the primary care setting. In 2013, they elected to make these HEDIS® measures part of the annual clinical practice guidelines adoption and dissemination process. MHP has also initiated utilizing Minnesota Community Measurement data on Depression Remission and Response of its major network providers into its data analysis of depression diagnosis and treatment.

MHP d/b/a Hennepin Health also has an antidepressant medication adherence program that is administered by the MHP pharmacy benefit manager (PBM), Caremark/CVS. MHP and Caremark currently collaborate to identify and address members not filling their medications as prescribed. A reminder letter is sent to these members on the importance of medication adherence. The MHP pharmacist will often contact the member's doctors to make them aware of the possible non-adherence.

3. MHP d/b/a Hennepin Health does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has Hennepin Health's rate for How People Rated Their Specialist at 63.00%. This measure is a ranking question on a scale from 1 to 10, 10 being the best and 1 being the worst. The CAHPS® methodology states that '10', '9', and '8' are all considered achievement scores. When MHP d/b/a Hennepin Health reviewed its CAHPS® data, Hennepin Health calculates a rate of 83.10%. The MHP d/b/a Hennepin Health derived rate of 83.10% is statistically strong and this element would not have been a weakness for Hennepin Health. MPRO only accepted the answers of '10' and '9' as successful, not following the CAHPS® methodology. The data presented by MPRO for Hennepin Health is at worst misleading and at best unclear. Hennepin Health does not feel that responses answered '8' to this question should be deemed as negative. Additionally, Hennepin Health is a unique MCO product in Minnesota, in that it serves only the State's Medicaid early expansion population of adults without dependent children aged 21-64 and with % earnings < 75% FPL. Because the risk profile and needs of this sub-population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid.

4. MHP d/b/a Hennepin Health does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has Hennepin Health's rate for How People Rated Their Health Care at 50.00%. This measure is a ranking question on a scale from 1 to 10, 10 being the best and 1 being the worst. The CAHPS® methodology states that '10', '9', and '8' are all considered achievement scores. When MHP d/b/a Hennepin Health reviewed its CAHPS® data, Hennepin Health calculates a rate of 69.7%. MPRO only accepted the answers of '10' and '9' as successful, not following the CAHPS® methodology. The data presented by MPRO for Hennepin Health is at worst misleading and at best unclear. Hennepin Health does not feel that responses answered '8' to this question should be deemed as negative. Additionally, Hennepin Health is a unique MCO product in Minnesota, in that it serves only the State's Medicaid early expansion population of adults without dependent children aged 21-64 and with % earnings < 75% FPL. Because the risk profile and needs of this sub-

population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid.

5. MHP d/b/a Hennepin Health does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has Hennepin Health's rate for How People Rated Their Health Plan at 47.00%. This measure is a ranking question on a scale from 1 to 10, 10 being the best and 1 being the worst. The CAHPS® methodology states that '10', '9', and '8' are all considered achievement scores. When MHP d/b/a Hennepin Health reviewed its CAHPS® data, Hennepin Health calculates a rate of 71.7%. The MHP d/b/a Hennepin Health derived rate of 71.7% would not have been considered a weakness for Hennepin Health. The challenges that exist when simultaneously developing and implementing a new health plan product is bound to cause some lower satisfaction responses in the beginning. MPRO only accepted the answers of '10' and '9' as successful, not following the CAHPS® methodology. The data presented by MPRO for Hennepin Health is misleading. Hennepin Health does not feel that responses answered '8' to this question should be deemed as negative. Additionally, Hennepin Health is a unique MCO product in Minnesota, in that it serves only the State's Medicaid early expansion population of adults without dependent children aged 21-64 and with % earnings < 75% FPL. Because the risk profile and needs of this sub-population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid.

6. MHP does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has MHP d/b/a Hennepin Health combined rate for How Well Doctors Communicate at 76.00%. This composite measure is a combination of four questions, all with four possible answers of Never, Sometimes, Usually, and Always. The CAHPS® methodology states that 'Usually' and 'Always' are both considered achievement scores. MHP d/b/a Hennepin Health calculates a rate of 93.10%. The MHP derived rate of 93.10% is statistically strong and this element would have been a strength for Hennepin Health, not a weakness. MPRO only accepted the answer of 'Always' as successful, not following the CAHPS® methodology. The data presented by MPRO for MHP is at worst misleading and at best unclear. MHP d/b/a Hennepin Health does not feel that responses answered 'Usually' to these questions should be deemed as negative. MHP and Hennepin Health providers' are highly experienced in working with our member populations with the majority of Hennepin Health providers serving the urban areas of Minnesota including safety net hospitals and organizations. Our providers generally communicate well with our members and MHP d/b/a Hennepin Health has virtually no member grievances related to inadequate physician communication. Additionally, Hennepin Health is a unique MCO product in Minnesota, in that it serves only the State's Medicaid early expansion population of adults without dependent children aged 21-64 and with % earnings < 75% FPL. Because the risk profile and needs of this sub-population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid.

7 & 8. Members of Hennepin Health Plan are very prone to episodic and disconnected acute care that is most commonly sought out at the closest hospital emergency department. Many members have lived much of their lives not trusting others. Some of this distrust comes from underlying mental and/or chemical health issues whether they are diagnosed issues or not, the result is the

same. Many members are often resistant to allowing a primary care physician into their personal health. In addition to that resistance, many of the Hennepin Health members live in what some might call "survival mode." This survival mode ultimately means that members think only of the present day and what their needs are in that moment. What they might need a month, a year or multiple years from now is not something in the forefront of many members' thoughts. This aversion to thinking long term is often a major barrier to members receiving preventive health care services. In many ways, the HEDIS® rates that Hennepin Health received for preventive visits for ages 20-64 are much higher than many Hennepin Health staff originally thought they would be. MHP d/b/a Hennepin Health and the Hennepin Health partner organizations were pleased to see rates in the 79%-85% range. Additionally, the Hennepin Health Plan is a unique product that is not fully comparable to state or national benchmarks. Until Hennepin Health has been able to conduct HEDIS® measurements for at least a few more years and can benchmark from itself; it is not clear whether this rate is a true weakness.

In 2013, Hennepin Health launched an official performance improvement project to reduce emergency department utilization and to increase clinic use. Hennepin Health has begun to incorporate many unique solutions to connecting members with primary care and to discouraging the emergency department as a regular source of care. In the fall of 2012, the Hennepin County Medical Center (HCMC) as a partner in Hennepin Health and the primary hospital used by Hennepin Health members opened a new Urgent Care facility to work parallel to the emergency department. The use of urgent care by patients is one of the first steps to breaking the ED cycle, and the use of HCMC urgent care services by Hennepin Health members has increased significantly since its opening.

In early 2013, Hennepin Health began an ED Inreach Program that worked parallel to the ED social workers to engage frequent users of the ED when they would present in the ED. MHP d/b/a Hennepin Health contracted with a specialized Mental Health Case Management organization to come into the ED, when called by a social worker, to provide intensive and immediate assistance to members, including help connecting with primary care services. The Hennepin Health Partnership has also made this topic of replacing episodic care with ongoing primary and preventive care a focus for the 2014 Hennepin Health reinvestment initiative.

Hennepin Health has dedicated risk sharing dollars to shared re-investment projects that can be proposed by the various staff throughout the partner organizations. One example of a proposal from last year was a Sobering Center to divert chronic inebriates from the ED to a lower level of care when clinically appropriate. This Sobering Center project continues to move forward and is expected to launch in 2014.

9. MHP d/b/a Hennepin Health does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has Hennepin Health's combined rate for Getting Needed Care at 52.00%. This composite measure is a combination of two questions, both with possible answers of Never, Sometimes, Usually, and Always. The CAHPS® methodology states that 'Usually' and 'Always' are both considered achievement scores. MHP d/b/a Hennepin Health calculates a rate of 79.80%. The Hennepin Health derived rate of 79.80% is statistically much stronger than the MPRO rate and this element would have been a not a weakness. MPRO only accepted the answer of 'Always' as successful, not following the CAHPS® methodology and the data presented is at worst misleading and at best unclear. MHP does not feel that responses answered 'Usually' to these questions should be deemed as negative.

One large challenge for Hennepin Health members accessing care is often with Mental Health and Chemical Dependency categories of service. There is a general shortage of Mental Health and Chemical Dependency providers within the reach of members. MHP d/b/a Hennepin Health keeps the network to these services as open access, and MHP will provide transportation to and from appointments wherever the members are able to get in. However, these measures have not been enough to ensure that all of our members get their needed care, when they need it. Many of the members with mental and/or chemical health issues who cannot get the care that they need will often end up presenting at the closest hospital emergency department.

Some unique benefits come along with Hennepin Health's relationships to the county human services department and to the Hennepin County Medical Center (HCMC) for members in need of mental or chemical health care. Hennepin Health is better able to connect members to services available through the county or county partners. The Acute Psychiatric Services (APS) at HCMC is a uniquely positioned psychiatric emergency room that serves the primary area where many of the MHP members reside. Even with the arrangement of MHP mental health and chemical dependency services, there is still a shortage of providers making it difficult for members to receive needed care.

10. MHP d/b/a Hennepin Health does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has MHP d/b/a Hennepin Health combined rate for Health Plan Customer Service at 64.00%. This composite measure is a combination of two questions, all with four possible answers of Never, Sometimes, Usually, and Always. The CAHPS® methodology states that 'Usually' and 'Always' are both considered achievement scores. Hennepin Health calculates a rate of 82.80%. MPRO only accepted the answer of 'Always' as successful and did not follow the CAHPS® methodology. The data presented by MPRO for Hennepin Health is at worst misleading and at best

unclear. MHP d/b/a Hennepin Health does not feel that responses answered 'Usually' to these questions should be deemed as negative.

It is not surprising that customer service is among the lower scoring measures for MHP d/b/a Hennepin Health. Satisfaction with customer service is a topic commented on by members and occasionally by staff. Additional customer service trainings have been provided to staff over the last few years and members and staff have noticed an improvement. MHP staff has commented that it is not necessarily the tone in which customer service representatives respond to inquiries, but the need to communicate negative information to the member such as denial for taxi rides or cosmetic procedures. The challenge for any health care organization is to stay on top of constantly changing information and processes. MHP has invested significant time and effort into training, oversight and accountability within the customer services area in an effort to improve this CAHPS® result for all product lines.

A need recognized by MHP d/b/a Hennepin Health early last year was that many members were physically coming in to the MHP front office for customer service assistance rather than by calling in. The number of walk-in members averages from 70 to 150 per day. It is highly unusual for a health plan to offer walk-in customer services at its location. Based on this information, MHP implemented multiple changes to its walk-in customer service approach that has helped with member satisfaction. MHP created a 'Care Guide on Call' schedule so that a professional nurse or social worker care guide is available to assist members in the front lobby. The 'Care Guide on Call' is always posted around the departmental areas for staff to see. Also, MHP began staffing the front desk with Community Health Workers to provide better assistance to members regarding their coverage and eligibility needs. Due to this growing walk-in service, MHP will be expanding and remodeling its front desk operation. The plan was to complete the remodel in 2013, however due to MHP offices being located in a historic building, construction approval has been a lengthy process. The remodel has been rescheduled for 2014, and will include at least one TV monitor to broadcast health-related information. It appears that many of MHP's members prefer to come in to MHP to address their customer service needs. MHP typically has 2 or 3 staff people at the front desk to assist the volume of walk-in traffic.

Although this issue has been mentioned previously in other MCO responses to the Annual Technical Report, it is a significant cause of dissatisfaction amongst MHP and Hennepin Health members and it is necessary to be brought up again. MHP Customer Service handles a large number of transportation requests that require a sometimes frustrating process to meticulously verify appointments and logistical details. Additionally, many Hennepin Health member grievances are related to transportation issues. Members can be very agitated regarding transportation. MHP does regular training with customer service representatives regarding transportation, including how to provide individual member assistance in order to de-escalate conflicts. In 2012, MHP d/b/a

Hennepin Health did create an escalation/engagement and resolution resource, commonly referred to as the "E&R Desk" or the "ERD". This resource has been critical in assisting the customer service staff in providing adequate time and attention to members, especially individuals with extremely complex situations.

11. As previously stated, many Hennepin Health members find the concept of preventive care services unnecessary and sometimes invasive unless the member has a strong trusting relationship with the provider. Cervical cancer screenings are among the most avoided preventive screenings across all demographics and even more so with the Hennepin Health population. MPRO stated that the Hennepin Health rate of cervical cancer screening in 2012 was 53.08%. MHP d/b/a Hennepin Health's audited HEDIS® data displayed a higher rate of 59.85%. Additionally, Hennepin Health is a unique MCO product in Minnesota, in that it serves only the State's Medicaid early expansion population of adults without dependent children aged 21-64 and with % earnings < 75% FPL. Because the risk profile and needs of this sub-population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid. Hennepin Health is a relatively small product (average monthly 2012 enrollment of 5-6,000 members). When continuous enrollment requirements are applied for data such as HEDIS® measures (especially for female-only measures since Hennepin Health is over 75% male), the sample size becomes very small and potentially unreliable.

Although the MCO derived rate for cervical cancer was higher than the MPRO rate, it is still far lower than desired for this population. MHP d/b/a Hennepin Health is supporting an upcoming MDH cancer screening incentive program to boost colorectal, breast and cervical cancer screening rates. The program will be implemented in waves with cervical cancer screening being implemented in late 2014. MHP will be supporting MDH with this effort, and will be training its customer service and medical administration staff on how to address questions regarding the program while encouraging members to participate in this opportunity.

12. MHP has acknowledged this generally lower rate for comprehensive diabetes care LDL-C screenings, and has submitted to DHS a formal Performance Improvement Project for 2014 on improving LDL-C screenings for the diabetic Hennepin Health population. A key component of this performance improvement project is using the diagnosis of diabetes as a way to prioritize members being targeted for outreach by the community health workers (CHWs) that reside at each Hennepin Health clinic. The challenge that the Hennepin Health Plan faces is getting members connected to a primary care clinic as their regular source of health care. Thus, the PIP focuses in on the clinic resource of the CHWs to get members engaged and ultimately having routine LDL-C screenings. There is still a common problem amongst Hennepin Health Plan providers that they will not order an LDL-C screening unless the individual has been fasting. The performance improvement project will also have elements of provider education surrounding these screenings to address issues such as the

fasting vs. non-fasting LDL screening. All of the comprehensive diabetes care measures will also remain part of the annual practice guidelines adoption and dissemination process.

The MHP Disease Management Program for Diabetes and Cardiovascular Conditions as also set a goal for 2014 that all products increase their rates of LDL screenings for members with diabetes or a cardiovascular condition. The disease manager has designed new educational materials and a new outreach protocol for identifying and encouraging those members to know all of their important numbers; including their LDL-C levels.

It also should be acknowledged that the health plan audited HEDIS® data for this measure reflects approximately a 5% higher rate of 77.34%. The health plan derived rate is above the Medicaid 50th percentile, the MHCP State Average and the National Medicaid Average. Additionally, Hennepin Health Plan is a unique product that is not fully comparable to state or national benchmarks. Until Hennepin Health has been able to conduct HEDIS® measurements for at least a few more years and can benchmark from itself; it is not clear whether this rate is a true weakness.

13. MHP d/b/a Hennepin Health does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has Hennepin Health's combined rate for Getting Care Quickly at 53.00%. This composite measure is a combination of two questions, both with possible answers of Never, Sometimes, Usually, and Always. The CAHPS® methodology states that 'Usually' and 'Always' are both considered achievement scores. Hennepin Health calculates a rate of 79.4% for this measure. MPRO only accepted the answer of 'Always' as successful and did not follow the CAHPS® methodology. The data presented by MPRO for Hennepin Health is at worst misleading and at best unclear. MHP d/b/a Hennepin Health does not feel that responses answered 'Usually' to these questions should be deemed as negative. Additionally, Hennepin Health is a unique MCO product in Minnesota, in that it serves only the State's Medicaid early expansion population of adults without dependent children aged 21-64 and with % earnings < 75% FPL. Because the risk profile and needs of this sub-population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid.

- ***2012 Recommendation:*** Determine strategies to improve performance in the 11 areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

  MCO Response: IMCare has recently implemented a HEDIS® intervention committee. This committee is working on developing and implementing interventions that will improve HEDIS® measures, which includes several of the weaknesses listed. Some of the interventions include, providing incentives to meet the well child care visits, putting more information in the member newsletter, targeted reminder phone calls, and mailing information to applicable members. We have added any screenings or visits that members have not received yet to the main screen of our software system. Therefore, when a member calls we can give them a reminder and will even help them schedule the appointment if necessary.

  Transportation is a significant issue in our rural community and has been identified through analysis as a barrier. Therefore, we work to find transportation for members and have a relationship with the local transportation system. We are also exploring the idea of contracting with a homecare agency to go to the member's home and obtain the lab for LDL-C screening.

  We have continually been working on improving our CAHPS® rating by identifying exactly what the issue is, and educating the members. Through further exploration it was identified that IMCare members thought their financial worker was an IMCare worker. Therefore, when completing CAHPS® they are scoring IMCare based on their experience with non-IMCare staff. IMCare has assessed and evaluated staff performance and found the customer service to be exceptional. IMCare is also working on improving the provider network and currently two of the clinics in Itasca County have implemented urgent care clinics, which has improved efficient access to care. The primary clinic in the network has recently begun a program to improve Asthma scores, which should have a positive impact on that measure in the future.

- ***2012 Recommendation:*** Ascertain causes and strategically identify and implement interventions to address the loss of withhold points in the areas of lead screening, ED utilization, and hospitalizations. Consider working collaboratively with other MCOs to identify common barriers, best practices, or other successful strategies.

  MCO Response: The identified cause for the loss of withhold points regarding lead screening is due to two factors; Some PCP's will not screen if there is no identifiable risk and the counties Public Health department does not screen for lead. Many providers do not see levels that are considered high by medical standards, so they do not screen. IMCare has provided education to providers and urged them to screen for lead explaining that even if the level is low and not within the medically

adventitious threshold, the Public Health Department will still provide education. We have also tried to work with the Public Health Department to determine if they could start screening for lead in their WIC clinic. However, this effort was futile.

The identified cause of ED utilization is due to a high number of members using the ED if they could not get into their PCP in the clinic. Often utilization did not truly warrant an emergency. IMCare works on this issue by doing ED focus studies every month and providing case management. ED utilization is also monitored through quarterly special health care needs reports where individuals can be identified to receive case management. Two clinics in the network are now providing urgent care which has reduced these numbers. Another clinic in the network is also providing the Health Care Home program which also targets high ED utilizers. IMCare has sent a provider update to that clinic to communicate our appreciation for this program and encourage them to enroll IMCare members as applicable. The Care Coordinator for this program came and spoke to the QI staff and a plan was developed to collaborate as case managers when high ED utilizers are identified.

IMCare is working on improving the case management program to focus on preventing hospitalizations. Another significant intervention for this measure was the change in the transitions program. A "transition coordinator" position was created to handle the transitions with focused case management designed to ensure services are in place to reduce hospitalizations and ensure after care is provided. Eric Coleman's, "four pillars" was added to the transition process as well as other key questions.

- ***2012 Recommendation:*** Perform an in-depth analysis of the two measures demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

  MCO Response: During this time frame, IMCare was not required to report MSC+ HEDIS® measures and MNCare was compiled with F&C-MA. Beginning in 2014, IMCare will be looking at MNCare rates separately and can track and analyze this data.

  Through analysis of the breast cancer screening measure we discovered that many providers were now discouraging patients to have this screening on a yearly basis. IMCare is working on this through interventions of the HEDIS® intervention committee as mentioned above. The plan is to reach out to members who are due for a screening and assist them with this in any way we can. It is anticipated that this rate will rise with a significant change in the 2015 data.

  IMCare is working on improving the adolescent well child care rate through efforts of the HEDIS® intervention committee. In the past there was an incentive program that was effective to a point. However, a new incentive program with a better incentive would be much more effective. We are currently working on determining the most effective approach to increase this measure.

- ***2012 Recommendation:*** Determine strategies to improve performance in the ten areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

  MCO Response: Note: Weakness is defined by the PRO as less than the Quality Compass Medicaid 50th percentile. The HMO Commercial 50th percentile was used for benchmarking.

Measure	Discussion	Strategies
Quality		
Appropriate Use of Asthma Medications [5-64] years	Per the DHS calculation Medica at 82.79% is 1.91% points below the Medicaid 50th percentile and 9.9% below the commercial 50th percentile. Medica's Medicaid rate was 85.82% in 2012 and 84.76% for 2013.	Medica has identified an improvement opportunity with children. 14% of Medica's children have a diagnosis of Asthma. Medica explored a number of options and determined an enhanced Asthma Health Coaching program would provide the strongest intervention. This program was implemented in early 2014. The program targets kids ages 5-17, and is a model that includes integration of nursing and health coaching caregiver/member interventions, including a pharmacy/MTM component.
CAHPS® How Well Doctors Communicate	This composite is composed of 4 questions that address: explaining , listening , showing respect, and spent enough time. DHS scored this composite at 79.2%. Medica's NCQA Medicaid CAHPS® scored at 92.08% in 2012, and 93.03% in 2013. This is 10.2% below the 50th percentile. Per Medica's NCQA Medicaid HEDIS® results we were at 92.08% in 2013 and dropped to 92.03% when Usually and Always responses were combined. Per the DSS report Medica was about the DSS average in 2013.	Medica has identified this composite measure as improving in 2013. Over time this metric shows a fair amount of variability. We have not been able to identify a region or county with greater issues. Given the high scoring found in Medica's own CAHPS®, this metric is being monitored.

Measure	Discussion	Strategies
Access		
CAHPS® Getting Needed Care	This is a composite measure that averages Got an appointment with a specialist as soon as needed and Getting needed care, tests or treatment was easy. Per DHS the Medica rate was 55.2% and 25.77 percentage points below the 50th percentile. Per Medica's CAHPS we were at 84.92% in 2012 and 85.7% in 2013 for the combined Usually and Always. The percentage for Always was 56.92% in 2012 and 55.4% in 2013.	Medica has a very large network and monitors its appointment access each year. Medica's CAHPS® results show higher rates than the DHS study, but does offer an opportunity with regard to access to specialists. The most frequently identified issue with specialist access is members would like access to Mayo clinic which is not in the network. Network management is exploring a contract with Mayo Clinic. Medica will continue to monitor this metric.
CAHPS® Health Plan Customer Service	Per DHS Medica scored 65.8% which is 20.66% lower than the Medicaid 50th percentile. Per Medica's survey we scored 77.74% in 2012 and 86.84% in 2013.	Medica identified an opportunity to improve the listening skills of customer service staff through numerous focus groups after engaging a consultant to identify potential issues. A new training program called Listen Up was created and implemented in 2013. We hope to see significant improvement in the 2014 survey results.

Measure	Discussion	Strategies
Timeliness		
Childhood Immunization Combo 3	Per DHS Medica scored 71.13% or 1.75 percentage points below the 50th percentile. Per Medica's HEDIS® results we scored 75.43% in both 2012 &2013[rotated measure]. This rate has been 74 or 75% since 2009. No improvement seen.	In 2013 Medica did a mailing to parents of children who were missing any of the vaccines. In 2013, Medica developed and was ready to implement a project which would address immunization rates in children with a Pharmaceutical company. This program was not implemented due to privacy law constraints. Medica has been addressing data collection issues, looking carefully at our chart chase logic to improve this rate. Medica began using the Johns Hopkins Evidenced Based Medicine [EBM] GAPs in Care software in 2013. This software prompts case managers and health coaches about missing tests such as LDL-C and HbA1c. The training and tools available to Medica staff evolved during 2013 and a greater emphasis is being focused on this in 2014.
Adolescent Well Child Care [12-21 years]	Per DHS Medica scored 36.52% or 11.93 percentage points below the 50th percentile. Per Medica's survey we scored 37.85% in 2012 and 27.81% in 2013.	Medica has implemented a work plan for Child & Teen Check-Up, in an effort to improve our rates. As a part of this work plan, the team conducts an analysis of activities and barriers to assist in future planning. Activities in 2013 include: conducting key clinic trainings on C & TC; participating in regional collaborations/partnerships that provide information to providers and education to members; placing articles about the benefits of Child & Teen Check Ups in the member newsletter. Barriers noted include cultural and linguistic barriers that prevent members from receiving appropriate education and information about the benefit of prevention and early information. Medica will look for additional, innovative ways to connect with these members and provide culturally sensitive health care education.

Measure	Discussion	Strategies
Comprehensive Diabetes Care [LDL-C Screening]	Per DHS Medica scored 69.65% or 6.63 percentage points below the 50th percentile. Per Medica's HEDIS® data we scored 84.18% in 2012 and 13- the measure was rotated.	Medica began using the Johns Hopkins Evidenced Based Medicine [EBM] GAPs in Care software in 2013. This software prompts case managers and health coaches about missing tests such as LDL-C and HbA1c. The training and tools available to Medica staff evolved during 2013 and a greater emphasis is being focused on this in 2014.
Well Child Care in First 15 months [6+ visits]	Per DHS Medica scored 61.67% 10.59 percentage points below the 50th percentile Per Medica's HEDIS® we scored	Medica has implemented a work plan for Child & Teen Check-Up, in an effort to improve our rates. As a part of this work plan, the team conducts an analysis of activities and barriers to assist in future
	58.93% in 2012 and 55.93% in 2013. So a gap is growing. This rate has bounced around since 2009; it was highest in 2010 but has fallen steadily since then. This is below the DSS average of 77.31%.	planning. Activities conducted in 2013 include: conducting key clinic trainings on C & TC; participating in regional collaborations/partnerships that provide information to providers and education to members; placing articles about the benefits of Child & Teen Check Ups in the member newsletter. Barriers noted include cultural and linguistic barriers that prevent members from receiving appropriate education and information about the benefit of prevention and early information. Medica will look for additional, innovative ways to connect with these members and provide culturally sensitive health care education. Medica began using the Johns Hopkins Evidenced Based Medicine [EBM] GAPs in Care software in 2013. This software prompts case managers and health coaches about missing tests such as LDL-C and HbA1c. The training and tools available to Medica staff evolved during 2013 and a greater emphasis is being focused on this in 2014.

Measure	Discussion	Strategies
Well Child Care [3-6 years]	Per DHS Medica's rate is 64.32% which is 7.94 percentage points below the 50th percentile. Per Medica's HEDIS® rate we are at 69.54% in 2012 and 70.72% in 2013. This is below the DSS average by 13%.	Medica has implemented a work plan for Child & Teen Check-Up, in an effort to improve our rates. As a part of this work plan, the team conducts an analysis of activities and barriers to assist in future planning. Activities conducted in 2013 include: conducting key clinic trainings on C & TC; participating in regional collaborations/partnerships that provide information to providers and education to members; placing articles about the benefits of Child & Teen Check Ups in the member newsletter. Barriers noted include cultural and linguistic barriers that prevent members from receiving appropriate education and information about the benefit of prevention and early information. Medica will look for additional, innovative ways to connect with these members and provide culturally sensitive health care education.
CAHPS® Getting Care Quickly	Per DHS Medica's score is 60.5% or 20.97 percentage points below the 50th percentile. Medica's CAHPS® [Usually & Always] was at 86.55% in 2012 and the same for 2013. We are 6 percentage points above the DSS average. We were at 56.92% for Always in 2012 and 55.44% in 2013. We have more Usually than Always than DHS's data.	Medica's scores in 2013 are statistically above the DSS, our CAHPS® vendor, average. The in depth analysis of the CAHPS® data did not identify this as a driver of satisfaction. Further analysis show appointments with specialists as a likely contributor to the rating. Medica continues to monitor this as our network, with the exception of Mayo, is very large.

- ***2012 Recommendation:*** Track adherence to the corrective action plans developed to address deficits in the quality program administration, complaints, grievances, utilization review and access and availability closely to promote future compliance with MDH QA Exam requirements. Medica should monitor process measures to identify and implement timely mid-course adjustments and ensure changes are integrated.

  MCO Response: Medica's Supervisor of Delegation and Compliance created and followed-up on all MDH issues using a detailed work plan. When DHS returned to re-audit all identified issues were resolved. Annual monitoring of MDH requirements continues at Medica.

- ***2012 Recommendation:*** Continue careful analysis of PIP progress making mid-course adjustments as necessary especially as it relates to efforts to improve blood pressure control for the SNBC population. Collaborative efforts provide opportunities for collective learning and the MCO should seek opportunities to identify and promote spread of best practices. Strengthen areas of weakness through mentoring and sharing of lessons learned.

  MCO Response: Medica strongly supports collaborative efforts. The Blood Pressure PIP did involve each health plan working with a clinic partner so that "front line" feedback could be obtained. This information was shared among the health plans and with the network providers. The rate of Blood Pressure control for the SNBC population was 78.04% for 2012. While this rate did not meet the goal, it is a high rate for this membership. The most significant factor impacting reaching the goal appears to be the high SNBC 140/90 baseline rate of 82.05%. [This compares to the original proposal 130/80 baseline rate of 61.74%]. With a change in guidelines came a higher rate of compliance. Although not a 3% RIR, the current rate of 78.04% continues to exceed the rate of compliance for the F&C-MA/MNCare and MSHO/MSC+ populations. The SNBC membership has some unique characteristics that could contribute to the difficulty in reaching the goal for this population. All health plans working with the SNBC population had significant growth in membership during the project time period. Much of this growth happened in 2012. For Medica, UCare and MHP, the combined SNBC membership increased from 4925 in December 2011 to 32982 in December, 2012. With the SNBC membership, it takes significant time for relationship building with both the primary care physician and care coordinators, and thus improvement in this kind of rate takes more time. While all SNBC members have access to a Care Navigator or Care Coordinator, this is a population that is much more transient and is more difficult to reach. Many members are difficult to find and do not respond to initial attempts to reach them by their Care Navigator/Coordinator. Members are often not responsive to Care Navigator/Care Coordinator outreach until in crisis or in the hospital. Upon review of the Blood Pressure rates, it was noted that of the 218 members not compliant for BP=140/90, 112 (51.4%) had their systolic less than or equal to 150. As discussed in the 2012 analysis, located on page 63, a higher percentage of the SNBC population has mental health and chemical dependency issues that impact the ability of providers to achieve hypertension control.

- ***2012 Recommendation:*** Ascertain causes and strategically identify and implement interventions to address the loss of withhold points in the areas of ED utilization and 30-day readmissions. Consider working collaboratively with other MCOs to identify common barriers, best practices, or other successful strategies.

  MCO Response: In 2013, we continued the ER intervention strategy with health coaching and case management. In addition, we developed or began development of the following:

  a. Revised member identification/intervention capabilities for members who had been admitted for an ambulatory care sensitive condition and expanded identification/intervention capabilities specific to members with unstable behavioral health co-morbidities (SHCN algorithm).
  b. Expanded the Integrated Care Coordination program to all F&C-MA & MnCare adults in collaboration with the telephonic case management and healthy pregnancy programs. The

original program targeted the adults without children members (former GAMC) based on ER or inpatient utilization &/or cost.

c. Researched approaches to transitional interventions to prevent re-admission. This included a review of findings from RARE and a North Carolina study of utilization interventions for the Medicaid population. Further, we reviewed member data associated with 2012 re-admission rate and determined common conditions and co-morbidities associated with members who had a re-admission. We also defined and tested a method to capture faxed admission data along with additional elements to support a daily admission report to identify members for a transition intervention. We are currently in the process of defining a targeted approach with a high utilization hospital.
d. Began development of a pediatric asthma program; based on the identification of pediatric asthma as one of the ER utilization drivers.
e. Identified a need for and researched options for an approach to MTM services to support utilization interventions.

- ***2012 Recommendation:*** Perform an in-depth analysis of the eight measures demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

MCO Response:

Quality	
Chlamydia Screening	Medica has a performance improvement project which identified many barriers to this testing. The project addresses the barriers to Chlamydia screening as Medica too had identified a downward trend. Medica is working collaboratively with 2 other large health plans to address primarily the provider barriers.
Access	
Adult Preventive Visits [20-44]	Medica's HEDIS® rate has been stable for the past 5 years, varying by 1% or less from year to year. Medica will continue to monitor this rate.
Adult Preventive Visits [65+]	Medica's investigation found this HEDIS® rate is below our desired rate. The numbers of members in this cohort is low so variability it common from year to year. Medica will continue to monitor. Medica's Care Coordinators emphasize the importance of preventive visits when working with members.
Child PCP Visits [7-11]	Medica's investigation found HEDIS® rates have varied little from year to year since 2009, less than 1% from year to year and not always in the same direction. Our data shows a slight increase in 2013 results. This will continue to be monitored.

Timeliness	
Breast Cancer Screening	Rates for breast cancer screenings have been dropping, in part due to the changing guidelines. This makes it difficult for women to believe it is an important test. The rates for breast cancer screening are falling nationally; this is not only a local phenomenon. An educational mailing was sent in late 2013 to women who were missing this screening test reminding them of the importance and to make an appointment. It was developed in collaboration with the American Cancer Association.
Cervical Cancer Screening	Specific causes for the decreasing rates have not been identified. The service is widely available and included in the benefit set. An educational mailing was sent in late 2013 to women who were missing this screening test reminding them of the importance and to make an appointment. It was developed in collaboration with the American Cancer Association.
Comprehensive Diabetes Care [HbA1c Testing]	Per DHS, Medica scored 84.26% which is just above the 50th percentile. Per Medica's HEDIS® data, Medica scored 94.40% in 2012. This measure was rotated in 2013. Medica will continue to monitor this rate and continue to use the hybrid method as it is obvious that claims reviewed alone undercount the amount of testing performed. Medica began using the Johns Hopkins Evidenced Based Medicine [EBM] GAPs in Care software in 2013. This software prompts case managers and health coaches about missing tests such as LDL-C and HbA1c. The training and tools available to Medica staff evolved during 2013 and a greater emphasis is being placed on this in 2014.
Comprehensive Diabetes Care [LDL-C Screening]	Per DHS Medica scored 69.65% or 6.63 percentage points below the 50th percentile. Per Medica's HEDIS® data we scored 84.18% in 2012 and in 2013 the measure was rotated. This is above the 50th percentile. Medica will continue to monitor this rate and continue to use the hybrid method as it is obvious that claims reviewed alone undercount the amount of testing performed. Medica began using the Johns Hopkins Evidenced Based Medicine [EBM] GAPs in Care software in 2013. This software prompts case managers and health coaches about missing tests such as LDL-C and HbA1c. The training and tools available to Medica staff evolved during 2013 and a greater emphasis is being placed on this in 2014.

- ***2012 Recommendation:*** Determine strategies to improve performance in the four areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

MCO Response:

A. CAHPS® How Well Doctors Communicate
B. CAHPS® Getting Needed Care
C. CAHPS® Health Plan Customer Service
D. CAHPS® Getting Care Quickly

A. MHP does not fully agree with how MPRO came to the rate for this CAHPS® Measure. MPRO has MHP's combined rate for How Well Doctors Communicate at 76.33%. This composite measure is a combination of four questions, all with four possible answers of Never, Sometimes, Usually, and Always. The CAHPS® methodology states that 'Usually' and 'Always' are both considered achievement scores. When MHP teased its data apart from the health plans DHS grouped together due to small numbers and averaged each question's numbers into one composite, MHP calculates a rate of 94.10% as a combined rate for SNBC, MSHO and MSC+. The MHP derived rate of 94.10% is statistically strong and this element would have been a strength for MHP, not a weakness. MPRO only accepted the answer of 'Always' as successful, not following the CAHPS® methodology. The data presented by MPRO for MHP is at the worst misleading and at the best unclear. MHP does not feel that responses answered 'Usually' to these questions should be deemed as negative. Additionally, MHP providers' are highly experienced in working with our member populations with the majority of MHP providers serving the urban areas of Minnesota including safety net hospitals and organizations. Our providers generally communicate well with our members and MHP has virtually no member grievances related to inadequate physician communication.

B. MHP does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has MHP's combined rate for Getting Needed Care at 56.33%. This composite measure is a combination of two questions, both with possible answers of Never, Sometimes, Usually, and Always. The CAHPS® methodology states that 'Usually' and 'Always' are both considered achievement scores. When MHP teased its data apart from the health plans DHS grouped together due to small numbers and averaged each question's numbers into one composite, MHP calculates a rate of 87.37% as a combined rate for SNBC, MSHO and MSC+. The MHP derived rate of 87.37% is statistically strong and this element would have been a strength for MHP, not a weakness. MPRO only accepted the answer of 'Always' as successful, not following the CAHPS® methodology and the data presented is at the worst misleading and at best unclear. MHP does not feel that responses answered 'Usually' to these questions should be deemed as negative.

One large challenge for MHP members accessing care is often with Mental Health and Chemical Dependency categories of service. There is a general shortage of Mental Health and Chemical Dependency providers within the reach of members. MHP keeps the network to these services as open access, and MHP will provide transportation to and from appointments wherever the members are able to get in. However, these measures have not been enough to ensure that all of our members get their needed care, when they need it. Many of the members with mental and/or chemical health issues who cannot get the care that they need will often end up presenting at the closest hospital emergency department.

Some unique benefits come along with MHP's relationships to the county human services department and to the Hennepin County Medical Center (HCMC) for members in need of mental or chemical health care. MHP is better able to connect members to services available through the county or county partners. The Acute Psychiatric Services (APS) at HCMC is a uniquely positioned psychiatric emergency room that serves the primary area where many of the MHP members reside. Even with the arrangement of MHP mental health and chemical dependency services, there is still a shortage of providers making it difficult for members to receive needed care.

C. MHP does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has MHP's combined rate for Health Plan Customer Service at 66.00%. This composite measure is a combination of two questions, all with four possible answers of Never, Sometimes, Usually, and Always. The CAHPS® methodology states that 'Usually' and 'Always' are both considered achievement scores. When MHP teased its data apart from the health plans DHS grouped together due to small numbers and averaged each question's numbers into one composite, MHP calculates a rate of 84.67% as a combined rate for SNBC, MSHO and MSC+. MPRO only accepted the answer of 'Always' as successful and did not follow the CAHPS® methodology. The data presented by MPRO for MHP is misleading. MHP does not feel that responses answered 'Usually' to these questions should be deemed as negative.

It is not surprising that customer service is among the lower scoring measures for MHP. Satisfaction with customer service is a topic commented on by members and occasionally by staff. Additional customer service trainings have been provided to staff over the last few years and members and staff have noticed an improvement. MHP staff have commented that it is not necessarily the tone or manner in which customer service representatives respond to inquiries, but the need to communicate negative information to the member such as denials of taxi rides or cosmetic procedures. The challenge for any health care organization is to stay on top of constantly changing information and processes. MHP has invested significant time and effort into training, oversight and accountability within the customer services area in an effort to improve this CAHPS® result. A need recognized by MHP early last year was that many members were physically coming in to the MHP front office for customer service assistance rather than by calling in. The number of walk-in members averages from 70 to 150 per day. It is highly unusual for a health plan to offer walk-in customer services at its location. Based on this information, MHP implemented multiple changes to its walk-in customer service approach that has helped with member satisfaction. MHP created a 'Care Guide on Call' schedule so that a professional nurse or social worker care guide is available to

assist members in the front lobby. The 'Care Guide on Call' is always posted around the departmental areas for staff to see. Also, MHP began staffing the front desk with Community Health Workers to provide better assistance to members regarding their coverage and eligibility needs. Due to this growing walk-in service, MHP will be expanding and remodeling its front desk operation. The plan was to complete the remodel in 2013, however due to MHP offices being located in a historic building, construction approval has been a lengthy process. The remodel has been rescheduled for 2014, and will include at least one TV monitor to broadcast health-related information. It appears that many of MHP's members prefer to come in to MHP to address their customer service needs. MHP typically has 2 or 3 staff people at the front desk to assist the volume of walk-in traffic.

Although this issue has been mentioned previously in other MCO responses to the Annual Technical Report, it is a significant cause of dissatisfaction amongst MHP members and it is necessary to be brought up again. MHP Customer Service handles a large number of transportation requests that require a sometimes frustrating process to meticulously verify appointments and logistical details. Additionally, many MHP member grievances are related to transportation issues. Members can be very agitated regarding transportation. MHP does regular training with customer service representatives regarding transportation, including how to provide individual member assistance in order to de-escalate conflicts.
In 2012, MHP did create an escalation/engagement and resolution resource, commonly referred to as the "E&R Desk" or the "ERD". This resource has been critical in assisting the customer service staff in providing adequate time and attention to members, especially individuals with extremely complex situations.

D. MHP does not fully agree with how MPRO came to the rate for this CAHPS® measure. MPRO has MHP's combined rate for Getting Care Quickly at 63.00%. This composite measure is a combination of two questions, both with possible answers of Never, Sometimes, Usually, and Always. The CAHPS methodology states that 'Usually' and 'Always' are both considered achievement scores. When MHP teased its data apart from the health plans DHS grouped together due to small numbers and averaged each question's numbers into one composite, MHP calculates a rate of 84.19% as a combined rate for SNBC, MSHO and MSC+. MPRO only accepted the answer of 'Always' as successful and did not follow the CAHPS® methodology. The data presented by MPRO for MHP is at the worst misleading and at best unclear. MHP does not feel that responses answered 'Usually' to these questions should be deemed as negative.

- ***2012 Recommendation:*** Explore reasons for the notable ongoing voluntary disenrollment for MSHO. MPRO recommends MHP perform a trend analysis including identifying root causes.
  MCO Response: A recent barrier for MHP that has certainly resulted in higher voluntary disenrollment for both SNBC and MSHO is the reluctance of a certain dominant provider in the Hennepin County area to contract with MHP. MHP has been aggressively pursuing this particular provider for quite some time with no positive results. This provider has loyal patients who have been known to leave the plan when they see that their provider is not part of the MHP network.

MHP will continue to pursue this provider's participation despite MHP's prior road block to remedy the situation.

At this time, MHP believes this lack of a certain provider in the network for MSHO is the primary reason for the elevated MSHO voluntary disenrollment. MHP's MSHO population makes very few complaints regarding the reasons given for voluntary disenrollment. MHP MSHO members give their health plan and care coordinators very positive feedback during member events. MHP MSHO members provided the following feedback at a recent member event:

What do you like about MHP MSHO/MSC+?

Members stated they like the following providers:
HCMC and the doctors
HCMC Whittier Clinic
N.W. Eye Clinic
Pearl Vision
HCMC Eye Clinic
Care Guide is very good (nearly every member stated their care guide was the best)
Care Guide keeps me up on things I need to know
Best Care Coordinator ever "I love her"
Member Statements…"I love my care guide, …..my hero, …..we appreciate it from the bottom of my heart.."

What can MHP improve upon?

More member events
Stated they like this member event the best
Dentists say they get paid too little to see members
Don't want to see dental providers who are not modern and are not using the most modern equipment or treatment practices.
The members stated they don't like it when they do see a dentist that they try to use up all of their dental benefits in one appointment.

Front Lobby Experience at MHP

Good
Everything is good
They have good experiences
Help me get my bus pass
Help me get to the YMCA
Good response when calling for a ride

MHP is currently in the process of conducting a larger USpeq survey of its membership in an effort to obtain feedback from more than just the members who attend the semi-annual member events. Hopefully this survey will assist MHP in identifying any other causes for the voluntary disenrollment

of members. MHP is also researching the availability of some other validated tool (such as Press-Ganey) to use to measure member satisfaction and decrease disenrollment trends.

- ***2012 Recommendation:*** Consider further analysis of SNBC voluntary disenrollment especially as it relates to clinic wait times and access to mental health services.

  MCO Response: MHP conducts an annual assessment of appointment availability as a component of a network adequacy review. Appointment availability is determined through a provider survey process and is measured against a set of clinically viable standards for appointment wait times. MHP has set the internal benchmark of providers being able to meet those clinical standards at least 85% of the time or greater. The various appointment types reviewed in the survey fall into four categories of services; primary care, ob/gyn care, mental health care and specialty care. Under these four categories is a wide array of appointment types that the survey questions address. The total percent of providers in each category that meet the 2013 standards are as follows:

Table 1: 2012 MHP Providers Meeting Appointment Availability Standards

Care Category	# of Responding Providers	# of Responding Providers at Clinical Standard	Percent of Providers at Clinical Standard
Primary Care	476	453	95.2%
OB/GYN Care	136	129	94.9%
Mental Health Care	234	179	76.5%
Specialty Care	190	165	86.8%
Total	1,036	926	89.38%

Source: MHP Provider Appointment Survey Results 2013

As the above results indicate, the only real over-arching category that MHP struggles with is Mental Health Care in terms of accessing appointments within the clinically acceptable time frames. MHP has been fully aware of this gap in available care services and providers. This gap is primarily caused by a provider shortage. MHP has responded to this mental health care shortage by keeping the network for these services open access and assuring members that MHP can provide transportation to these types of appointments, as previously mentioned.

MHP is exploring the possibility of conducting member education related to appointment wait time standards. The difficultly in providing care quickly to members is that the definition of "quickly" can be subjective. MHP members are high users of the emergency department and other walk in health services. Knowing this fact about MHP members can lead to the conclusion that many members have a very different perception of what it means to get care quickly and the clinically acceptable standards are probably not perceived as fast enough for many individuals. MHP network management staff review appointment wait times and network adequacy very seriously. If a clear gap emerges, everything is done to find a sustainable solution to providing seamless member care.

One barrier with the appointment availability data is that MHP is only able to capture a relatively low response rate by providers in the random sample of providers to contact. These lower numbers can distort the survey results and give MHP an inaccurate understanding of its appointment availability. Additionally, the random sample could prove to not be representative of MHP providers as a whole. MHP is in the process of upgrading its provider database and provider contact information. There has been a great deal of discussion around the possibility that the data given the contracted vendor who completes the MHP provider appointment availability survey could be improved to achieve a higher success rate for getting providers to respond. MHP also has a notification mailing scheduled to go out to MHP providers before the next survey is conducted to reduce the number of providers who do not participate due to a lack of awareness of the forthcoming survey. MHP Provider Relations also plans to contact the providers who have historically not completed the survey to be trained on the importance and purpose of the survey.

As previously mentioned under weaknesses B and D, ensuring that members have access to mental health and chemical dependency care services is extremely challenging for MHP, but it is also a top priority. First, there is a general shortage of mental health providers in the state of Minnesota. Secondly, the MHP SNBC population is fraught with mental health and chemical dependency issues, many members suffer from multiple conditions in addition to other co-morbidities. MHP struggles with the age old issue of high demand and low supply.

As also previously discussed, one way MHP tries to compensate for this issue is by keeping the behavioral health provider network open access for all members, including providing transportation for behavioral health care visits. MHP has also improved its care guide resources for Targeted Case Management (TCM). MHP has an internal TCM nurse coordinator who works closely with the TCM care guide to ensure that the external TCM care guides are able to seamlessly access the member's health plan benefits in order to get the member in to see a mental health provider. MHP also has contracted with three behavioral health specialized care guide agencies for SNBC that have helped MHP begin to reach the goal of having one accountable individual to assist members navigate health care services. In 2014, MHP will begin two different pay for performance partnership arrangements for SNBC that will have mental health as a component. One project is designed around a primary

care clinic that has integrated behavioral health services available, and the other is with one of the specialized mental health care guide agencies.

Another more recent barrier for MHP that has certainly resulted in higher voluntary disenrollment for both SNBC and MSHO is the reluctance of a certain dominant provider in the Hennepin County area to contract with MHP. MHP has been aggressively pursuing this particular provider for quite some time with no positive results. This provider has loyal patients who have been known to leave the plan when they see that their provider is not part of the MHP network. MHP will continue to pursue this provider's participation despite MHP's prior road block to remedy the situation.

- ***2012 Recommendation:*** Continue careful analysis of PIP progress making mid-course adjustments as necessary especially as it relates to efforts to improve blood pressure control for the SNBC population. Collaborative efforts provide opportunities for collective learning and the MCO should seek opportunities to identify and promote spread of best practices. Strengthen areas of weakness through mentoring and sharing of lessons learned.

  MCO Response: MHP continues to collaborate on performance improvement projects whenever appropriate in an effort to share best practices and achieve collective learning. The 2010 PIP, Blood Pressure Control for Members with Diabetes, concluded with 2013 HEDIS® data representing services provided in 2012. The inability of SNBC to achieve the desired relative improvement rate (RIR) was due to the baseline rates already being very high for the population at 82.05%. The high baseline rate was the result of a significant change in the guideline for blood pressure control, forcing the collaborative to change its blood pressure measurement goal from 130/80 to 140/90. (The original proposal 130/80 baseline rate was 61.74%) Although not a 3% RIR, at 78.04% the SNBC population achieved a higher blood pressure control rate than the other products included in the project; F&C-MA/MNCare and MSHO/MSC+.

  The SNBC population is fraught with mental health and chemical dependency issues. As noted in the current ICSI and JNC guidelines, providers are less able to achieve hypertension control in populations noted to have increased use of alcohol, mental illness, obesity, or stress. Thus, it is an achievement that the high SNBC rates are able to be maintained at that level.

  A variety of clinic and provider based interventions have been implemented in the course of this project with the intention that system changes will be embedded into their practices.

- ***2012 Recommendation:*** Perform an in-depth analysis of the one measure demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

  MCO Response: MHP's MSC+ population did experience a decrease in Breast Cancer Screening Rates from CY 2011 to CY 2012, but MHP derived HEDIS® data does not show a three-year downward trend for the product. MPRO did not include the three trending rates when determining the three-year downward trend, so MHP cannot fully evaluate this finding. The rate increased from CY 2010 to

CY 2011 by 2% per MHP derived data. Additionally, the denominators for this product have continuously decreased. The denominator in CY 2010 was 83, and 70 in CY 2011. In CY 2012, the denominator was 61. The decreasing dominator also could have played a role in the lower CY 2012 rate.

In 2012, MHP's MSC+ population had an average age of 72 years. Breast Cancer Screening is not always seen as critical after women reach this age. The 2012 NCQA HEDIS® Technical Specifications only include women between the ages of 42 and 69 years. MHP has noticed in recent months that the MSC+ average age has been getting younger; this could assist MHP in achieving higher breast cancer screening rates as members may be more receptive to being screened. Additionally, NCQA changed its specifications for HEDIS® 2014 to include women up to age 74. MHP is supporting an upcoming MDH cancer screening incentive program to boost colorectal, breast and cervical cancer screening rates. The program will be implemented in waves with breast cancer screening being implemented in early 2014. MHP will be supporting MDH with this effort, and will be training its customer service and medical administration staff on how to address questions regarding the program while encouraging members to participate in this opportunity.

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- ***2012 Recommendation:*** Determine strategies to improve performance in the 11 areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

  MCO Response: PrimeWest Health reviews its final Healthcare Effectiveness Data and Information Set® (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey rates annually with staff from various departments and determines plans for improvement as appropriate. PrimeWest Health is aware that MPRO has identified 11 areas of weakness for PrimeWest Health. Below is a description of the strategies PrimeWest Health has chosen to implement for each area as well as how and when the strategy will be implemented. The descriptions will also contain the expected outcomes or goals of the actions to be taken and PrimeWest Health's process for monitoring the action to determine effectiveness.

  Chlamydia Screening: Members do not always admit they are sexually active, and providers do not always ask, especially if parents are in the exam room. If sexual activity is not addressed, chlamydia screening is also not addressed. PrimeWest Health reminds members annually of this important screening through articles in our member newsletter. In addition, PrimeWest Health is currently working on implementing alternative reimbursement strategies for providers to complete chlamydia screening when appropriate. Chlamydia screening is being added as a quality measure in PrimeWest Health's Accountable Rural Community Health (ARCH) initiative. This initiative shifts the PrimeWest Health operational approach from traditional managed care to an approach of provider-payer shared accountability. Action items will be accomplished in 2014, and the expected goal is to increase the Chlamydia screening rate. The process for monitoring the action to determine its effectiveness will be to monitor claims for attributed ARCH member clinics and review HEDIS® rates for improvement.

  Adolescent Well-Child Care (12 – 21 years): Members in this demographic do not usually schedule well-child visits, but rather present to the provider for sick or problem-based visits. PrimeWest Health reminds members annually of the importance of well-child visits through articles in our member newsletter. In addition, PrimeWest Health is currently working on implementing alternative reimbursement strategies for providers to complete well-child visits. Child and Teen Checkups (C&TCs) is the subject of a quality measure in PrimeWest Health's ARCH initiative. Action items will be accomplished in 2014, and the expected goal is to increase the Adolescent Well-Care (AWC) HEDIS® rate. The process for monitoring the action to determine its effectiveness will be to monitor claims for attributed ARCH member clinics and review HEDIS® rates for improvement.

  Cervical Cancer Screening: PrimeWest Health's Medicaid HEDIS® 2013 rate for Cervical Cancer Screening was 70.32 percent, which is above the Medicaid 50th percentile. PrimeWest Health uses

its HEDIS® rates, which include chart review data in combination with claims data, to produce a hybrid rate to gauge areas of strengths and opportunity. As the HEDIS® 2013 rate was above the Medicaid 50th percentile as well as the national mean, it was not identified as an area of weakness by PrimeWest Health.

Comprehensive Diabetes Care (HbA1c Testing): PrimeWest Health's Medicaid HEDIS® 2013 rate for Comprehensive Diabetes Care (HbA1c Testing) was 87.45 percent, which is above the national mean as well as the Medicaid 50th percentile. PrimeWest Health uses its HEDIS® rates, which include chart review data in combination with claims data, to produce a hybrid rate to gauge areas of strengths and opportunity. As such, it was not identified as an area of weakness by PrimeWest Health.

Comprehensive Diabetes Care (LDL-C Screening): PrimeWest Health's Medicaid HEDIS® 2013 rate was 71.59 percent, which is below the national mean as well as the Medicaid 50th percentile. PrimeWest Health's outreach efforts have included personalized reminders for members and their treating providers as well as phone calls. However, in light of the proposed changes for HEDIS® 2015 and the updated guidance for the treatment of blood cholesterol from the American College of Cardiology/American Heart Association (ACC/AHA) Task Force on Practice Guidelines, PrimeWest Health is not planning any additional outreach efforts for this particular measure. PrimeWest Health will continue to focus efforts on other Comprehensive Diabetes Care elements that align with the latest ACC/AHA and Joint National Committee (JNC 8).

Well-Child Care in the First 15 Months of Life (W15) (6+ visits): PrimeWest Health's Medicaid HEDIS® 2013 rate for Well-Child Visits in the First 15 Months of Life (6+ visits) was 66.67 percent, which is above the national mean as well as the Medicaid 50th percentile. Although the rate was not considered a weakness by PrimeWest Health, outreach efforts continue with parents/guardians of children as well as providers. PrimeWest Health is currently working on implementing alternative reimbursement strategies for providers to complete well-child visits. C&TCs is the subject of a quality measure in PrimeWest Health's ARCH initiative. Action items will be accomplished in 2014, and the expected goal is to increase the W15 HEDIS® rate. The process for monitoring the action to determine its effectiveness will be to monitor claims for attributed ARCH member clinics and review HEDIS® rates for improvement.

Well-Child Care (3 – 6 years) (W34): Parents/guardians of members in this demographic do not often schedule well-child visits, but rather the member presents at the provider for sick or problem-based visits. PrimeWest Health reminds parents/guardians of members and providers annually about this important visit through articles in our member and provider newsletters. In addition, PrimeWest Health is currently working on implementing alternative reimbursement strategies for providers to complete well-child visits. C&TCs is the subject of a quality measure in PrimeWest Health's ARCH initiative. Action items will be accomplished in 2014, and the expected goal is to increase the W34 HEDIS® rate. The process for monitoring the action to determine its effectiveness will be to monitor claims for attributed ARCH member clinics and review HEDIS® rates for improvement.

In the next section, please note PrimeWest Health uses different methodologies when analyzing CAHPS® results. When the Minnesota Department of Human Services (DHS) CAHPS® project analyzes CAHPS® results, it considers responses of "9" and "10" or "Always" to be most favorable, and therefore has a slightly different take on the results. PrimeWest Health considers favorable responses as "8," "9," and "10" as well as "Usually" and "Always".

CAHPS® How Well Doctors Communicate: PrimeWest Health's analysis of the composite, "How Well Doctors Communicate" did not show any populations that were significantly higher/lower than the Minnesota program rate at a 95 percent confidence level. The scores that follow represent a composite of the percentage of members who responded favorably ("Usually" or "Always") to the following questions when their response choices were "Never," "Sometimes," "Usually," or "Always":

- In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?
- In the last 6 months, how often did your personal doctor spend enough time with you?

As such, PrimeWest Health did not consider this an area of weakness. See the following table.

	How Well Doctors Communicate								
Program	2006	2007	2008	2009	2010	2011	2012	2013	2013 MN
F&C-MA)	92.0%	91.3%	95.1%	94.9%	94.1%	94.8%	91.8%	94.4%	95.3%
MinnesotaCare	-	-	-	94.4%	96.8%	85.3%	95.8%	96.7%	95.9%
MSC+	-	-	-	92.7%	91.9%	94.4%	93.9%	95.0%	95.6%
PrimeWest Senior Health Complete	96.1%	94.3%	95.6%	96.5%	96.2%	96.1%	96.6%	97.2%	96.0%
SNBC/Prime Health Complete	-	-	-	94.5%	91.6%	96.3%	95.4%	92.6%	92.0%

↑↓ Indicates a rating significantly higher/lower than the Minnesota program rate at a 95 percent confidence level.

CAHPS® Getting Needed Care: PrimeWest Health's analysis of the composite, "Getting Needed Care" showed that a couple of populations were significantly higher than the Minnesota program rate at a 95 percent confidence level. The following scores represent a composite of the percentage of members who responded favorably ("Usually or "Always") to the following questions when their response choices were "Never," "Sometimes," "Usually," or "Always":

- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

As such, PrimeWest Health did not consider this an area of weakness. See the following table.

Program	Getting Needed Care						
	2008	2009	2010	2011	2012	2013	2013 MN
F&C-MA	87.0%	82.5%	84.6%	81.1%	84.1%	83.9%	86.5%
MinnesotaCare	-	92.0%	92.9%	90.4%	90.7%	88.5%	88.0%
MSC+	-	90.6%	88.2%	93.5%	90.4%	94.4% ↑	87.9%
PrimeWest Senior Health Complete	94.5%	93.3%	93.8%	91.2%	93.8%	95.5% ↑	91.2%
SNBC/Prime Health Complete	-	91.5%	95.2%	89.3%	90.6%	86.6%	83.7%

↑↓ Indicates a rating significantly higher/lower than the Minnesota program rate at a 95 percent confidence level.

CAHPS®: Health Plan Customer Service: PrimeWest Health's analysis of the composite, "Customer Service" showed one population that was significantly higher than the Minnesota program rate at a 95 percent confidence level. The following scores represent a composite of the percentage of members who responded favorably ("Usually or "Always") to the following questions when their response choices were "Never," "Sometimes," "Usually," or "Always":

- In the last 6 months, how often did your health plan's customer service staff give you the information or help that you needed?
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

As such, PrimeWest Health did not consider this an area of weakness. See the following table.

Program	Customer Service						
	2008	2009	2010	2011	2012	2013	2013 MN
F&C-MA	77.1%	82.1%	82.1%	83.3%	81.5%	82.8%	85.6%
MinnesotaCare	-	76.3%	92.9%	88.3%	78.0%	86.6%	84.3%
MSC+	-	94.1%	93.4%	90.5%	91.7%	85.0%	87.6%
PrimeWest Senior Health Complete	95.2%	89.3%	93.8%	93.6%	97.2%	89.5%	91.8%
SNBC/Prime Health Complete	-	87.9%	97.4%	84.7%	86.0%	92.2% ↑	84.6%

↑↓ Indicates a rating significantly higher/lower than the Minnesota program rate at a 95 percent confidence level.

CAHPS®: Getting Care Quickly: PrimeWest Health's analysis of the composite, "Getting Care Quickly" showed one population that was significantly higher than the Minnesota program rate at a 95 percent confidence level. The following scores represent a composite of the percentage of members who responded favorably ("Usually or "Always") to the following questions when their response choices were "Never," "Sometimes," "Usually," or "Always":

- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you needed?

As such, PrimeWest Health did not consider this an area of weakness. See the following table.

Program	Getting Care Quickly						
	2008	2009	2010	2011	2012	2013	2013 MN
F&C-MA	85.3%	85.7%	83.5%	84.2%	84.6%	83.6%	82.9%
MinnesotaCare	-	81.1%	87.6%	87.2%	87.6%	83.6%	85.2%
MSC+	-	92.8%	91.9%	93.8%	89.8%	89.9%	86.6%
PrimeWest Senior Heath Complete	93.7%	92.8%	93.5%	92.8%	93.4%	95.2% ↑	88.8%
SNBC/Prime Health Complete	-	91.9%	87.8%	87.1%	91.4%	84.0%	81.8%

↑↓ Indicates a rating significantly higher/lower than the Minnesota program rate at a 95 percent confidence level.

- ***2012 Recommendation:*** Track adherence to the corrective action plans developed to address deficits in the quality program administration, grievance system, access and availability, and utilization review closely to promote future compliance with MDH QA Exam requirement. PrimeWest should monitor process measures to identify and implement timely mid-course adjustments and ensure changes are hardwired.

  MCO Response: PrimeWest Health continues to track adherence to the corrective action plans (CAPs) resulting from previous Quality Assurance Examinations and Triennial Compliance Audits. PrimeWest Health has a Quality Workgroup comprised of staff from all departments that reviews documents related to these audits regularly as well as previous CAPs and continued monitoring. This Workgroup meets at least quarterly to monitor process measures to identify and implement timely mid-course adjustments as appropriate.

  2012 Recommendation: Ascertain causes and strategically identify and implement interventions to address the loss of withhold points in the areas of lead screening, ED utilization, hospitalizations, and 30-day readmissions. Consider working collaboratively with other MCOs to identify common barriers, best practices, or other successful strategies.

- ***MCO Response:*** PrimeWest Health strives to obtain as many withhold points as possible each year. However, PrimeWest Health has acknowledged the barriers involved with each measure as well as the aggressive targets set.

  Lead: The specifications for this measure include members who age into the specified age range up to the very last day of the measured time frame. For example, if a member was 9 months old on December 31, the member would be included in the denominator and would have to have had a lead screening on the same day to be included in the numerator. Similarly, members who enroll in a health plan in the last month of the year are attributed to that health plan's denominator with the same weight as someone who was enrolled for the entire year.

  Utilization: In rural areas where there are not always urgent care options, members utilize the emergency department (ED). In addition, the specifications for this measure are based on the HEDIS® Ambulatory Care measure and state that "only changes consistent with the measure specifications will be considered." However, the attribution methodology is not part of the HEDIS®

specs and attributes member months and ED utilization to the program (F&C-MA/MinnesotaCare) and pay system (fee-for-service/managed care organization [FFS/MCO]) depending only on the last month of the recipient's eligibility in the time period. If a member was with an MCO for the first 11 months out of the year and in the last month switched to FFS, it is unclear if all of the member months and ED utilization would be attributed to FFS. The withhold target was to decrease the 2011 rate by 10 percent. PrimeWest Health did not meet this target.

Hospitalizations: PrimeWest Health had a few questions about the specifications for this measure. First, the specifications list age criteria in two different ways. The first bullet under "Rates" indicates the members need to be "1 through 64 years old during the year" and the first bullet under Denominator Detail indicates "1 through 64 years old, calculated as of Dec 31st." Assuming the methodology under Denominator Detail is correct, this excludes all members born in the measurement year and those who turn 65 in the measurement year. If the idea is to exclude newborns, it isn't excluding those who were born at the end of the prior year—a member born on December 31, 2011, would be included in the 2012 rate but one born January 1, 2012, would not be. If a baby born December 31, 2011, was transferred on January 1, 2012, it is unclear if that would count as an admission. PrimeWest Health's calendar year 2011 Hospital Admission Baseline rate was 3.32 admissions/1,000 months. The withhold target was to decrease the 2011 rate by 5 percent. PrimeWest Health did not meet this target.

Readmissions: PrimeWest Health's 2011 score was the second lowest out of the seven health plans at 7.05 percent. The aggressive withhold target was to reduce the 2011 rate of 7.05 by 5 percent. PrimeWest Health did not meet this very difficult target.

- ***2012 Recommendation:*** Perform an in-depth analysis of the seven measures demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

MCO Response: PrimeWest Health has reviewed and performed an analysis of the seven measures showing a downward trend in performance by program. These are all preventive measures that will be added to PrimeWest Health's efforts in implementing alternative reimbursement strategies for providers in these areas. In addition, quality indicators for PrimeWest Health's ARCH initiative may be revised to include these areas where appropriate.

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- ***2012 Recommendation:*** Determine strategies to improve performance in the nine areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

  MCO Response: South Country takes a comprehensive approach toward reviewing, monitoring, and evaluating Quality indicators, and identifying and implementing best practices to improve the quality of care, services, and health outcomes for our members. South Country performs ongoing monitoring of performance metrics so that results of such activities are addressed in a timely and efficient manner. Interdepartmental workgroups meet regularly to review outcomes, focusing on high achieving measures to identify factors influencing success in an attempt to glean best practices that can be applied to other topics in need of improvement. The workgroups also review lower performing measures to identify key drivers of rates and opportunities for improvement. The process includes analyzing demographic information of members included in the respective measures for location of service or primary care clinic, county of residence, age, and living arrangements. Understanding trends in these variables allows for more confidence in developing interventions that address specific barriers related to access to care, quality of care, or utilization of services and that will lead to improvements in the associated performance measures. Quality improvement efforts are routinely tracked through South Country's Quality Work Plan, with trends and activities reported on in the Annual Quality Program Evaluation.

  South Country finds it difficult to evaluate HEDIS® measures reported using DHS methodology that combines populations, uses only administrative data, and only uses National Medicaid rates as comparison where Medicare members are included. Although we recognize that this process may allow for equitable comparison over time, the evaluation and reporting of HEDIS® results by unique population tells a more accurate story – it allows us to distinctly identify gaps in access to care or utilization of services and tailor action plans more appropriately. Similarly, South Country evaluates CAHPS® scores for each of our member populations (not aggregated) as reported by DataStat. This process allows for more meaningful interpretation of results, a better understanding of areas of dissatisfaction by population, and an enhanced ability to identify and implement more relevant actions for improvement. South Country recommends that DHS and IPRO analyze and report data in the ATR in a similar manner; once HEDIS® software is locked for rate calculations, health plans cannot go back and look at population combinations reported in the ATR that were not required or reported in the HEDIS® year.

  South Country followed the comprehensive monitoring and evaluation process previously described for the nine topics identified as weaknesses in the 2012 ATR.

Chlamydia Screening

In 2012, South Country implemented member education and incentive programs in an attempt to engage members and increase compliance with Chlamydia screening recommendations. Member education on the topic continues to occur through newsletters and other wellness programming, but the incentive was discontinued in 2013 because it offered no impact on member behavior. Consultations with county public health staff and other healthcare providers suggests that patients are most likely to receive the screening during a well-care visit, and it is not reasonable to expect them to schedule an appointment specifically for the screening and no other service – so South Country incorporates the topic into broader preventive care education for members. Provider beliefs and practices continue to vary over the necessary frequency for these screenings, especially in light of recent changes to cervical cancer screening guidelines, but South Country continues to promote the topic alongside other preventive care service guidelines. In addition, a pay-for-performance incentive program was piloted for a group of South Country providers in 2012. Although it appeared to support a small increase in Chlamydia screenings, it was unfortunately discontinued after 2013 due to budget constraints and competing priorities to address topics that are reflective of DHS regulatory requirements, and that South Country believes have a more immediate pertinence to the quality of care and services for our members. However, we will continue to monitor rates and consider other feasible means of improving member and provider compliance with Chlamydia screenings.

CAHPS® How Well Doctors Communicate

South Country's MA population had the highest rate (81%) compared to all MCOs for this measure, and was at the top in MSHO with one other health plan at 80%. The rates for MinnesotaCare and SNBC were on par with the MCO average for these products. Monitoring will continue on this topic, with information incorporated into member communications that offers suggestions on how to better communicate with providers and setting expectations for office visits.

CAHPS® Getting Needed Care

For this measure, South Country's MSHO rate was the second highest among all MCOs, scoring 5 percentage points above the MHCP average. The MSHO rate continued to improve in 2013, again surpassing the MHCP average. For the MA population, satisfaction ratings for Getting Needed Care increased by 7 percentage points, placing our rate above the MHCP average and most other MCOs. Adequate access to necessary services remains a priority for South Country because of the significant implications it has on members' quality of health. Provider education on access and availability standards is completed through newsletters and South Country's web site. South Country monitors network compliance with access and availability standards through quarterly review of geoaccess reports and annual audits of appointment availability for primary care and behavioral health clinics. In addition, member communications will continue to include information about appropriate wait times for scheduling routine and urgent care appointments, as well as tips for determining what level of care (routine or urgent/emergency) is appropriate to seek.

CAHPS® Health Plan Customer Service

South Country's Customer Service rating exceeded the MHCP average in 2012 for all products. Notably, the rate was the highest of all MCOs at 83% and was acknowledged as being significantly higher than the MSHO program average for that year. Although the higher than average performance on this CAHPS® measure reflects positively on our service to members, South Country strives to treat all members with utmost respect and exceed their expectations. Customer service has been a focus area for improvement since 2011 when our call center survey process was modified to better capture member perceptions on quality of service and experience. Member participation in the optional survey following a call to South Country's member services line has increased, notably at the end of 2013 when the process became automated and allowed for more anonymity. Although satisfaction rates vary by product, all results are in the 80-100% satisfaction range and none of the measures vary significantly from state averages. Results of the customer service surveys are monitored on a monthly basis; as trends arise that indicate areas of dissatisfaction, subject matter experts within South Country are engaged to help determine contributing factors and to identify strategies for improvement.

Adolescent Well Child Care (12-21 yrs and 3-6 yrs) and Well Child Care in First 15 months

Discussions with local public health agencies and primary care clinicians suggest a few key factors affecting these rates include the complexity of billing for full well-care exams (resulting in coding issues), stronger demand for sports physicals (in lieu of well-care exams) for adolescents, belief among parents and some providers that generally healthy children do not need to have a well-care visit on an annual basis, and challenges within clinics on well-care appointment availability due to high volumes of sick visits. For the 3-6 year age group, an analysis of rates shows it is the 6 year well-care exam that is typically not completed and thus negatively impacts the overall HEDIS® rate. Feedback from stakeholders suggests that parents do not find the 6 year well visit to be necessary because children have received all vaccinations required for school (typically during the 5 year well-care exam), and providers do not necessarily encourage a return visit at age 6 if the child is otherwise healthy. Similarly, regardless of age, if immunizations are not due then parents are less likely to have their child receive a full well-care exam. South Country has tasked a specific Family Health Committee, comprised of internal staff and county public health nurses, to identify opportunities for collaboration between South Country and its partnering counties to engage members and providers on the recommended well-care visit schedule. In the meantime, South Country has reward programs in place tailored to address visits for 15 month olds, 3-6 year olds, 11-17 year olds, and 18-21 year olds, with program strategies recently revised to draw more attention to the topic for the respective age groups. Key messages, material design, and reward types are tailored to appeal to the specific age groups. Evaluations of the adolescent (11-17 years) well-care visit reward program suggest that it positively impacts South Country's HEDIS® adolescent well-care visit rates; the 3-6 year and 18-21 year programs are new and have not had adequate time for evaluation. Educational interventions continue as well, with frequent promotion of guidelines to members and providers through mailings, newsletters, website, and materials distributed in public health offices. Evaluations of these improvement efforts are monitored at least annually, with changes made as necessary to ensure meaningful impact on member and provider compliance.

Cervical Cancer Screening

South Country is aware of the low compliance with cervical cancer screenings, particularly among our MA and SNBC populations. Changes in clinical practice guidelines for this topic in recent years may have caused confusion among members and providers about the current recommended schedule. To address this, South Country continues to promote screening guidelines alongside other preventive care topics in member and provider materials and other outreach. Aside from general education, South Country does not have any specific improvement initiatives in place for cervical cancer screenings but intends to further analyze data and root causes for low compliance in order to determine effective strategies for improvement. This will be done in collaboration with our local public health partners through the Family Health Committee.

CAHPS® Getting Care Quickly

South Country's results for the Getting Care Quickly CAHPS® measure exceeded the MHCP average in 2012 for all products – the second year in a row, with the exception of MinnesotaCare where the rate was slightly lower the year prior. Regardless, it remains an important topic for achieving and maintaining high satisfaction from members because it reflects their ability to get the care they need in a timely manner. South Country will continue to address this in a manner similar to that previously described for the "Getting Needed Care" measure, as the two topics are closely related.

- ***2012 Recommendation:*** Continue careful analysis of PIP progress making mid-course adjustments as necessary.

  MCO Response: South Country follows the DHS and CMS protocols for the development and implementation of PIPs. This includes ongoing performance evaluation through monitoring of process measures related to specific interventions as well as program outcome measures. We take a comprehensive and structured approach to these projects, integrating activities into South Country's Quality Work Plan to ensure project success and compliance. As issues are identified with process or outcome measure performance, or implementation of key activities, appropriate internal and county staff are involved in making necessary adjustments to point the project in a more appropriate and successful direction. The 2014 MCO contracts with DHS included significant changes to PIP requirements, which will allow South Country to dedicate more resources to the ongoing monitoring and adjusting of projects throughout their lifecycles.

- ***2012 Recommendation:*** Ascertain causes and strategically identify and implement interventions to address the loss of withhold points in the areas of ED utilization, hospitalizations, and 30-day readmissions. Consider working collaboratively with other MCOs to identify common barriers, best practices, or other successful strategies.

  MCO Response: South Country took a comprehensive approach toward reviewing, monitoring, and evaluating the withhold measures of ED utilization, hospitalization and 30-day readmissions. South Country reviewed performance metrics including utilization, stratification, cost and claims report to evaluate the possible causes of the loss of withhold points. One of the drivers for the loss in withhold points in 2012 was due to the change in composition of members enrolled in the F&C-MA product. During the first six months of 2012, South Country gained new membership of low-income adults between the ages of 21 and 64 years who did not have dependent children. This population

was being managed through the State of Minnesota prior to enrollment into managed care, and showed to have high medical and pharmaceutical needs upon enrollment into South Country. Another driver in the loss of withhold points is that the three measures were new to South Country in 2012 and many of the interventions were not fully implemented throughout 2012 due to limited staff resources.

Interventions that were implemented in 2012 and modified in 2013 included a utilization management program of monitoring and evaluating hospitalizations daily and ED visits weekly. South Country receives a daily hospitalization report. This report is created due to a contractual requirement of hospitals to notify South Country within 24 hours of the admission. Clinical staff reviews the report and identifies members who need additional assistance based upon diagnosis, length of stay, and prior utilization history. Members who need assistance are referred to either the complex case management program or to the local Community Care Connector. The local Community Care Connector is a position unique to South Country that assists in connecting members with local resources in the community. The Connector is a liaison between the health plan and local county/community resources and services. South Country receives a weekly emergency department claims report of members who have visited the emergency department two times in the last three months. Clinical staff reviews the emergency department utilization report and identify members who need additional assistance similar to the process outlines above for the hospitalization report. Staff identifies members based upon diagnosis, number of visits to the emergency department, and prior utilization history. Members are referred to complex case management or to the local Community Care Connector if needed. South Country also implemented a new utilization stratification software to begin identifying members who are at high risk for hospitalizations. Names of members who are identified through this new software is referred to multiple resources including the South Country Disease Management program, Restricted Recipient program, Complex Case Management program, or the Community Care Connector. Clinical staff provides follow-up to assure the member has been offered resources to assist the member.

South Country Health Alliance also expanded its Pay-for-Performance to additional health care Providers. The pay-for-performance measure was also expanded to include emergency department visits and 30-day readmission. South Country works with provider groups to identify and establish

key performance measures. Once the measures have been identified and agreed upon, South Country runs reports from previous years to establish "baseline rates" which are then used to create performance targets for the upcoming year. South Country will provide the provider groups with quarterly reports to monitor their progress.

The expected outcomes of these interventions is a reduction in the areas of emergency department utilization, hospital admissions, and 30-day hospital readmission in order to meet the Minnesota Department of Human Services withhold measures as outlined in the managed care contract. In order to measure monitor and measure effectiveness, South Country monitors the withhold rates on a quarterly basis at a minimum and compares internal rates to the rates provided by the State of Minnesota. Preliminary numbers for 2013 are showing that South Country was successful in reducing emergency department visits by 9.1% and in meeting the hospital admissions and 30-day readmissions measures which was a reduction of each rate by 5%.

- ***2012 Recommendation:*** Perform an in-depth analysis of the six measures demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

  MCO Response: South Country followed a comprehensive monitoring and evaluation process (as previously described) for the six measures identified as having a three-year downward trend in performance for specific programs.

  <u>Antidepressent Medication Management – Continuous (MinnesotaCare)</u>
  South Country recognizes the consistently low performance on this measure in recent years. Analysis of data and underlying factors are underway. The momentum for addressing this topic is strong as it is also a 2014 DHS Withhold measure and 2015 PIP topic; such alignment allows South Country to dedicate more resources toward a focused improvement plan. It is worthy of noting that Antidepressent Medication Management rates for South Country's SNBC and MSHO populations are higher, likely due in part to the care coordination services those members receive from county and South Country staff, and a closer connection to mental health providers because of coexisting conditions also being treated.

  <u>Adult Preventive Visits (x2) – 20-44 years (MA and SNBC) and 45-64 years (SNBC)</u>
  Despite the low preventive visit HEDIS® rates, internal monitoring efforts show that SNBC members have the highest utilization rates for primary care visits across all products. This has remained consistent for the last two years, and is likely due to the fact that these members have more comorbidities that require monitoring by and visits to primary care providers. Analyses of data during a previous Preventive Care PIP suggested that among SNBC members who lacked preventive visits, claims showed many members still received fairly comprehensive visits entailing multiple studies, blood work, and vaccines; however, it was difficult to determine if the purpose for the visits

was preventive care because they were usually coded according to the member's primary ailment, complaint, or disability. Therefore, while South Country agrees that attention on the completion of full preventive care exams for SNBC members is certainly warranted, the low rates do not necessarily reflect a lack of access to preventive care services. This perspective applies to the lower rates for the MA population as well, where primary care provider utilization has remained fairly steady in recent years. In addition to continuing frequent member education campaigns regarding preventive care services, South Country has developed a new reward program to encourage young adults ages 18-21 to complete a well-care visit with their primary care provider. It is believed that this will engage members and increase compliance more than the education alone. South Country will monitor the impact of this new program on rates, consider its application to other member populations, and continue to research best practices for improving preventive care visit compliance among members and providers.

Cervical Cancer Screening (MA and SNBC)

South Country rotated this HEDIS® measure in 2011 and therefore slightly skewed the trend line, but nevertheless it is evident that this is a topic requiring further research and action. See the details above under Recommendation # 1, Cervical Cancer Screening section, provided previously regarding South Country's plan for improvement.

Comprehensive Diabetes Care (x2) – HbA1c Testing and LDL Screening (MSHO)

Although a downward trend is noted for these diabetes care measures among the MSHO population, the hybrid rates remain relatively high (>90% compliance for HbA1c and >85% compliance for LDL screenings). South Country's diabetes disease management staff and county care coordinators continue to address these important screenings with members through personal outreach. In 2013, the diabetes program underwent significant revisions in terms of educational focus and personalized health coaching; it is expected that members will demonstrate an increased awareness in the importance of HbA1c testing and LDL screenings as a result.

- ***2012 Recommendation:*** Determine strategies to improve performance in the eight areas identified as weaknesses. Identify industry best practices and use to extrapolate methods that appropriately address the root causes for the population served.

MCO Response:

CAHPS® How Well Doctors Communicate: UCare continues to develop the relationship with our provider network to ensure comprehensive care to our members. UCare trains its provider network on our Model of Care. We employ care coordinators to facilitate communication and coordinate care across all providers within the Interdisciplinary Care Team. Our 2013 CAHPS® rates are at or above the Minnesota average for F&C-MA and SNBC and are within 6% of the Minnesota average for MSHO, MinnesotaCare and MSC+.

CAHPS® Getting Needed Care: UCare identified the issue of access to timely care from the 2012 CAHPS® survey. When members call for non-urgent or specialist appointments, members anticipate that they will be seen within their expected time-frame. UCare has in place access and availability standards for providers. To ensure these standards are met, UCare conducts annual secret shopper calls.

This measure is part of the NCQA Quality Improvement Standard 4, which requires an annual analysis of this area and identification of opportunities for improvement. UCare identified those areas and is formulating a strategy to better address the needs of our members. We are also conducting member focus groups to identify other needs and where there is room for improvement.

CAHPS® Health Plan Customer Service: UCare identified a need to improve and track customer service interactions with members from the 2012 CAHPS® survey. When members call Customer Service they expect to be treated courteously and with respect, as well as receive accurate information. In 2013 UCare Customer Service took several actions to improve the MSHO member customer service experience:

- Established a core team of specially trained MSHO representatives to develop in-depth knowledge of the MSHO product to achieve a deeper appreciation and understanding of the unique needs of this member segment. Specialized training was delivered and continues to be refined and improved.
- Our Quality Assurance team delivers direct coaching to representatives to supplement training provided by Customer Service supervisors. This training is primarily focused on soft skills, in support of treating members with courtesy and respect.
- In late 2012 we implemented speech analytics software to enable systematic analysis of customer service calls. Reporting is done using this system to analyze customer call

handling, including various aspects of courtesy and knowledge. The speech analytics reports, combined with automated post-call surveys measuring courtesy and knowledge, plus standard call monitoring activity, identify opportunities for coaching and performance management of representatives.

- Our new-hire training program was revised with the goal of developing better quality skills in our new representatives. There are multiple sessions conducted through the training period, which include knowledge components, best practices and expectations for call handling quality.

Adolescent Well Care (12-21 Years): UCare sends out a MOMS booklet to all expecting mothers. The booklet highlights the importance of every child and teen UCare member receiving a Child and Teen Checkup (C&TC) (EPSDT) exam at certain ages. A chart is presented in the MOMS booklet noting at what age members need to have a C&TC exam. The age chart reflects that adolescents need a primary care visit at 12, 14, 16, 18, 20 years of age, with immunizations due at 12 years, plus regular dental exams due at 12, 14, 16, 18, 20 years of age. Our 2013 Medicaid combined rates increased by 4% and are 7.5% higher than the Minnesota average.

Child Immunizations (Combo #3 – 2 Years): The MOMS booklet notes that immunizations are due for children at 0-1 months, 2 months, 4 months, 6 months, 12 months, 15 months, and 18 months. The booklet also states that members are eligible for a gift card if their children complete their immunizations at 2 years of age.

Well Child Care in First 15 Months (6+ Visits): UCare partners with WellShare International to improve well child visits in the first 15 months. Primarily via outbound calls, Community Health Workers provide an outreach intervention to better educate mothers/families on the importance of well child visits. Community Health Workers also provide face-to-face meetings with families to better educate families on the importance of children receiving six visits by their first 15 months of life.

As noted, UCare sends out the MOMS booklet to all expecting mothers. The age chart notes that children need well child care visits at 0-1 month, 2 months, 4 months, 6 months, 9 months, 12 months, and 15 months of life. Our 2013 Medicaid combined rates have increased slightly, and they are also slightly above the Minnesota average.

Well Child Care (3-6 Years): The MOMS booklet's age chart notes that children need well child care visits at 3, 4, 5, and 6 years of age, highlighting that immunizations are due at 5 years of age, and noting that regular dental exams are due at 3, 4, 5, and 6 years of age. The booklet lets members know that they are eligible for a gift card if their child completes a C&TC exam at 3 and 4 years of age. We are pleased that our 2013 Medicaid combined rates have increased by 3.5% and are 5% higher than the Minnesota average.

CAHPS® - Getting Care Quickly: UCare identified the issue of access to timely care from the 2012 CAHPS® survey. When members call for non-urgent or specialist appointments, members anticipate that they will be seen within their expected time-frame. UCare has in place access and availability standards for providers. To ensure these standards are met, UCare conducts annual secret shopper

calls. This measure is part of the NCQA Quality Improvement Standard 5 report for accessing the provider network, and we perform a yearly analysis of this area and identify opportunities for improvement. UCare identified those areas and is formulating a strategy to better address the needs of our members. We are also conducting member focus groups to identify other needs and where there is room for improvement.

- **2012 Recommendation:** Ensure ongoing monitoring of corrective actions taken to address the deficits especially in the grievance system to ensure proper delegation oversight and appropriate communication regarding denials. UCare should monitor process measures to identify and implement timely mid-course adjustments and ensure changes are integrated prior to the next MDH QA Examination to enhance the likelihood of future compliance with requirements.

  MCO Response: As do all managed care organizations, UCare takes seriously the results of each MDH QA Examination. In our 2012 mid-cycle review, MDH found that we had further work to do on only one of the corrective action plans and had met all but one of the mandatory improvements. We continued to monitor the finding and the mandatory improvement. As a result, neither of these two "deficits" were noted by MDH in our 2013 Quality Assurance Examination.

- **2012 Recommendation:** Continue careful analysis of PIP progress making mid-course adjustments as necessary especially as it relates to efforts to improve blood pressure control for the SNBC population. Collaborative efforts provide opportunities for collective learning and the MCO should seek opportunities to identify and promote spread of best practices. Strengthen areas of weakness through mentoring and sharing of lessons learned.

  MCO Response:
  Reducing Non-Urgent Emergency Department Use in the F&C-MA/MinnesotaCare Population: In 2013, the Reducing Non-Urgent Emergency Department Use Performance Improvement Project completed its first year of interventions.

  Minnesota Head Start Association (MHSA) Master Trainers conducted additional trainings as needed to train newly hired MHSA staff in a health literacy intervention, which includes not only education for the Head Start staff, but also the book What To Do When Your Child Gets Sick. In distributing the book to parents, Head Start staffs empower parents to educate themselves to make good decisions about caring for their children when the children are sick and to utilize health care resources in the

most appropriate way. MHSA staff members also work with families to make sure every family has a primary care clinic and understands the importance of preventive care for their young children.

In-person meetings were held between MHSA trainers and health plan collaborative members to check-in on progress to date and empower and motivate trainers to continue their work. MHSA staff continues to conduct interventions and gather data for analysis. MHSA and health plan activities in 2013 included the following:

- Project Planning Group, including lead trainers from each participating MHSA program and health plan collaborative representatives, held a conference call and three in-person meetings.
- Additional training sessions led by Head Start master trainers were conducted as needed, resulting in 101 additional trained staff as of March 31, 2013.
- 1095 pre-surveys were submitted by MHSA as of March 31, 2013, of which 716 were able to be matched to collaborative health plan data.
- The Collaborative updated the Health Literacy Project Program Guide for MHSA staff. The guide offers step-by-step instructions on needed steps for completion of the health literacy intervention and data collection.

Breast Cancer Screening: The goal of the project is to increase breast cancer screening for MSHO, MSC+ and SNBC enrollees aged 40-69 years. The project is designed using a multidimensional approach aimed at provider and clinical services engagement, member outreach, and organizational collaboration. The approaches include modifying interventions to address cultural barriers. The results for the MSHO and MSC+ products met or exceeded the project goal in the first measurement year. Interventions include:

- Care coordinator training
- Quarterly action lists of non-compliant members
- Mammogram incentive voucher mailings
- Articles in member publications
- Marketing and advertising messages
- Provider articles
- Collaboration with other organizations (i.e., American Cancer Society)
- Mobile mammogram van at UCare
- Call campaign to non-compliant members

Diabetes and Blood Pressure Control: The overall goal was to increase the proportion of members age 18-75 with diabetes who had blood pressure under control as measured by the HEDIS® Comprehensive Diabetes Care measure. Although the project goal was met for the F&C-MA/ MinnesotaCare and MSHO/MSC+ populations, the 3% Relative Improvement Rate (RIR) goal was not met for the SNBC population for measurement year two. However, the SNBC population baseline and measurement year two rates were above 80%.

During the project implementation, there were significant changes to the PIP, with modifications to changes in the blood pressure guidelines, Minnesota Community Measurement (MNCM) and HEDIS® measurements. In July 2011, the Collaborative changed the study indicator from 130/80

mmHg to < 140/90 mmHg to align with the newly updated guidelines. This change resulted in a higher baseline rate of compliance for the SNBC population. The Collaborative considers the high baseline rate, the complexity of the SNBC population, and significant growth in SNBC membership to be contributing factors to the difficulty in reaching the measurement goal. In 2011, the thought was that it would require more time to show further improvement in the rates with this population, because it takes time for SNBC members to build relationships with their primary care physicians, care navigators, or care coordinators. Also, this population tends to be more difficult to reach.

However, because of the problems noted above, in February 2014, DHS decided to accept the PIP as final.

- ***2012 Recommendation:*** Identify causes and strategically identify and implement interventions to address the loss of withhold points in the areas of ED utilization, hospitalizations, and 30-day readmissions. Consider working collaboratively with other MCOs to identify common barriers, best practices, or other successful strategies.

MCO Response:

Emergency Room (ER) Utilization Reduction Measure

UCare has an established Emergency Room Utilization Reduction Workgroup in place that analyzes data on a quarterly basis to identify specific members, primary care providers, and treating facilities with high volume avoidable emergency room visits. UCare implemented multiple strategies to reduce avoidable emergency room visits such as targeted health coaching, in-home educational visits conducted by Community Health Workers focusing on parents and children with high ER utilization, and consistent application of the Minnesota Restricted Recipient Program for members who abuse/over use the ER setting for non-emergent care.

In addition, UCare implemented innovative care models with a large pediatric care system and a high volume clinic to address mental health concerns. UCare continues the previously described strategies/interventions and closely monitors data to correct course as required to achieve the 2013 ER utilization withhold. Pursuant to data received from DHS, UCare is on target to show an improvement in achieving this withhold, with reduced ER utilization by this population compared to the previous year.

Hospital Admissions and 30-Day Readmissions Reduction Measure

UCare has established an Admissions/Readmissions Reduction Workgroup to analyze utilization patterns related to admissions and readmissions and to develop interventions that will be maximally

effective in reducing the rates of inpatient care for our Medicaid and MinnesotaCare members. To date we have noted patterns of utilization and readmissions such as variable rates of admissions vs. observation stays, high rates of readmissions for certain conditions such as pancreatitis, and patterns of admissions directly from hospital emergency rooms vs. other entry points.

In addition to data analysis, the workgroup has assessed UCare's existing and potential new initiatives through literature research and brainstorming sessions. As we evaluate how to leverage existing programs such as ICSI's Reducing Avoidable Readmissions Effectively (RARE) initiative for readmission reduction, we review other interventions such as: (1) focusing on ambulatory-care-sensitive conditions like bronchiolitis/pneumonia, pancreatitis, cellulitis and sickle cell crises; (2) routine (scheduled) visits for some conditions such as asthma; (3) in-home asthma interventions for frequent utilizers; and (4) improved transition of care management for members with chronic conditions.

- ***2012 Recommendation:*** Perform an in-depth analysis of the seven measures demonstrating a three-year downward trend in performance for specific programs. This is especially important as these measures may signal the need for further investigation and resource allocation.

  MCO Response:
  Adult Preventative Visits (20-44 yrs, 45-64 yrs, 65+ yrs): While we have seen a slight three-year downward trend in certain products for adult preventative visits, it has also continued to be an overall strength for us. All three measures are greater than the Medicaid 90th percentile for our combined average.

  UCare sends out a mammogram incentive reminding members within the selected age range to see their health care provider for a mammogram. UCare is also working on a breast cancer Performance Improvement Project. Care navigators and care coordinators are making outbound calls to remind members to schedule mammogram screens. UCare also hosted an event targeting breast cancer awareness by providing space for a mobile mammography unit at headquarters to incent members to receive their mammogram screens.

  Our 20-44 years 2013 SNBC rates are still in the 90th percentile nationally. Our 45-64 years 2013 F&C-MA rates have stayed about the same, with the second quarter of 2013 rates increasing slightly.

  Child PCP Visits (12-24 Months): UCare sends out the MOMS booklet to all expecting mothers. The age chart notes that children need C&TC exams at 12 months, 15 months, 18 months, and 24 months, with immunizations due at 12 months, 15 months, 18 months, and 24 months. The booklet also notes that children should have a regular dental exam at 12 months and 24 months, and a blood lead test at 12 and 24 months. Our 2013 MinnesotaCare rates increased by .6% and are 5.5% higher than the Minnesota average. Our preliminary 2014 rates show a slight increase for F&C-MA and for MinnesotaCare.

Child PCP Visits (12-19 Years): The chart in our MOMS booklet notes that teens need checkups at 12, 14, 16, and 18 years of age. Our preliminary 2014 rates show an increase for both F&C-MA and MinnesotaCare.

Cervical Cancer Screening: UCare currently does not have any specific performance improvement projects focused on cervical cancer screening, but we are looking into ways to improve these rates for 2014. We note that our Medicaid combined rates for 2013 are 2.3% higher than the Minnesota average.

Comprehensive Diabetes Care (LDL-C Screening): UCare currently does not have any specific PIPs focused on CDC-LDL screening. We would like to note that NCQA proposes removing the indicator LDL-C Screening. These changes align with new blood cholesterol guidelines by the American College of Cardiology/American Heart Association (ACC/AHA) Task Force on Practice Guidelines and new hypertension guidelines by the eighth Joint National Committee (JNC 8).

Our 2013 SNBC rates have increased by 2% and are 1% higher than the Minnesota average. And, we note that UCare is in the 90th percentile nationally.

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B. EQRO Response to MCO Follow-Up to 2012 ATR Recommendations

The External Quality Review (EQR) process is intended to identify strengths and opportunities for improvement as they relate to the quality of, timeliness of and access to health care received by Medicaid beneficiaries at the MCO and statewide levels. The results of the EQR are shared with the Health Plans with the understanding that the Health Plans will work towards addressing identified opportunities for improvement. A careful review of the Health Plans' responses to the 2012 Annual Technical Report recommendations suggests that there are several opportunities in which the MCOs could enhance their quality improvement approaches.

IPRO recommends that the Health Plan's consider the following points when addressing the 2013 ATR recommendations:

- Data captured by DHS to calculate HEDIS® rates and CAHPS® scores are generally shared with the MCOs. These data are provided in modifiable formats and at the program level. IPRO recommends that the MCOs use these data to support barrier analyses and to develop quality improvement initiatives for poor performing measures.

- The quality improvement approach does not end at the identification of a barrier. For example, one Health Plan stated that "members find the concept of preventive care services unnecessary", however, the Health Plan did not describe its action plan for member outreach or member education. Upon identification of a barrier, it is the MCO's responsibility to put in place an intervention that aims to address that specific barrier.

- MCOs have a responsibility to actively address persistent quality of care issues. The effectiveness of implemented interventions should be routinely assessed and modified as needed, especially for those areas of care where improvement is difficult to achieve. One MCO indicated that it had difficulty improving lead screening rates despite its efforts to change provider behavior, while another MCO indicated that low child primary care access rates had remained constant since 2009; however, these Health Plans did not use this information to promote improvement strategies that would address these areas of care.

- There appears to be general concern regarding the DHS methodologies for calculating performance measures (i.e. HEDIS®, CAHPS® and Withhold). DHS contracts with NCQA-certified HEDIS® and CAHPS® vendors and employs specifications agreed upon by both the state and the health plans for calculating Withhold points. With that being said, IPRO strongly encourages the MCOs to focus less on the methodology employed and more on improving the overall quality of care provided to their members. As mentioned above, the intent of the ATR and the recommendations presented within is to support the MCOs in delivering care that is high quality, accessible and timely.

Chapter 5: MCO Feedback on 2013 ATR

The DHS/MCO Contract, Section 7.5.3, states that each MCO shall be provided with the opportunity to review and comment on the final draft of the ATR prior to publication. This Chapter presents MCO feedback on the final draft of the 2013 ATR. MCO comment resulting in modification to the ATR is noted as "addressed".

Blue Plus

This report appears to be comprehensive and accurate based on the reporting populations' HEDIS® results. The document clearly defines how IPRO analyzed DHS and MCO performance in 2014. HEDIS® and CAHPS® measure results are fairly consistent with our plan reported data allowing minimal variation with results based on DHS's administrative data and plan reported hybrid data.

Additionally, this report is an improvement to the ATR reports in the past. Data is concise and current (HEDIS® 2014 rates!) and the entire report is easier to read and understand. IPRO's recommendations for improvement in each of the MCO sections are helpful and relevant to quality benchmarks and contract requirements.

HealthPartners

We are writing with regard to the final draft of the 2013 Annual Technical Report (ATR) as produced by IPRO and the Minnesota Department of Human Services (DHS). As specified in the 2014 Families and Children DHS/MCO Contract, Section 7.5.3, we have the opportunity to review the final draft prior to publication and submit written comments about the report.

HealthPartners welcomes the opportunity to enhance collaboration across the state on improving the health and experience of DHS populations. As an integrated organization which includes care delivery, research, medical education, and a health plan, we see many ways to connect with and support DHS goals. HealthPartners is interested in further collaboration with DHS in the areas, for example, of mental health, children's health, and closing the gaps in health equity.

HealthPartners has the following comments on the overall report:

HealthPartners uses the Triple Aim (simultaneously improving the health of the population served, improving the experience of each individual, and improving affordability) as the guiding mechanism for organizational goals, monitoring our performance, and identifying opportunities for improvements. We work to simultaneously improve Health, Experience, and Affordability for our members and patients.

To optimize alignment and clear quality goals, the Minnesota community is best served when nationally accepted methodology and rates are shared and used consistently with providers, enrollees, plans and purchasers. HealthPartners understands the compliance requirement for DHS to produce administrative performance measures for reporting purposes to CMS. These administrative measures, however, are not effective in understanding our performance, quality improvement status, and initiatives. HealthPartners notes that DHS has chosen to report a combination of DHS-produced (administrative) and MCO-produced (hybrid) HEDIS® rates for the first time in this year's ATR. Specifically, 6 of 19 HEDIS® measures for Families and Children, and 3 of 5 HEDIS® measures for MSHO are reported with hybrid rates. The DHS-produced administrative measures in the report are not the same and provide different results for the standardized, full, audited HEDIS® measurement methods used by the community.

HealthPartners recommends that the health plans' publicly reported and audited full HEDIS® measures are used for all HEDIS® measures analyzed in the ATR. This will support clarity, priority setting, and alignment on performance, goals, and opportunities for improvement.

In the 2013 ATR report, a weakness is defined as any rate that falls below or equal to the 50th percentile from the National Committee for Quality Assurance (NCQA) Quality Compass 2014 while a strength is any rate that is above or equal to the 75th percentile for Quality Compass 2014. Please note that Quality Compass utilizes the full HEDIS® methodology (i.e. hybrid). If DHS is utilizing Quality Compass as the basis to determine strength or weakness, then the full HEDIS® methodology needs to be utilized when making this determination to ensure consistent comparisons of Minnesota plans to national results.

HealthPartners has the following comments on the HealthPartners-specific report content:

Our comments on the Opportunities for Improvement and Recommendations are provided in four general categories:

1. Financial Withhold
2. HEDIS® measures below the 75th percentile
3. CAHPS® measures below the 75th percentile
4. PIPs

1. **Financial Withhold –** Our response pertains to the following HealthPartners-specific content:
    - **DHS ATR Opportunity for Improvement #1 – The Health Plan demonstrated an opportunity for improvement in regard to the Financial Withhold. HealthPartners failed to earn full points for the F&C –MA Contract.**

    - **DHS ATR Recommendation #1 - As this is the second year that the Health Plan lost points under the Financial Withhold for the Emergency Department (ED) Rate measure and the 30-Day Readmission Rate measure and the 30-Day Readmission Rate measure, the Health Plan should evaluate the effectiveness of the current interventions and modify them as needed. Interventions conducted under the ED-related PIP should also be evaluated and modified.**

    HealthPartners closely monitors the emergency room (ER), admission, and readmission rates. We have implemented numerous outreach, education and access interventions for members as well as partnered with clinics and hospitals to address rates. We have seen progress toward the goals. Our initiatives to improve include:

    - HealthPartners® CareLine service is a 24-hour nurse phone line and it is heavily supported and promoted as a decision-making tool to determine the best place of care. CareLine is promoted to all members, with special emphasis on new moms who are encouraged to use this service frequently. In addition, we have designated CareLine nurses making outreach phone calls to our membership and to introduce CareLine and made a connection.
    - Our MHCP members have access to virtuwell®, the HealthPartners online clinic, at no cost and we have seen a steady increase in usage.
    - HealthPartners collaborated with a HealthPartners Clinic with higher daytime ER usage to offer a walk-in practitioner and promotes this as an alternative to daytime use of the ER. It is being monitored to see if this model warrants being expanded.
    - We have worked with clinics and hospitals to implement ER discharge notifications to clinics so follow-up can occur.
    - HealthPartners is implementing a community outreach campaign to our members and the broader community to highlight alternatives to the ER as the best choice for some care.
    - Additional social worker support for clinics, members, and patients has been implemented. This includes expansion of social worker resources and tools at the health plan and clinics with a high volume of Medicaid patients.

- Regions Hospital has a ER-based based case manager who supports HealthPartners members using the ER for non-emergent reasons. The case manager connects patients with primary care and other resources. This model has been shared with additional hospitals to explore how they can increase their patient education and support, including in our work as the Northwest Alliance ACO (also contracted with DHS as an Integrated Health Partnership demonstration).
- HealthPartners is also supporting several hospitals in testing of the community paramedic resource for patient follow-up and education.
- HealthPartners continues to support the Health Care Home (HCH) model. We provide support (financial and technical) to support the adoption and expansion of HCH capacity. The HCH care model helps identify and manage patients and members at high risk for ER utilization, admissions and readmissions.

HealthPartners Disease and Case Management area works closely with our hospitals and clinics on discharge planning and access to post-discharge medical care and Medication Therapy Management (MTM) services to avoid readmissions such as ensuring timely and meaningful post discharge outreach for patients that included medication reconciliation, timely follow up appointments with physicians, and patient education regarding red flags for all members participating in case management.

Disease and Case Management has enhanced our integration with provider partners by leveraging Electronic Medical Record (EMR) access to improve communication and address post-discharge needs. In addition, they have intentionally furthered the integration of case management and pharmacy resources including MTM and dedicated pharmacy support to improve identification of patients with complex pharmaceutical needs and strengthen patient medication adherence outcomes.

The Reducing Non-Urgent Emergency Department Use Performance Improvement Project has been concluded and the results showed that families who received education from trained Head Start staff (on alternatives to the ER, how to determine the best location of service and resources to help make those decisions) utilized the ER at a 13% lower rate than those who did not receive the intervention. HealthPartners is exploring alternatives for spreading this intervention to members. For example, beginning in 2015, we will share the *What to Expect When Your Child is Sick* book with members who have a baby. A nurse will follow up with the family by phone to provide education on how best to utilize the book to make care decisions (similar to what Head Start did).

HealthPartners considers the DHS clinical withhold areas as high-priority goals and improvement opportunities, and continues to address these.

2. HEDIS® Measures Below the 75th Percentile

HealthPartners analyzes our HEDIS® results each year and focuses specific attention to measures which are clinical priorities for our members. For those measures, extensive root cause analysis is conducted and evaluation of potential interventions are conducted and implemented as appropriate.

2a. HEDIS® Measures Below the 75th Percentile – Child and Adolescent Care - Our response pertains to the following:

- **DHS ATR Opportunity for Improvement #2 – The Health Plan demonstrates an opportunity for improvement in regard to child and adolescent care**. Although access rates for the 12-24 Month group were at or above the 75th percentile, access rates for the 25 Months-6 Years, 7-11 Years and 12-19 Years age groups of the F&C-MA program were below the 75th percentile. HealthPartners also reported rates below the 75th percentile for the HEDIS® *Adolescent Well-Care Visit* and *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life* measures for the F&C-MA and MinnesotaCare programs and for the *Well-Child Visits in the First 15 Months of Life (6+ Visits)* measure for the F&C-MA program.

- **DHS ATR Recommendation #2 - The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers.** The Health Plan should consider conducting a future focused study aimed at improving adolescent care, specifically targeting well-care visits.

Well-child visits are a cornerstone for supporting child health and are offered and encouraged for all members. HealthPartners collaborates with our county and clinic partners to promote Child and Teen Check-up (C&TC) visits for our members, including adolescents, and the community at large.

We promote the use of our preventive registry to clinics to identify children who are in need of C&TC visits and immunizations. HealthPartners includes children and adolescents in the preventive registry and updates counties with lists of members who are behind on their C&TC visit schedule. HealthPartners registries are updated quarterly with a variety of preventive measures so that clinics can easily identify patients who are in need of preventive services. HealthPartners provides a contact resource, training, and technical assistance to clinics in the use of these registries. In addition, health plan staff visit clinics on a regular basis with county C&TC staff to provide education and can share ways that the clinics may choose to outreach to their patients. Consultation is made available from the Quality Improvement area if clinics need additional support. We are evaluating potential strategies, such as member outreach, that will support improvement in adolescent care rates, specifically adolescent immunizations which are often an indicator of needed well care.

In 2014, HealthPartners implemented an incentive for members to encourage well-baby visits for infants' birth-15 months of age, and sends reminders to children of all ages who are not up to date on immunizations. HealthPartners immunization rate for Combo 2 was at 80%, higher than the statewide average of 72.2%, and our rate for adolescent immunizations was at 65.3%, which is also higher than the statewide average of 58.4%. We are evaluating potential strategies to continue to improve both immunization rates and well child rates for all age groups.

There are differing schedules for well child visits, which can affect community and clinic practice. We encourage DHS and CMS to further align their schedules for well child care with broader guidelines and schedules, including HEDIS®. We will continue to work with our providers and community partners to promote the C&TC schedule and encourage our members to seek appropriate preventive care for children.

2b. HEDIS® Measures Below the 75th Percentile – Adult Access to Care - Our response pertains to the following:

- **DHS ATR Opportunity for Improvement #3 – HealthPartners demonstrates an opportunity for improvement in regard to adult access to care for F&C-MA members aged 45-64 years**. The Health Plan's performance for the HEDIS® Adults' Access to Preventive/Ambulatory Health Services measure for this age group was below the 50th percentile.

HealthPartners promotes the use of our Preventive Registry to clinics to assist them in identifying patients who may be in need of preventive health screenings. This registry includes such screenings as colorectal, breast and cervical cancer screenings, which are common flags for the need for preventive care.

In addition, HealthPartners utilizes preventive reminders directly to our members who are in need of preventive screenings throughout the measurement year. This includes reminders for mammograms, colorectal cancer screening and cervical cancer screening. Missing these screenings is often a flag for lack of preventive care.

This is another area where there is opportunity to increase alignment between the adult preventive visits schedule and the ICSI schedule.

2c. HEDIS® Measures Below the 75th Percentile – Asthma Care - Our response pertains to the following:

- **DHS ATR Opportunity for Improvement #4 - The Health Plan demonstrates an opportunity for improvement in regard to asthma care** as HealthPartners reported rates below the 75th percentile for the HEDIS® *Use of Appropriate Medications for People With Asthma* measure for

the 5-11 Years, 12-18 Years and 19-50 Years groups in the F&C-MA program and for the 12-18 Years and 51-64 Years groups in the MinnesotaCare program.

HealthPartners supports our provider groups to utilize our Asthma registries and encourages clinics to reach out and schedule appointments for patients with gaps in care or treatment. HealthPartners provides provider groups with a quarterly patient registry that lists patients in their practice who are past due for services.

HealthPartners' Asthma Condition Support program provides self-management education, guidance and tailored coaching to meet participant's needs dependent upon the severity of their condition. Coaching topics include methods to detect early warning signs of an asthma attack, the importance of using different types of asthma medications, and strategies to identify and avoid triggers. Newsletters also keep participants up to date on asthma self-management. High-risk participants receive personalized support via the telephone from registered nurses who assess the individual's asthma self management, help support the participant's asthma action plan, provide comprehensive medication information, and encourage positive behavior changes.

3. **CAHPS® Measures Below the 75th Percentile – Child and Adolescent Care - Our response pertains to the following:**

- **DHS ATR Opportunity for Improvement #5 - The Health Plan demonstrates an opportunity for improvement in regard to member satisfaction.** HealthPartners reported CAHPS® rates below the 10th percentile for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service measures across all programs. The Health Plan also reported rates below the 75th percentile for the Rating of Health Plan measure for the F&C-MA and MinnesotaCare program, for the Shared Decision Making measure for the MinnesotaCare, MSC+ and MSHO programs, for Rating of Specialist Seen Most Often measure for the F&C-MA program and for the Rating of All Health Care measure for the MinnesotaCare program.

- **DHS ATR Recommendation #3 - As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers.** Poor performance on the Getting Care Quickly and Getting Needed Care measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.

Compared to the Minnesota statewide averages, HealthPartners performs at or near the statewide average in these results. For example, HealthPartners MinnesotaCare has the highest score across all Minnesota plans for the Customer Service measure but falls in the less-than-tenth percentile nationally. The ATR identified CAHPS® improvement opportunities that are common across all Minnesota plans. These opportunities may be addressed more effectively under an initiative with

health plans in partnership with DHS to determine if there is common ground for improvements that are specific to the Minnesota PMAP/Medicaid populations. For example, health literacy initiatives specific to ethnic communities may improve provider-patient communication.

HealthPartners is committed to enhancing member experience as integral to our Triple Aim approach of improving health, experience and affordability for all members. To do this, we monitor and evaluate our CAHPS® scores to identify areas of opportunity for improving how members experience their care within our integrated organization.

HealthPartners has an internal work group dedicated to improving member experience (CAHPS® and Health Outcomes Survey) for all PMAP, MNCare, MSC+, and MSHO members. The work group is comprised of staff from key departments and draws in leaders from a variety of areas (e.g., pharmacy, behavioral health, etc.). The work group reviews CAHPS® scores, and identifies areas of improvement or new initiatives that are implemented throughout the organization. For example, the work group provides input into content for member newsletters and works to help members receive the care they need more simply. With regards to the root cause analysis, this group plans to host focus groups with MSHO/MSC+ members in 2015, to better understand obstacles to accessing care, including medicines. The group will explore expanding the focus groups to address PMAP/MNCare members.

The report indicates poor performance in several key CAHPS® results. While we perform well as compared to the Minnesota State Average, we have also identified these as areas for improvement, and have implemented the following initiatives across our integrated system of care:

Getting Needed Care & Getting Care Quickly

These measures focus on getting needed care and the ability to get an appointment with specialists and with the members' personal doctor. Current work around these measures centers on providing members with alternative and convenient options of care in order to expand access. To do this, we have expanded HealthPartners Urgent Care sites for later evening hours and Saturday hours, increased promotion of CareLine, our 24/7 nurse line, as well as virtuwell®, our 24/7 online clinic, to which PMAP members receive free appointments. The enhancement of online and mobile apps and upgrades to the CareFinder function empowers members to find appropriate care when they need it.

We agree that there are challenges accessing certain medical specialists. For example, of the fifteen metropolitan areas in the United States, Minneapolis ranks in the bottom three for access to dermatologists. As an integrated organization which includes care delivery, we are working to improve access. For example, we have worked closely with HealthPartners Clinics to improve access for our members to specialists. Two specialty departments implemented "smart" scheduling questionnaires that allowed our centralized appointment center to accurately schedule more patient appointments. This improvement has expanded access to schedule appointments on nights

and weekends, decreased the likelihood of transferring a patient to clinic scheduler, and decreased the time a patient spends on the phone. Due to the success of these scheduling optimization practices, they will be expanded to five other departments in first quarter 2015.

How Well Doctors Communicate

We are able to support improved doctor communication by working closely with our medical group and our contracted providers. These measures focus on how well the members' personal doctor listens, explains and makes good use of time with patients. To address these measures, we have enhanced several best practices to improve patient care.

Reducing disparities and serving our diverse membership is a top priority. We have excellent access to interpreters, with multilingual staff in Member Services, Disease and Case Management, Behavioral Health, and at our clinics. We also have interpreters onsite at our clinics and through Language Line, HealthPartners Clinics Equitable Care Fellows program continues to promote best practices in clinical care for patients of diverse cultures with limited English proficiency. We continue our physician shadowing program that helps physicians improve their interactions with their patients.

To improve a patient's experience at the clinic, we upgraded our EPIC medical records system to ensure that the most up-to-date information is available to providers when they are with a patient. As part of our Population Health Initiative, nurses contact PMAP members to assess health and social needs in order to connect members with appropriate health and social services. We have also expanded shared visits where a nurse practitioner and a physician act as a care team to address the full needs of a patient. We have also improved our care team training with special emphasis on visit warm welcomes and closes, both in person and with appropriate wording in after-visit summaries. Additionally, providers and care teams create individualized care team action plans that outline actions they will take to improve their scores in patient satisfaction survey measures.

Customer Service

In 2014, HealthPartners Member Services was named 2014 Customer Champion by JD Powers, and we pride ourselves in our commitment to an excellent customer experience. Our Medicaid CAHPS® scores also can be improved. We have implemented a variety of activities to address the customer services measures. All new PMAP and MNCare members receive welcome calls to confirm members know how to access services, have received their materials, and answer questions they may have. We also continue to hire member-facing staff with diverse language skills that reflect our membership, set high standards for staff training, and in 2015 we are maintaining staffing levels appropriate to the size of our membership.

4. **PIPs -** Our response pertains to the following:

- **DHS ATR Recommendation #4 - In regard to PIPs, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.**

HealthPartners routinely monitors the status of Performance Improvement Projects (PIP) and adjusts interventions as needed.

Blood Pressure Control for Members with Diabetes PIP successfully concluded in 2013 with improved Relative Improvement Rates (RIR) of 14.77% for PMAP/MNCare and 25.51% for MSHO/MSC+. Both exceeded the goal of 3% increase.

Increasing the use of Spirometry Testing for Diagnosis of COPD was successfully completed at the end of 2013 by reaching a 3.28% improvement over baseline, exceeding the goal of 3%.

The Colorectal Cancer Screening PIP was ended at the close of 2013 on the direction of DHS. After numerous interventions with each of the partner clinics, we saw a 27.87% Relative Improvement Rate increase, surpassing the goal of 15%.

The Chlamydia Screening PIP concluded at the end of 2013 on the direction of DHS. There was much progress and education during the first year of activity, which did not include a measurement outcome. The health plans continue to partner to raise awareness of this public health issue because of internal priorities. HealthPartners has hosted provider webinars on issues related to Chlamydia screening and offers quality consultation to clinics who would like to pursue this as a performance measure. In 2014, we did a broad member mailing to all female members in the 18-24 year old age group, as well as a Facebook campaign to the broader communities in Minnesota and Wisconsin. We continue to collaborate with the Minnesota Chlamydia Partnership to improve screening rates across the state.

In closing, thank you again for the opportunity to comment on the DHS report. We continue our commitment to and investment in improving Triple Aim performance for our members and patients.

Hennepin Health

2013 Recommendation #1:

The Health Plan should conduct root cause analysis for HEDIS® and CAHPS® measures that performed below the 75th percentile and implement interventions to address identified barriers. As all CAHPS® measures were below the 50th percentile, Hennepin Health should consider conducting a future study aimed at improving member satisfaction.

HEDIS® Below 75th Percentile

1. Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)
2. Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)
3. Cervical Cancer Screening (24-64 Years)
4. Comprehensive Diabetes Care: LDL-C Screening (18-64 Years)
5. Controlling High Blood Pressure

CAHPS® Below 50th Percentile

1. Getting Needed Care
2. Getting Care Quickly
3. How Well Doctors Communicate
4. Customer Service
5. Rating of All Health Care
6. Rating of Personal Doctor
7. Rating of Specialist Seem Most Often
8. Rating of Health Plan

MCO Response:

General Statement Regarding HEDIS® and CAHPS® Benchmarks for Hennepin Health

Hennepin Health is a unique MCO product in Minnesota, in that it serves only the State's Medicaid early expansion population of adults without dependent children aged 21-64 and with % earnings < 133% FPL. Because the risk profile and needs of this sub-population are so unique, comparisons to other MCOs, products, or Medicaid performance benchmarks are not valid. Hennepin Health is a relatively small product (average monthly 2013 enrollment of 6,250 members). When continuous enrollment requirements are applied for data such as HEDIS® measures (especially for female-only measures since Hennepin Health is approximately two-thirds male), the sample size becomes very small and potentially unreliable.

HEDIS® Rates

Adults' Access to Preventive/Ambulatory Health Services

It still holds true that members of Hennepin Health are very prone to episodic and disconnected acute care that is most commonly sought out at the closest hospital emergency department. Many members are often resistant to allowing a primary care physician into their personal health. In addition to that

resistance, many of the Hennepin Health members live in what some might call "survival mode." This survival mode ultimately means that members think only of the present day and what their needs are in that moment. What they might need a month, a year, or multiple years from now is not something in the forefront of many members' thoughts. This aversion to thinking long term is often a major barrier to members receiving preventive health care services. In many ways, the HEDIS® rates that Hennepin Health received for preventive visits for ages 20-64 are much higher than many Hennepin Health staff originally thought they would be. MHP d/b/a Hennepin Health and the Hennepin Health partner organizations were pleased to see rates in the 79%-85% range.

In early 2013, Hennepin Health began an ED Inreach Program that worked parallel to the ED social workers to engage frequent users of the ED when they would present in the ED. MHP d/b/a Hennepin Health contracted with a specialized Mental Health Case Management organization to come into the ED, when called by a social worker, to provide intensive and immediate assistance to members, including help connecting with primary care services.

The Hennepin Health Partnership has also made this topic of replacing episodic care with ongoing primary and preventive care a focus for the 2014 and 2015 Hennepin Health reinvestment initiatives. Results for this ED-Inreach project have shown not only decreases in ED visits by 7%, but actual increases in outpatient primary care services by 28.6%. This project is a prime example of the desired outcome for all ED reduction programs.

Hennepin Health has dedicated risk sharing dollars to shared re-investment projects that can be proposed by the various staff throughout the partner organizations. One example of a proposal from last year was a Sobering Center to divert chronic inebriates from the ED to a lower level of care when clinically appropriate. One 2015 initiative plans to integrate primary care service directly into a mental health clinic for even greater access to preventive services for members who might be receive behavioral health care, but not medical follow-up.

MHP d/b/a Hennepin Health will continue to work on improving the number of members receiving the necessary preventive care services that can lead to early detection of disease and in turn better care management. Encouraging and supporting the behavior change from acute care to routine is an ongoing process that Hennepin Health as a plan works on through innovative initiatives, such as ED Inreach. This HEDIS® rate will be an ongoing and ever present focus for Hennepin Health.

Cervical Cancer Screening

As previously stated, many Hennepin Health members find the concept of preventive care services unnecessary and sometimes invasive unless the member has a strong trusting relationship with the provider. Cervical cancer screenings are among the most avoided preventive screenings across all demographics and even more so with the Hennepin Health population. IPRO stated that the Hennepin Health rate of cervical cancer screening in 2013 was 48.5 percent. MHP d/b/a Hennepin Health's audited HEDIS® data displayed a higher rate of 54.26 percent. As also mentioned above, more than two-thirds of

Hennepin Health members are male and thus some female only measures such as Cervical Cancer are often not as widely focused on from a system perspective.

Although the MHP derived rate for cervical cancer was higher than the rate displayed in the 2013 ATR, it is still far lower than desired for this population and the rate decreased from last year by 5.59 percent. Rates of Cervical Cancer Screening have also been on the decline due to changing practice guidelines regarding the frequency and risk factors that warrant screening. MHP d/b/a Hennepin Health is supporting an upcoming MDH cancer screening incentive program to boost colorectal, breast and cervical cancer screening rates. The program will be implemented in waves with cervical cancer screening being implemented in late 2014. The greatest opportunity for MHP to address cervical cancer screening is to approach it in conjunction with trying to increase general preventive care services.

Comprehensive Diabetes Care: LDL-C Screening

Prior to DHS choosing the next Hennepin Health Performance Improvement Project, MHP had submitted a PIP proposal in 2014 on improving LDL-C screenings for the diabetic Hennepin Health population. A key component of this performance improvement project was planning to use the diagnosis of diabetes as a way to prioritize members being targeted for outreach by the community health workers (CHWs) that reside at each Hennepin Health clinic. The challenge that the Hennepin Health Plan faces is getting members connected to a primary care clinic as their regular source of health care. Thus, the PIP would have focused in on the clinic resource of the CHWs to get members engaged and ultimately having routine LDL-C screenings. There is still a common problem amongst Hennepin Health Plan providers that they will not order an LDL-C screening unless the individual has been fasting. The performance improvement project would have also had elements of provider education surrounding these screenings to address issues such as the fasting vs. non-fasting LDL screening. All of the comprehensive diabetes care measures will also remain part of the annual practice guidelines adoption and dissemination process.

The MHP Disease Management Program for Diabetes and Cardiovascular Conditions also set a goal for 2014 that all products increase their rates of LDL screenings for members with diabetes or a cardiovascular condition. The disease manager has designed new educational materials and a new outreach protocol for identifying and encouraging those members to know all of their important numbers; including their LDL-C levels. It also should be acknowledged that Hennepin Health improved from last year on this measure by 1.38 percent.

Controlling High Blood Pressure

Between 2012 and 2013, Hennepin Health improved in this measure by .49 percent. The Hennepin Health population has high levels of alcohol and/or other drug use, mental illness, and stress due to a lack of basic needs such as housing and food. It is documented in current clinical practice guidelines that these populations have a greater difficulty maintaining blood pressure control. The main areas of focus for Hennepin Health members are addressing these psychosocial needs in addition to their medical needs.

Every additional resource of investment made by Hennepin Health goes into increasing the level of service and care provided to these members to ultimately make things like controlling high blood pressure more achievable for members and their medical care providers.

Over the last two years, there have been significant changes in the clinical blood pressure guidelines. Due to the fluctuating guidelines Hennepin Health did not start any new initiative for controlling high blood pressure. Efforts continue to be made by MHP disease management and other Hennepin Health clinic-driven disease management programs to identify and assist Hennepin Health members with hypertension manage their blood pressure.

CAHPS® Rates

General/Overall CAHPS® Statement

Due to the conflicting methodologies used to determine achievement for particular populations on the CAHPS® questions and composite scores, Hennepin Health feels that this inconsistency creates particular difficultly in isolating areas of priority based on these results. When CAHPS® data becomes available, Hennepin Health leadership reviews the reports that are provided by DHS and DataStat. Once opportunities are reviewed and discussed based on the DataStat report, actions are taken based on those data points and identified strengths and weaknesses.

Later when the ATR is released and points to different areas of concern and different data points, leadership is unsure how best to review the data. Hennepin Health requests, as a plan trying to utilize the CAHPS® data, that the ATR align its methodology to be consistent with DataStat or vice versa. It takes additional administrative resources to review the CAHPS® data in two different ways, even if both methods are valid. Additionally, this inconsistency points to the Data Stat reports being less helpful as the plans would still need to conduct their own analysis to match the ATR methodology.

Realistically, a satisfaction score of 'Usually' or 'Always' and a ranking '8, 9, or 10' is not the area of most opportunity for improvement. Hennepin Health would prioritize the areas of 'Never' or 'Sometimes' and '1-5' as being of greatest concern and opportunity.

Getting Needed Care and Getting Care Quickly

Hennepin Health was below the 50 percentile for both of these CAHPS® composite measures using the methodology selected by IPRO. Getting Needed Care and Getting Care Quickly improved from 2013 to 2014 for Hennepin Health based on DataStat's report. Still a large challenge for Hennepin Health members when accessing care is often with Mental Health and Chemical Dependency categories of service. There is a general shortage of Mental Health and Chemical Dependency providers across the nation.. Hennepin Health keeps the network to these services as open access, and Hennepin Health will provide transportation to and from appointments wherever the members are able to get in. However, these measures have not been enough to ensure that all of our members get their needed care, when they need it. Many of the members with mental and/or chemical health issues who cannot get the care that they need will often end up presenting at the closest hospital emergency department.

Some unique benefits come along with Hennepin Health's relationships to the county Human Services Department and to the Hennepin County Medical Center (HCMC) for members in need of mental or chemical health care. Hennepin Health is better able to connect members to services available through the county or county partners. The Acute Psychiatric Services (APS) at HCMC is a uniquely positioned psychiatric emergency room that serves the primary area where many of the Hennepin Health members reside. Even with the arrangement of Hennepin Health mental health and chemical dependency services, there is still a shortage of providers making it difficult for members to receive needed care.

MHP d/b/a Hennepin Health conducts an annual assessment of appointment availability as a component of a network adequacy review in addition to GeoAccess maps for physical access. Appointment availability is determined through a provider survey process and is measured against a set of clinically viable standards for appointment wait times. MHP has set the internal benchmark of providers being able to meet those clinical standards at least 85% of the time or greater. The various appointment types reviewed in the survey fall into four categories of services; primary care, ob/gyn care, mental health care and specialty care. Under these four categories is a wide array of appointment types that the survey questions address. The total percent of providers in each category that meet the 2013 standards are as follows:

2013 MHP Providers Meeting Appointment Availability Standards

Care Category	Percent of Providers at Clinical Standard 2013	Percent of Providers at Clinical Standard 2012
Primary Care	88.6%	95.2%
OB/GYN Care	88.9%	94.9%
Mental Health Care	77.77%	76.5%
Specialty Care	89.5%	86.8%
Total	87.6%	89.38%

Source: MHP Provider Appointment Survey Results 2014

As the above results indicate, the only real over-arching category that MHP struggles with is Mental Health Care in terms of accessing appointments within the clinically acceptable time frames. MHP has been fully aware of this gap in available care services and providers. This gap is primarily caused by a provider shortage that impacts all of Minnesota. MHP has responded to this mental health care shortage by keeping the network for these services open access and assuring members that Hennepin Health can provide transportation to these types of appointments, as previously mentioned.

One area of concern that might be causing a greater amount of dissatisfaction across MHP members for both getting needed care and quickly is the rates for primary care and ob/gyn care appointment availability, as visible in the table above. When digging deeper into this data, MHP had more providers on this survey for 2013 indicating that they were not accepting new patients or that appointments for new patients, as they usually take longer, could not be scheduled until almost a year out, as one provide commented. The provider relations and network management area at MHP will be doing a root cause analysis of this issue. Rates for appointments within the standard wait times are still at an acceptable

range of 88 percent; however the decline and the provider and member feedback suggests an opportunity for further investigation. As Hennepin Health and other health plans have been working harder on getting members out of the ED and into primary care and with the increases in the number of citizens now gaining coverage, the longer appointment wait times could also be pointing at greater system issues starting to emerge.

How Well Doctors Communicate

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The DataStat report for Hennepin Health shows improvement from last year on this measure. The rate for members chose the 'Usually' or 'Always', per DataStat, is above 90%. This measure would not be considered a weakness for Hennepin Health. MHP and Hennepin Health providers' are highly experienced in working with our member populations with the majority of Hennepin Health providers serving the urban areas of Minnesota including safety net hospitals and organizations. Our providers generally communicate well with our members and MHP d/b/a Hennepin Health has virtually no member grievances related to inadequate physician communication.

Customer Service

Hennepin Health was below the 50th percentile for this CAHPS® composite measure using the methodology selected by IPRO. Hennepin Health sees the greatest opportunity here be with providing continuing training opportunities to staff who have direct contact with members either in person or by phone. MHP d/b/a Hennepin Health has been transitioning "Quality of Service Grievance" into a new process that has them more thoroughly investigated, similar to a Quality of Care Grievance. The MHP quality staff will look for more opportunities through this new grievance category to address customer service issues more directly.

Over the past year MHP d/b/a Hennepin Health has been working to implement a new claims and customer service system that is more nimble and modern. MHP also hopes that these system upgrades will eventually help improve the customer experience as staff will be able to find needed information faster and with greater accuracy. The challenge for any health care organization is to stay on top of constantly changing information and processes. MHP has invested significant time and effort into training, oversight and accountability within the customer services area in an effort to improve this CAHPS® result.

As mentioned in the 2012 ATR, Hennepin Health still maintains a high number of members physically coming in to the MHP front office for customer service assistance rather than by calling in. The number

of walk-in members averages from 70 to 150 per day. It is highly unusual for a health plan to offer walk-in customer services at its location. Based on this information, MHP implemented multiple changes to its walk-in customer service approach that has helped with member satisfaction. MHP created a 'Care Guide on Call' schedule so that a professional nurse or social worker care guide is available to assist members in the front lobby. The 'Care Guide on Call' is always posted around the departmental areas for staff to see. Also, MHP began staffing the front desk with Community Health Workers to provide better assistance to members regarding their coverage and eligibility needs. MHP typically has 2 or 3 staff people at the front desk to assist the volume of walk-in traffic. In 2014, Hennepin Health also began placing clinic based community health workers part-time in the MHP lobby and part-time in the various Hennepin Health clinics to create better coordination from the coverage environment to the point of care and better communication across organizations at a level directly serving members.

Although this issue has been mentioned previously in other MCO responses to the Annual Technical Report, it is a significant cause of dissatisfaction amongst Hennepin Health members and it is necessary to be brought up again. MHP Customer Service handles a large number of transportation requests that require a sometimes frustrating process to meticulously verify appointments and logistical details. Additionally, many MHP member grievances are related to transportation issues. Members can be very agitated regarding transportation. MHP does regular training with customer service representatives regarding transportation, including how to provide individual member assistance in order to de-escalate conflicts.

Based on the report from DataStat, Hennepin Health improved scores in customer service from last year to this year by about .5 percent. MHP hopes to see that this composite measure improve further for the Hennepin Health population especially in 2015-2016 when the new data systems for MHP go live.

Rating of All Health Care

Hennepin Health scored lower than the 50th percentile in the CAHPS® Rating of Health Plan. Hennepin Health scored 46% with members reporting 9 or 10 on the satisfaction scale. The 2014 Minnesota State average for this population was 48%, making Hennepin Health relatively normal for Minnesota on this measure. If you were including an 8 as acceptable, Hennepin Health would be showing a 1% improvement of this rate from last year.

Many MHP members across all products are extremely high needs individuals with very complex medical, behavioral and social determinants of their care. They are exposed to a very large array of services and settings of care. In this question of rating of all health care it is very hard to see opportunities for improvement with such a broad range of possible unique member situations.

Rating of Personal Doctor

Hennepin Health scored lower than the 50 percentile in the CAHPS® Rating of Personal Doctor. Hennepin Health scored 62% with members reporting 9 or 10 on the satisfaction scale. Connected to the earlier comments regarding the lower appointment availability for primary care providers, MHP d/b/a Hennepin Health feels that this response and decline in rate from last year could be related. This would also be included in the root cause analysis discussions led by provider relations and network management.

Rating of Specialist Seen Most Often

Hennepin Health scored lower than the 50 percentile in the CAHPS® Rating of Specialist Seen Most Often. Hennepin Health scored 63% with members reporting 9 or 10 on the satisfaction scale. The 2014 Minnesota State average for this population was 61%, making Hennepin Health above Minnesota on this measure.

Rating of Health Plan

Hennepin Health scored lower than the 50 percentile in the CAHPS® Rating of Health Plan. Hennepin Health scored 50% with members reporting 9 or 10 on the satisfaction scale. When it comes to overall rating of health plan, much of a person's score is going to be based on company image and perceived level of service. Due to the complex nature of Hennepin Health members and their unique life experiences, it is necessary for MHP d/b/a Hennepin Health to be very meticulous when monitoring member utilization patterns for fraud, waste and/or abuse of services. When members are appropriately denied coverage for certain services in efforts to protect their health and safety, it can often cause them to have a negative view of their plan or at least diminish their satisfaction. MHP d/b/a Hennepin Health is a very unique plan with a very active restricted recipient program that can often impact overall health plan satisfaction. Hennepin Health has high rates of members with criminal backgrounds and drug use. Additionally, Hennepin Health has low literacy rates that make the health plan actions often confusing and frustrating. All of these things impact the perceived level of service of Hennepin Health.

2013 Recommendation #2:

The Health Plan should implement interventions to improve its annual dental visit rate to ensure members are receiving appropriate care and to ensure it earns all available points under the Financial Withhold.

MCO Response:

The listed results of the 2013 Hennepin Health Withholds are not the most current as of MHP d/b/a Hennepin Health's records. Final Withhold results were documented in a memo on September 10th, 2014. MHP will reserve comment on Hennepin Health Withholds until IPRO is provided the correct results and the ATR had been updated. ***Addressed.***

2013 Recommendation #3:
In regard to the "Reducing Emergency Department Utilization in Adults through a Collaborative Healthcare Model" PIP, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.

MCO Response:
After a very successful initial year of this performance improvement project, MHP saw a significant reduction in the rate of emergency department visits per 1000 member months. Unfortunately, due to changes in the PIP process/protocol determined by DHS in 2014, MHP d/b/a Hennepin Health was asked, as were all the other MN Health Plans, to close all current PIPs and start on a new topic for 2015 with a clean slate.

Due to the heavy resources that were planned to go into the second year of the ED reduction PIP, now being needed to focus efforts on a new topic of Antidepressant Medication Management with the added complexity of working on a disparity reduction, MHP d/b/a Hennepin chose to close the ED PIP, while maintaining many of the interventions that were put in place and working well such as ED Follow-Up calls and the EPIC process for connecting the Hennepin County Medical Center clinic Community Health Workers (CHWs).

One added challenge with this PIP's measurement is that there are literally an estimated 50+ ED reduction initiatives for the Hennepin Health product active between 2012 and the present across the very large Hennepin Health partnership. The message on ED reduction was very strongly communicated as a priority from the beginning of Hennepin Health, thus making teasing apart which interventions had the biggest impact on the significant ED reduction, essentially impossible to determine with any real accuracy.

Itasca Medical Care (IMCare)

Opportunities for Improvement:

1. Itasca Medical Care recognizes that there exists an opportunity for improvement in regard to child and adolescent care. The IMCare HEDIS® Intervention Committee is currently in the process of evaluating an incentive program to improve rates. IMCare remains within 5% of the state average for Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (State Average = 65.6%; IMCare = 62.8%); and Well-Child Visits in the First 15 Month of Life (State Average = 62.5%; IMCare =57.1%).

2. Although IMCare is below the 75th percentile, IMCare is within 5% of the State average for Breast Cancer Screening for women age 50-64 (State Average = 61.2%; IMCare = 58.2%).

3. IMCare recognizes the opportunities for improvement with regard to Controlling High Blood Pressure and Comprehensive Diabetes Care; however, these measures have been modified by NCQA. IMCare will continue to monitor based upon the updated measures, and evaluate compliance with benchmarks.

4. IMCare is committed to accessible, quality, and comprehensive care for our enrollees. However, response rates to surveys are consistently low. IMCare continues to explore ways to improve these rates.

Medica

Thank you for the opportunity to respond to the draft of the 2013 External Quality Review Annual Technical Report ("ATR") prepared by IPRO, which was received by Medica Health Plans ("Medica") on December 16, 2014. Medica appreciates the feedback provided in the ATR as Medica is committed to providing quality care for its members. Feedback from members and key stakeholders, especially the Minnesota Department of Human Services ("DHS"), is important to Medica's ability to improve the services it provides to its members.

Introduction

Medica is committed to providing quality services and care to its members. To that end, Medica has established a formal organizational structure to address quality and to identify its quality priorities each year.

The Quality Program Executive Steering Committee ("QUEST") is Medica's overall management committee for quality improvement. QUEST has responsibility to develop an enterprise-wide definition of and strategy for quality improvement. Oversight and strategy direction includes, but is not limited to: clinical quality; quality standards and measures in network management contracting; risk adjustment strategies; HEDIS®/Stars ratings; and NCQA accreditation. QUEST communicates Medica's overall quality strategy through the Quality Improvement Subcommittee, which directs, oversees and evaluates the Medica quality improvement program, with the goal of promoting and continually improving clinical quality, service quality, provider quality and patient safety. Several other committees report into the Quality Improvement Subcommittee, including the Quality Indicators Review Committee and the HEDIS®/Stars Clinical Quality Improvement Committee.

The Quality Indicators Review Committee monitors, analyzes and recommends action on member service quality indicators, including member satisfaction, member complaints and appeals, customer service performance, network quality and adequacy, and cultural and linguistic competency

The HEDIS®/Stars Clinical Quality Improvement Committee is responsible for identifying, prioritizing, and implementing clinical quality interventions to positively influence HEDIS®/Star ratings, thereby improving Medica's accreditation scores and/or Medica's Star ratings.

Medica established fifteen quality priorities in 2014 and nineteen quality priorities in 2015. The criteria used to select the quality priorities include HEDIS® results, CAHPS® results, financial withholds, other community measurement results, and internal analysis.

Financial Withhold

Medica has and will continue to address the opportunity for improvement in its Financial Withhold, specifically the reduction of emergency department utilization and reduction in hospital readmissions under the DHS Families & Children contract. Quality interventions in place in 2013 included: a 24/7 nurse line for members; a total cost of care contract requirement that provides incentives for provider partners to improve the Financial Withhold measures; cultural competency training for the Medica health management team; welcome home calls by case management staff to members recently discharged from the hospital; and a health management algorithm to identify members needing outreach by health coaching or case management staff.

In 2014, Medica expanded its health care interventions to: address evidence based management gaps in care; address inappropriate utilization through integrated care coordination; include a pediatric asthma case management pilot; and align medical and behavioral case management. Medica will continue to evaluate the effectiveness of its efforts and adjust its quality initiative to improve its effectiveness. Medica recognizes that clinical system engagement with Medica is critical to future success.

HEDIS® Performance

Medica appreciates the change made to the HEDIS® data so that managed care organization produced hybrid rates are included in the ATR. This provides a more accurate reflection of Medica's performance in those measures reported as hybrid than the previous method utilized in the technical review.

Medica closely monitors its HEDIS® performance through the HEDIS®/Stars Clinical Quality Improvement Committee, and the Quality Improvement Subcommittee, as discussed above. The HEDIS®/Stars Clinical Quality Improvement Committee works with internal stakeholders to analyze HEDIS® and other clinical quality data to identify trends and areas for concern; propose possible interventions; set implementation priorities; and implement and monitor interventions to improve low performing HEDIS® measures.

CAHPS®

Medica's CAHPS® Workgroup reviews the CAHPS® results across all programs and identifies barriers and possible interventions to help increase members' access to care. The Quality Indicators Review Committee reviews CAHPS® results and actions annually and reports findings to the Quality Improvement Subcommittee. Results are reported from the Quality Improvement Subcommittee to the Medical Committee of the Medica Board of Directors. The "getting care quickly" and "getting needed care" CAHPS® composites were highlighted and discussed in both the Quality Indicators Review Committee and the Quality Improvement Subcommittee. Other actions are being considered to improve the measures. Medica recognizes that the results show a downward trend in the "getting care quickly" and "getting needed care" measures, and is committed to improvement. The "getting needed care" measure has been identified as a quality priority for Medica in 2015.

Medica has an Access and Availability Committee that develops, monitors, and maintains compliance with Medica's standards surrounding access and availability of care for its members. In addition, the Access and Availability Committee identifies access shortcomings and possible interventions, including contracting with additional practitioners where appropriate. In rural and geographically-isolated parts of the Medica service area, Medica typically already has contracts with all available providers.

Lastly, Medica is concerned that the standard used to measure the CAHPS® results in this ATR is different from the data provided in the DataStat survey results, provided to Medica by DHS. Medica understands that the State's methodology scores all plans using the 9-10 scores, rather than the 8-9-10 that is used in the survey results and in other NCQA reports. Medica staff uses the DataStat reports to evaluate its CAHPS® performance, thus it is confusing to see a different methodology used in the ATR.

Performance Improvement Projects ("PIPs")

Medica requests that the written statements regarding its performance improvement projects be amended to correctly identify concluded PIPs, in-progress PIPs, and new PIPs. Due to DHS contract changes in 2014 regarding PIP requirements, DHS allowed several PIPs to sunset and considered reports submitted in November, 2013 to be the final reports for those projects. The colorectal cancer screening project, increasing use of spirometry testing project, transitions of care project, and the post discharge follow-up project concluded in early 2014. The Chlamydia PIP collaborative continues to work together on initiatives designed to help improve the Chlamydia testing rates. While the collaborative PIP projects ended, Medica continues to work on colorectal cancer screening as an internal quality priority. In addition, transitions of care remains a focus through the improving transitions post-hospitalization project, which serves MSHO and MSC+ members in addition to SNBC members through Medica's ongoing PIP and quality improvement project. The racial and ethnic disparities in the management of depression and follow-up after hospitalization for mental illness projects were approved in 2014, and will be implemented beginning in the first quarter of 2015.

Conclusion

With Medica leadership commitment and Medica's extensive quality improvement program, Medica is confident in its ability to continue to improve quality of services and care received by its members.

Metropolitan Health Plan (MHP)

2013 Recommendation #1

The Health Plan should conduct root cause analysis for HEDIS® measures that performed below the 75th percentile and implement interventions to address identified barriers.

MSHO/MSC+ HEDIS® Below 75th Percentile

1. Breast Cancer Screening (65-74 Years) 60.5% (MSHO) 56.5% (MSC+)

MCO Response #1

The only HEDIS® measure from calendar year 2013 that was below the 75% percentile for both MHP senior populations of MSHO and MSC+ was Breast Cancer Screening rates for members between the ages of 65 and 74 years of age. Breast Cancer Screening, although critical, is not always viewed as critical in these higher age groups. NCQA HEDIS® Technical Specifications only changed their age criteria recently to go as high as age 74. Unfortunately, moving forward to 2015, MHP will no longer be serving the senior population so any new interventions are not possible at this time. The most likely root cause is elderly women having changing views regarding breast cancer screening and a high average age for MHP senior populations in 2013. The MSHO denominator in 2013 was only 93 members. The average age of all MHP senior members was 76.1 years of age, at last evaluation. MSHO a bit higher at 78.8 years of age and MSC+ lower at 74.9 years of age.

2013 Recommendation #2

As several CAHPS® measures were below the 75th percentile, the Health Plan should conduct root cause analysis for poorly performing CAHPS® measures and implement interventions to address identified barriers. Poor performance on the *Getting Care Quickly* and *Getting Needed Care* measures across all programs suggests that barriers to care exist for Health Plan members. The Health Plan should closely monitor access rates via other methods such as GeoAccess analysis, appointment availability surveys, etc.

MSC+ CAHPS® Below 75th Percentile

1. Getting Needed Care
2. Getting Care Quickly
3. How Well Doctors Communicate
4. Customer Service
5. Shared Decision Making
6. Rating of Specialist Seen Most Often

MSHO CAHPS® Below 75th Percentile

1. Getting Needed Care
2. Getting Care Quickly
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SNBC CAHPS® Below 75th Percentile

1. Getting Needed Care
2. Getting Care Quickly
3. How Well Doctors Communicate
4. Customer Service
5. Shared Decision Making
6. Rating of All Health Care
7. Rating of Specialist Seen Most Often
8. Rating of Health Plan

MCO Response #2

General/Overall CAHPS® Statement

Due to the conflicting methodologies used to determine achievement for particular populations on the CAHPS® questions and composite scores, MHP feels that this inconsistency creates particular difficultly in isolating areas of priority based on these results. When CAHPS® data becomes available, MHP leadership reviews the reports that are provided by DHS and DataStat. Once opportunities are reviewed and discussed based on the DataStat report, actions are taken based on those data points and identified strengths and weaknesses.

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Getting Needed Care and Getting Care Quickly

All three MHP products of MSHO, MSC+ and SNBC were below the 75 percentile for both of these CAHPS® composite measures using the methodology selected by IPRO. Getting Needed Care improved from 2013 to 2014 for MHP SNBC based on DataStat's report. Still a large challenge for MHP members when accessing care is often with Mental Health and Chemical Dependency categories of service. There is a general shortage of Mental Health and Chemical Dependency providers in the State of Minnesota. MHP keeps the network to these services as open access, and MHP will provide transportation to and

from appointments wherever the members are able to get in. However, these measures have not been enough to ensure that all of our members get their needed care, when they need it. Many of the members with mental and/or chemical health issues who cannot get the care that they need will often end up presenting at the closest hospital emergency department.

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Source: MHP Provider Appointment Survey Results 2014

As the above results indicate, the only real over-arching category that MHP struggles with is Mental Health Care in terms of accessing appointments within the clinically acceptable time frames. MHP has been fully aware of this gap in available care services and providers. MHP has responded to this mental health care shortage by keeping the network for these services open access and assuring members that MHP can provide transportation to these types of appointments, as previously mentioned.

One area for concern that might be causing a greater amount of dissatisfaction across MHP members for both getting needed care and quickly is the rates for primary care and OB/GYN care appointment availability, as visible in the table above. When digging deeper into this data, MHP had more providers on this survey for 2013 indicating that they were not accepting new patients or that appointments for

new patients, as they usually take longer, could not be scheduled until almost a year out, as one provide commented. The provider relations and network management area at MHP will be doing a root cause analysis of this issue. Rates for appointments within the standard wait times are still at an acceptable range of 88 percent, however the decline and the provider and member feedback suggests an opportunity for further investigation. As MHP and other health plans have been working harder on getting members out of the ED and into primary care and with the increases in the number of citizens now gaining coverage, the longer appointment wait times could also be pointing at greater system issues starting to emerge.

MHP hopes to see that this composite measure improve for the SNBC population. Unfortunately, as MHP has terminated its senior and Medicare products effective 1-1-2015, no further interventions can be implemented for those populations.

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The DataStat report for SNBC shows improvement from last year on this measure. The rate for members who chose the 'Usually' or 'Always', per DataStat, is above 90%. This measure would not be considered a weakness for MHP SNBC. MHP providers are highly experienced in working with our member populations with the majority of MHP providers serving the urban areas of Minnesota including safety net hospitals and organizations. Our providers generally communicate well with our members and MHP has virtually no member grievances related to inadequate physician communication. MHP SNBC members have generally other major reasons that can impact the way that they perceive communication with their physician.

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Although this issue has been mentioned previously in other MCO responses to the Annual Technical Report, it is a significant cause of dissatisfaction amongst MHP members and it is necessary to be brought up again. MHP Customer Service handles a large number of transportation requests that require a sometimes frustrating process to meticulously verify appointments and logistical details. Additionally, many MHP member grievances are related to transportation issues. Members can be very agitated regarding transportation. MHP does regular training with customer service representatives regarding transportation, including how to provide individual member assistance in order to de-escalate conflicts.

Based on the report from DataStat, MHP SNBC improved scores in customer service from last year to this year by about 6 percent. MHP hopes to see that this composite measure improve further for the SNBC population. Unfortunately, as MHP has terminated its senior and Medicare products effective 1-1-2015, no further interventions can be implemented for those populations.

<u>Shared Decision Making</u>

As Shared Decision Making was a new composite measure in 2013-2014 CAHPS® cycle, MHP certainly plans to closely monitor its trending over the future. Shared Decision Making or SDM, is becoming quite a buzz worth concept in the health care delivery and quality realm. MHP has been working on SDM in the following ways:

- In 2014, MHP did conduct a provider survey to compliment the member CAHPS® survey on SDM practices. Overall, MHP saw similar results from the provider side, that although SDM was taking

place, there were still clinics reporting not utilizing some of the SDM tools, such as built in EHR algorithms to help prompt physicians to walk through treatment options more thoroughly.

- MHP has been working to implement the new 2015 Performance Improvement Project for the SNBC population, SDM has also been incorporated into the interventions planned to address Anti-depressant Medication Management/Adherence, primarily through guiding physicians to resources for SDM in practice.
- During the last MHP Quality Management Committee meeting of 2014, SDM was discussed in depth with the external physician advisors. The biggest take away from that discussion was that more SDM education was needed for current physicians and patients, but also that medical schools and residency programs would also need to change to begin teaching some of these patient centered concepts for providing good quality care.
- MHP has adopted SDM as a practice guideline for 2015, so more communication will be planned for this topic.

MHP hopes to see that this composite measure improve for the SNBC population. Unfortunately, as MHP has terminated its senior and Medicare products effective 1-1-2015, no further interventions can be implemented for those populations.

Rating of All Health Care

MHP's SNBC product was the only group that scored low in the CAHPS® Rating of Health Plan. MHP SNBC scored 50% with members reporting 9 or 10 on the satisfaction scale. The 2014 Minnesota State average for this population was 52%, making MHP SNBC relatively normal for Minnesota on this measure. If you were including an 8 as acceptable, MHP SNBC would be showing over a 5% improvement of this rate from last year.

Many MHP members across all products are extremely high needs individuals with very complex medical, behavioral and social determinants of their care. They are exposed to a very large array of services and settings of care. In this question of rating of all health care it is very hard to see opportunities for improvement with such a broad range of possible unique member situations.

Rating of Specialist Seen Most Often

MHP's SNBC product was the only group that scored low in the CAHPS® Rating of Health Plan. MHP SNBC scored 65% with members reporting 9 or 10 on the satisfaction scale. The 2014 Minnesota State average for this population was also 65%, making MHP SNBC normal for Minnesota on this measure. If you were including an 8 as acceptable, MHP SNBC would be showing over an 11% improvement of this rate from last year and a rate closer to the SNBC High Benchmark.

Rating of Health Plan

MHP's SNBC product was the only group that scored low in the CAHPS® Rating of Health Plan. MHP SNBC scored 59% with members reporting 9 or 10 on the satisfaction scale. The 2014 Minnesota State average for this population was also 59%, making MHP SNBC normal for Minnesota on this measure. If

you were including an 8 as acceptable, MHP SNBC would be showing over a 9% improvement of this rate from last year and a rate closer to the SNBC High Benchmark.

2013 Recommendation #3

In regard to PIPs, the Health Plan should routinely assess the effectiveness of implemented interventions and modify them as needed.

MCO Response #3

MHP continues to collaborate on performance improvement projects whenever appropriate in an effort to share best practices and achieve collective learning. In the 2014, a change was made by DHS for the PIP protocol and process. DHS requested that all current PIPs come to a close and for all of the Health Plans to begin work on a new topic for 2015, Antidepressant Medication Management Racial Disparities for all PMAP and SNBC products. It was left to each individual health plan to make decisions regarding continuing to put resources into closed PIPs and whether or not to continue measuring specific interventions and outcomes.

The MSHO and MSC+ products were to continue working on their federal "QIP" in place of a state "PIP" for reducing re-admissions and improving transitions post hospital discharge in 2013-2015. MHP continued working collaboratively on the re-admissions project until the end of 2014. Effective 1/1/2015, MHP is no longer serving the Senior or Dual SNBC product lines. Data will no longer be reported or collected for those groups, so trending on their active PIPs and QIPs will only be available through 2014 dates of service.

The Dental PIP for SNBC, MSHO and MSC+ was continued through 2014 also by MHP due to it being a strong project with only one final year. DHS requested no further reporting on the Dental PIP than the 2013 interim report and MHP could not continue to monitor the project past 2014 dates of service due to the termination of the Medicare contracts.

Many of the success measures from all of these various projects will continue to be monitored and used whenever possible for targeted improvement initiatives. One challenge with the new PIP protocol is that DHS will be choosing the future Health Plan PIP topics. MHP's opportunities will more greatly lie in focus studies, but resources are not always as abundant for studies.

PrimeWest Health

PrimeWest Health has reviewed this document and has no comments at this time. We look forward to providing our responses upon receipt of the final version. Thank you!

South Country Health Alliance (SCHA)

Thank you for the opportunity to review the 2013 ATR initial draft; we appreciate the earlier availability of this report.

We identified the following errors in our Corporate Profile as presented on page 71:

- "SCHA is a partnership of twelve (12) Minnesota counties formed in 2011…" We are actually a *partnership* of 11 counties, but we provide services in 12 counties (Freeborn County is not an official/vested partner, but we administer MSHO, MSC+, and SNBC programs for them). ***Addressed.***
- "SCHA is a partnership of twelve (12) Minnesota counties formed in 2011…" This should read *2001* instead, as that was when South Country began operating. ***Addressed.***
- South Country does not participate in the F&C-MA or MinnesotaCare programs in Freeborn County. Please consider modifying how the program participation and county service area is currently described in order to reflect this difference. ***Addressed.***

We look forward to responding with additional information related to the opportunities for improvement identified by IPRO, upon receipt of the Final 2013 ATR report.

UCare

Thank you for providing us with the final draft of the 2013 ATR, issued in December 2014. We appreciate the opportunity to provide comments.

- Page 10, 2014 MCO Transparency and Accountability Reports. We are unclear why IPRO chose to include a review of the 2014 (for CY 2013) reports for two of the three county-based purchasers' reports, when, as noted, all managed care contractors submitted 2013 reports. Please either delete this section or provide information for all (eight) submitted reports.

- Page 84, UCare's Quality Assurance Examination and Triennial Compliance Assessment. While UCare is proud that DHS determined us 100% compliant during its last Triennial Compliance Assessment, we are unclear why the scores from other DHS reviews are not included in the draft 2013 ATR.

Opportunities for Improvement, Recommendations

1. Diabetes and Blood Pressure Control

In August 2013, UCare, along with the Health Plan Collaborative, submitted the final Performance Improvement Project (PIP) report for Blood Pressure Control for Members with Diabetes. The overall PIP goal was to increase the proportion of members with diabetes who have blood pressure in control as measured by the HEDIS® Comprehensive Diabetes Care (140/90 blood pressure adults 18-75 years). Although the project goal was met for the F&C-MA/MinnesotaCare and MSHO/MSC+ populations, it was not met for the SNBC population.

In February 2014, DHS decided to accept the project as final. To ensure sustainability of the improvements achieved, UCare integrated the following PIP interventions into our disease management and other programs:

- Care coordinators identify and assist members needing extra assistance;
- The Collaborative's Diabetes Toolkit remains on the Stratis Health website, along with the training materials, to use as a resource;
- UCare works with the Diabetes and Heart Health Collaborative;
- Members continue to have access to disease management programs and staff at UCare; and
- UCare identified specific activities and areas to focus on moving forward in order to maintain improvements made as a result of this project. Some of those include:
    - Launching a diabetes self-management and educational micro site, *Diabetes: Take Charge!*, on our website in early 2015 for members to view valuable information and resources on how to manage diabetes and sign up for our disease management program.
    - Launching diabetes self-management programs in partnership with the Metropolitan Area Agency on Aging and its Living Well With Diabetes workshops. UCare is also

initiating conversations with the other health plans, Stratis Health, and providers to promote this initiative.

2. Withholds

Emergency Room (ER) Utilization Reduction Measure

UCare has an established Emergency Room Utilization Reduction Workgroup in place that analyzes data on a quarterly basis to identify specific members, primary care providers, and treating facilities with high volume avoidable emergency room visits. UCare continues to support multiple strategies to reduce avoidable emergency room visits such as targeted health coaching, in-home educational visits conducted by Community Health Workers focusing on parents and children with high ER utilization, and consistent application of the Minnesota Restricted Recipient Program for members who abuse or over use the ER setting for non-emergent care.

In addition, UCare implemented a targeted case management program for special needs children with frequent ER utilization and a program for high-risk obstetrics cases.

UCare works with the metropolitan hospitals to follow up with members who present with dental conditions, one of our top conditions for seeking emergent care. UCare contacts the member and arranges for primary dental care assignment and follow up care. In 2015, we will launch enhancements to our nurse advice line to include web services for members who prefer this type of interaction.

UCare intends to continue the previously described strategies/interventions and to closely monitor data for potential intervention opportunities or strategies for the 2015 ER utilization withhold.

30-Day Readmissions Reduction Measure

The UCare Admissions/Readmissions Reduction Workgroup continues to analyze utilization patterns related to admissions and readmissions, especially for members at highest risk of both of these adverse outcomes.

Rates of Ambulatory-Care Sensitive Condition prevalence have been calculated for F&C-MA and MinnesotaCare members. During 2013, UCare observed a movement of hospital stays from observation (outpatient) to inpatient status, and this change had a substantial year-over-year impact on our readmission performance. We anticipate a more steady-state rate based on consistent classification of admissions vs. observation stays going forward. Our members in the 19-64 year old age range are at highest risk of readmissions, so UCare's relatively greater increase in this population in 2013 increased our overall rate of admissions and readmissions.

UCare changed processes for follow-up of nurse advice line calls and resources for case management of especially high-risk F&C-MA members, and this change continued into 2014.

UCare's approaches to interventions in this area are centered on utilization–based initiatives:

- observation vs. inpatient stays;
- high ER utilizers including culturally-competent community health workers;
- potential cases for the Minnesota Restricted Recipient Program (MRRP); and
- condition-based interventions: asthma (patient education, medication monitoring and home asthma program), cellulitis (diabetes routine care, high-utilizer case review and stratification) and pancreatitis (enhanced integration with behavioral health program, polysubstance abuse issues addressed through the MRRP).

Enhancements planned for 2015:

- participation in the Potentially Preventable Admissions project of the locally-based Institute for Clinical Systems Improvement (ICSI) that is getting underway at this time. We anticipate effective partnership with care systems and other stakeholders. Psychosocial and cultural factors that might help avoid unnecessary inpatient (or ER) care will be considered as part of this initiative.
- a new care management stratification system was piloted in late 2013 and will continue to be used more extensively.
- efforts to reduce ER utilization may also help reduce admissions.

3. HEDIS® Scores

Annually, a cross-departmental team reviews and analyzes all of our HEDIS® data based on our comparison to the previous year, statistical significance of increases and decreases, comparison to NCQA national percentiles, and comparison to the Minnesota state average (which UCare leads and coordinates with the other health plans). UCare uses this analysis to set priorities for the year.

A committee is dedicated to the improvement of priority HEDIS® measures and assigns responsibility for improving the measures to Quality Improvement Specialists who work with content experts throughout the organization. These specialists conduct focused studies following the Plan-Do-Study-Act model for improvement taught by ICSI staff, such as at ICSI's Quality Improvement Basics workshop. They perform a root-cause analysis for all identified measures, which includes an understanding of the issue/measure, an environmental scan and literature review, barrier analysis, intervention planning and implementation, and analysis of the intervention. If the intervention is successful, it is operationalized within the organization.

Well-Child Care (in first 15 months/3-6 yrs/12-21 yrs)

UCare has an internal workgroup dedicated to improving the well-child measures, and in 2014, UCare conducted a number of different initiatives to improve this rate and the care for these members.

For our youngest members, we partnered with one of our providers, United Family Medicine, to fund a care coordinator to call overdue members to remind them to come in; appointments were scheduled during the calls. For all adolescent members, we partnered with locally-based WellShare International to conduct outreach for members. A community health worker (CHW) visited members' residences to

provide education on the importance of adolescent well-child examinations and information on other childhood measures, set up appointments, coordinate transportation and interpreter services, remind members about our incentives ($50 for members 0-15 mos/$25 for members 3-6 yrs/$25 for members 12-21 yrs) for completing this visit, and leave behind a Child and Teen Checkups (C&TC) magnet.

We conducted live calls reminding parents to bring in their children and young adults for visits, scheduled visits in real time, as well as any required transportation and interpreters. We also conducted automated calls reminding members about the importance of well-child visits. The calls were recorded in English, Somali, Hmong and Spanish by well-respected community leaders.

UCare collaborated with community groups including Parents in Community Action Head Start, the C&TC Metro Action Group in partnership with Dakota County, and Minnesota Early Head Start for various C&TC initiatives and educational opportunities.

We inserted newsletter articles in our provider newsletter *health lines* on the importance of completing C&TC visits and the incentives UCare has available. We included articles informing and encouraging parents to bring their children in for C&TC visits in our member newsletter and in *Zerkalo*, a Russian newspaper and community services directory. We received very positive feedback on these articles.

Here are two partial responses:

- "I wish to express my thanks to YOU for presenting necessary information to the Russian Community of Minnesota. We came to Minnesota not that long ago and, thanks to your publications, have been able to find all essential services in your newspaper: school, courses, and even about the child and teen medical screening. Now, we have found the right school, and the clinic where we can receive all required medical exams and procedures in order to register our children for school."
- "When I familiarized myself with information about child and teens checkups, I decided to immediately bring my children for such screening. As it turns out, I have not been bringing them to see their doctor for regular checkups for quite a long time."

UCare also sends out a MOMS (Management of Maternity Services) booklet to all expecting mothers and a *Parent's Guide* to mothers after delivery highlighting the importance of every child and teen UCare member receiving a C&TC exam at certain ages. A chart in the MOMS booklet and Parents Guide notes at what age members need to have a C&TC exam.

- For members 0-15 months, UCare's MinnesotaCare final hybrid rate increased by 3.22% from the HEDIS® 2013 Medicaid combined rate to the 2014 rate, and we expect another increase with our 2015 rate. UCare's F&C-MA preliminary 2015 administrative rate has already exceeded our final 2014 administrative rate by 2.09% for this measure, and we expect to improve this measure for our final 2015 rate. Note that the 2013 draft ATR uses UCare's administrative rate and shows UCare's HEDIS® 2014 rate is 61.8%, but our final hybrid reported rate for F&C-MA

was 62.04%. The 2013 draft ATR also shows UCare's HEDIS® 2014 rate is 66.3%, but our final reported rate for MinnesotaCare was 67.49%.

- For members 3-6 years, UCare's MinnesotaCare final hybrid rate increased by 0.85% from the HEDIS® 2013 Medicaid combined rate to the 2014 rate, and we expect another increase with our 2015 rate. According to the F&C-MA final reported rates from each of the plans, UCare's final rate was 5.85% higher than the Minnesota average for this measure. Note that the 2013 draft ATR uses UCare's administrative rate and shows UCare's HEDIS® 2014 rate is 67.8%, but our final hybrid reported rate for F&C-MA was 71.78%. The 2013 draft ATR also shows UCare's HEDIS® 2014 rate is 68.1%, but our final reported rate for MinnesotaCare was 73.48%.

- For members12-21 years, UCare's MinnesotaCare final hybrid rate increased by 1.59% from the HEDIS® 2013 Medicaid combined rate to the 2014 rate, and we expect another increase with our 2015 rate.

Child Immunizations (Combo #3 – 2 yrs)

UCare has an internal workgroup dedicated to improving the child immunizations combo 3 measure, and in 2014, UCare conducted a number of different initiatives to increase immunizations for two year olds. Please see our detailed responses, above (related to increasing well-child care visits), for our initiatives. These were:

- offering a $50 incentive for being up to date on immunizations at age two;
- partnering with WellShare International to conduct outreach;
- conducting automated calls in English, Somali, Hmong and Spanish to remind members about immunizations and well-child visits;
- collaborating with community groups for various C&TC initiatives and educational opportunities;
- articles in our provider newsletter, *health lines;*
- articles in our member newsletter, in the *Zerkalo*, a Russian newspaper and community services directory;
- mailing our MOMs booklet to all expecting members, which includes information on immunizations; and
- providing the *Parent's Guide* after delivery, which includes information on immunizations.

UCare's F&C-MA final hybrid rate increased by 3.03% from the HEDIS® 2013 Medicaid combined rate to the 2014 rate, and we expect another increase with our 2015 rate.

Child/Adolescent Access to PCPs [MinnesotaCare] (12-24 mos.)

UCare has an internal workgroup dedicated to improving this child/adolescent access to PCP measure, and in 2014, UCare conducted a number of different initiatives to improve this rate and the care for our young members. Please see our response to the well-child and child immunizations measures, above.

UCare's final MinnesotaCare rate increased by 0.01% from the HEDIS® 2013 rate to the 2014 rate, and we expect another increase with our 2015 rate. Note that the 2013 draft ATR shows UCare's HEDIS® 2014 rate for 12-24 mos. is 97.9%, but our final reported rate for F&C-MA was 97.33%. Similarly, the 2013 draft ATR states UCare's HEDIS® 2014 rate for MinnesotaCare is 97.6%, while our final reported rate was 96.92%.

Child/Adolescent Access to PCPs [F&C-MA] (7-11 yrs, 12-19 yrs)

UCare has an internal workgroup dedicated to improving this child/adolescent access to PCP measure, and in 2014, UCare conducted a number of different initiatives to improve this rate and the care for our young members and teens. Please see our responses to the well-child and child immunizations measures, above.

UCare's final F&C-MA final rate increased by 1.34% for ages 7-11 and by 1.01% for ages 12-19 from HEDIS® 2013 to 2014, and we expect another increase with our 2015 rate. UCare's F&C-MA preliminary 2015 rate has already exceeded our final 2014 rate for the 7-11 age range by 0.76% for this measure, and we expect to improve this measure for our final 2015 rate. Note that the 2013 draft ATR states UCare's HEDIS® 2014 for 7-11 yrs. rate is 92.7%, while our final reported rate for F&C-MA was 91.34%. Similarly, the 2013 draft ATR states UCare's HEDIS® 2014 for 12-19 yrs. rate is 91.1%, while our final reported rate for F&C-MA was 89.34%.

Adult Access to Preventive/Ambulatory Health Services [F&C-MA] (45-64 yrs)

To encourage members to see their physicians, UCare sends out a series of reminders for preventive screenings. This includes a mammogram incentive reminding members within the selected age range to see their health care provider for a mammogram. In addition, care navigators and care coordinators make outbound calls to remind members to schedule a mammogram screening.

Twice a year, UCare's CEO sends automated reminder calls prompting members to get mammogram screenings (during the month of May celebrating Mother's Day and in October during Breast Cancer Awareness Month). While we have seen a slight decrease in our age 45-64 rate, it was not a statistically significant decline and UCare is still higher than the Minnesota average. According to the F&C-MA final reported rates from each of the plans, UCare's final 45-64 rate was 0.66% higher than the Minnesota average for this measure. Note that the 2013 draft ATR shows UCare's HEDIS® 2014 45-64 yrs. rate at 90.3%, while our final reported rate for F&C-MA was 89.93%.

Breast Cancer Screening [F&C-MA, MSHO, SNBC] (50-74 yrs)

UCare has an internal workgroup dedicated to improving the breast cancer screening measure, and in 2014, UCare conducted a number of different initiatives to improve this rate. See UCare's 2014 Quality Program Transparency and Accountability Report for more information.

UCare twice hosted a mobile mammography van at our offices after calling members to schedule appointments and set up transportation and interpreter services. We also scheduled an entire day at

the Center for Diagnostic Imaging for members to receive mammograms. Prior to this date, UCare called members and scheduled the visits and any needed transportation and interpreter services.

UCare partnered with the Hmong American Partnership to promote breast cancer screening in the Hmong population. We also participated in the March 2014 Loving Yourself Event focusing on African-American women's health where we encouraged members to get their mammogram exams using the mobile mammogram unit that day, handed out breast cancer screening resources and incentives, and encouraged members to schedule their mammogram exams.

We offer a $50 incentive to F&C-MA and SNBC members and a $100 incentive to MSHO members.

Our CEO recorded an automated message that goes out to all female members in this age range, reminding them of the importance of breast cancer screening. We also conducted live calls with a customer service representative to remind members to get their mammogram screenings. The representatives helped schedule appointments with members' providers and set up needed transportation and interpreter services.

UCare's F&C-MA final rate increased by an outstanding 12.36% from HEDIS® 2013 to 2014 and SNBC by an impressive 7.99% -- and we expect another increase with our 2015 rate. Both of these increases were statistically significant year-over-year improvements. UCare's F&C-MA preliminary 2015 rate has already exceeded our final 2014 rate by 6.13% for this measure, and we expect to improve this measure for our final 2015 rate. UCare's SNBC preliminary 2015 rate has already exceeded our final 2014 rate by 0.55% for this measure, and we also expect to improve this measure for our final 2015 rate. According to the F&C-MA final reported rates from each of the plans, UCare's final rate was 0.41% higher than the Minnesota average for this measure.

Note that the 2013 draft ATR shows UCare's HEDIS® 2014 BCS rate is 62.3%, but our final reported rate for F&C-MA was 60.88%. The 2013 draft ATR also shows MSHO at 58.7%, but our final report rate was 59.56%. The draft ATR also shows SNBC at 61.1%, but our final reported rate was 61.79%.

Chlamydia Screening in Women [F&C-MA, MinnesotaCare] (16-24 yrs)

UCare has an internal workgroup dedicated to improving the Chlamydia screening measure, and in 2014 UCare conducted a number of different initiatives to improve this rate.

Partnering with numerous community partners for the Stop the Violence-hosted community resource fair, UCare promoted chlamydia screening and conducted screenings. We also worked with community partners including the Hue-MAN Partnership Project for the June 2014 Man-Up for Your Health event where we provided education, participated on a panel discussion, and provided Chlamydia screenings. We also partnered with the other Minnesota health plans and conducted a Chlamydia webinar for primary care providers that focused on universal screening. UCare continues to serve as a member of the Minnesota Chlamydia Partnership.

According to the F&C-MA final reported rates from each of the plans, UCare's final rate was 2.37% higher than the Minnesota average for this measure. Note that the 2013 draft ATR states UCare's HEDIS® 2014 rate is 61.7%, but our final reported rate for F&C-MA was 61.07%.

Controlling High Blood Pressure [F&C-MA, SNBC]

To encourage members to see their physicians, UCare sends out a series of reminders for preventive screenings that include blood pressure screening. Our rates are in the 50th percentile nationally and not statistically different than the Minnesota average.

Use of Appropriate Medications for People with Asthma [F&C-MA] (5-11 yrs)

UCare has an internal workgroup dedicated to improving the use of appropriate asthma medications measure, and in 2014 conducted a number of different initiatives to improve this rate.

We partnered with one of our providers, United Family Medicine, to fund a care coordinator to call members who have an asthma diagnosis and on an asthma medication. The care coordinator reached out to members to provide follow-up care on their asthma medication, provided education and reminders to fill their asthma prescriptions, and assisted in scheduling follow-up visits with members' primary care providers.

We partnered with WellShare International CHWs who conducted home visits with UCare's in-home respiratory therapist to reach diverse populations, including UCare's Somali members. The CHWs and the respiratory therapist visited members in members' residences to provide education on asthma triggers, the appropriate use of asthma medications, and the importance of using a controller medication.

We conducted a survey with school nurses to gather information regarding asthma management practices, barriers to asthma management, and best ways for health plans to support their asthma management programs. We are utilizing that data to enhance our asthma disease management program.

We also initiated a $25 incentive for members to fill their long-term control (maintenance) medication and made follow-up calls to those members to ensure members received their vouchers and encourage them to visit their pharmacy/physician to fill the controller.

According to the F&C-MA final reported rates from each of the plans, UCare's final rate for all ages was 0.55% higher than the Minnesota average for this measure. Note that the 2013 draft ATR states UCare's HEDIS® 2014 rate is 89.1%, while our final reported rate for F&C-MA was 89.74%.

Use of Appropriate Medications for People with Asthma [F&C-MA] (12-18 yrs)

UCare has an internal workgroup dedicated to improving the use of appropriate asthma medications measure, and in 2014 conducted a number of different initiatives to improve this rate. Please see our response on the ***Use of Appropriate Medications for People with Asthma (5-11yrs)***, above.

According to the F&C-MA final reported rates from each of the plans, UCare's final rate for all ages was 0.55% higher than the Minnesota average for this measure. Note that the 2013 draft ATR states UCare's HEDIS® 2014 12-18 rate is 87.6%, while our final reported rate for F&C-MA was 87.13%.

Adult BMI Assessment (SNBC non-duals)

To encourage members to see their physicians, UCare sends out a series of reminders for preventive screenings that includes BMI assessment. Our records show our Adult BMI Assessment for SNBC non-duals are in the 90th percentile nationally. According to the SNBC non-duals final reported rates from each of the plans, UCare's final rate was 2.37% higher than the Minnesota average for this measure. Note that the 2013 draft ATR states UCare's HEDIC 2014 rate is 84.7%, but our final reported rate for SNBC non-duals was 88.02%.

4. CAHPS® Scores

Annually, UCare establishes a cross-departmental team to review all of our CAHPS® survey results. The data is analyzed and reviewed based on our comparison to the previous year, statistical significance of increases and decreases, comparison to national benchmarks, and comparison to the Minnesota state average. UCare takes that analysis and sets priorities for the year.

Led by UCare's Member Experience Manager, our Member Experience Workgroup is dedicated to the improvement of these priority CAHPS® measures. Responsibility for improving the measures is assigned to the appropriate UCare team that works with content experts throughout the organization. The Member Experience Manager conducts a root-cause analysis of all identified measures, which includes an understanding of the issue/measure, environmental scan and literature review, barrier analysis, intervention planning and implementation, and analysis of the intervention. If the intervention is successful UCare operationalizes it within the organization. UCare also monitors member experience through other methods such as additional member surveys, focus groups, number of and types of complaints/appeals/grievances, customer service call analytics, and Member Advisory Committee feedback.

How Well Doctors Communicate

UCare continues to enhance and support the relationships we and our members have with our network providers to ensure comprehensive care and service to our members. UCare trains providers on our MSHO/MSC+ Model of Care. We employ care coordinators and case managers to facilitate communication and coordinate care across all providers within each Interdisciplinary Care Team.

Our 2014 CAHPS® rates are statistically on average with the Minnesota average for all programs except MSC+. We also saw year-over-year improvement for MSHO and SNBC.

Getting Needed Care

UCare identified the issue of access to timely care as an improvement area from the 2013 CAHPS® survey. When members call for non-urgent or specialist appointments, members anticipate that they will be seen within their expected time-frame. UCare has in place access and availability standards for providers. To ensure these standards are met, UCare conducts annual secret-shopper calls. This measure is part of the NCQA Quality Improvement Standard 4, which includes an annual GeoAccess analysis. In addition, we conduct a semi-annual service area analysis for MSHO and SNBC to identify opportunities for improvement. UCare identified those areas and is formulating a strategy to better address the needs of our members. We are also conducting member focus groups to identify other needs improvement opportunities to provide overall improved member experiences. This measure has been identified as one of our top priorities for the 2015 Member Experience Workgroup.

In addition, as of January 1, 2015, UCare's dental delegate is Delta Dental of Minnesota, which maintains UCare's dental network. This new affiliation has more than doubled the number of dentists available statewide. We expect that our new and member-focused relationship with Delta will provide improved, faster, and more convenient member access to dental services. The transition to Delta Dental is also a focus area for our Member Experience Manager and will be monitored closely by the Member Experience Workgroup.

Health Plan Customer Service

UCare identified a need to improve and track customer service interactions with members from the 2013 CAHPS® survey. When members call Customer Services they expect to be treated courteously and with respect, as well as receive accurate information. UCare's Customer Services team has taken several actions to improve the member customer service experience:

- Established a core team of specially trained representatives to develop in-depth knowledge of the products to achieve a deeper appreciation and understanding of the unique needs of this member segment. Specialized training was delivered and continues to be refined and improved.
- Extended the length of training for all of our classes to spend more time on customer service soft skills in order to better respond to our members and meet their customer service needs.
- Our Quality Assurance team delivers direct coaching to representatives to supplement training provided by Customer Services supervisors. This training is primarily focused on soft skills, in support of treating members with courtesy and respect.
- Increased the total number of call evaluations for newly hired employees so we can ensure members consistently receive courteous and accurate information from the representatives.
- In late 2012 we implemented speech analytics software to enable systematic analysis of customer service calls. Reporting is done to analyze customer call handling, including various aspects of courtesy and knowledge. The speech analytics reports, combined with automated post-call surveys measuring courtesy and knowledge, plus standard call monitoring activity, identify opportunities for coaching and performance management of representatives.

Our new customer service employee training program was revised with the goal of developing increased knowledge and higher quality service skills in our new representatives. There are multiple sessions conducted through the training period, which include knowledge components, best practices and expectations for call handling quality.

Our 2014 CAHPS® rates are statistically on average with the Minnesota average for all programs except MSC+. This measure has been identified as one of our top priorities for the 2015 Member Experience Workgroup.

Getting Care Quickly

UCare identified the issue of access to timely care as an improvement area from the 2013 CAHPS® survey. When members call for non-urgent or specialist appointments, members anticipate that they will be seen within their time-frame expectations.

UCare has established access and availability standards for providers. To ensure these standards are met, UCare conducts annual secret shopper calls. This measure is part of the NCQA Quality Improvement Standard 5 report for accessing the provider network, and we perform a yearly analysis of this area and identify opportunities for improvement. UCare identified these areas and is formulating a strategy to better address the needs of our members. We are also conducting member focus groups to identify other needs and areas where there is room for improvement.

Our 2014 CAHPS® rates are statistically on average with the Minnesota average for all programs except MSC+ and MSHO. We also saw year-over-year improvement for MinnesotaCare, MSHO, and SNBC.

Shared Decision Making

UCare has taken many steps to encourage providers to work with UCare members facing decisions regarding next steps in their care.

- UCare established a provider Shared Decision-Making (SDM) web site and is monitoring monthly traffic patterns. A SDM e-mail box and a SDM phone message line were established and included in provider communications.
- "My Health Decisions" access was added to UCare's web site and its use is encouraged.
- SDM key conditions were presented to UCare's Quality Improvement Advisory and Credentialing Council, which oversees and directs UCare's Quality Improvement Program.
- In the fourth quarter 2014, UCare launched its eHealth initiative *Diabetes: Take Charge!* This activity was publicized with providers and members and incorporates SDM content from Healthwise.
- UCare connected with Healthwise for a demo of its SDM resources, including its Care Management Solution product.
- UCare reviewed the Alliance of Community Health Plans (ACHP) web site and its SDM Tools Inventory grid in order to utilize the excellent work that has already been developed by incorporating it into our website and tools.

- A provider survey was conducted on a sample of UCare's provider network to assess providers' SDM priorities and resources and inquire how UCare could support clinics/care systems in SDM activities. The survey identified verbal patient coaching as the most often used SDM tool.
- UCare attended a 2014 Minnesota Council of Health Plans meeting with SDM as an agenda item and is active in the Minnesota Shared Decision-Making Collaborative.
- UCare invited representatives of UCare's provider network to attend ICSI's 2014 Reinertsen Lecture with SDM expert Glyn Elwyn, MD and a SDM workshop that Dr. Elwyn facilitated the following day.
- UCare's Professional Advisory Committee discussed Dr. Elwyn's surveys and Option Grid tools. In 2015, we plan to continue many of the 2014 SDM activities and explore the use of Dr. Elwyn's SDM tools and surveys for a possible implementation pilot at a clinic/care system.

Our 2014 CAHPS® rates are statistically on average with the Minnesota average for all programs. We also saw year-over-year improvement for MSC+, MSHO, and SNBC.

Rating of All Health Care [F&C-MA, MinnesotaCare]

UCare's mission is to improve the health (and health care) of our members. We continually work with our staff, providers, and delegates to provide exceptional care to our members. We have outlined all the quality improvement activities we perform on an annual basis to improve the health care our members receive in our Annual Quality Evaluation. Our 2014 CAHPS® rates are statistically on average with the Minnesota average for all programs.

Rating of Specialist Seen Most Often [F&C-MA, MinnesotaCare, SNBC]

UCare continues to enhance and support the relationships our members have with our network providers, including specialists, in order to ensure comprehensive care and services. UCare trains providers on our MSHO/MSC+ Model of Care. We employ care coordinators and case managers to facilitate communication and coordinate care across all providers within the Interdisciplinary Care Team. Our 2014 CAHPS® rates are statistically on average with the Minnesota average for all programs. We also saw year-over-year improvement for SNBC.

Rating of Health Plan [F&C-MA, MinnesotaCare, SNBC, MSC+]

UCare has many initiatives in place to support our members and enhance the care and services they receive. We constantly seek out feedback from our members on how we can improve and work diligently to meet their needs. We host numerous focus groups along with our quarterly Member Advisory Committee to ensure the voice of our members is heard, and then our Member Experience Manager and Member Experience Workgroup work to improve our programs accordingly. Our 2014 CAHPS® rates are statistically on average with the Minnesota average for all programs except MSC+ and were above the Minnesota average for F&C-MA and MSHO. We also saw year-over-year improvement for MinnesotaCare, MSC+, MSHO, and SNBC.

Again, thank you for the opportunity to comment.

Chapter 6: EQRO Recommendations to DHS

ATR Recommendations

This year, 2014, represents IPRO's first year as the External Quality Review Organization (EQRO) for the State of Minnesota; and the 2013 Annual Technical Report (ATR) is the first ATR that IPRO has prepared for the State. For this report, IPRO followed the presentation and format of prior ATRs in an effort to facilitate the MCOs' understanding and use of the information as they monitor their performance and further their quality improvement efforts. In future years' reporting, IPRO is considering modifying the report to reflect current Federal initiatives and to more closely align scoring methodologies to those utilized by other states and the Centers for Medicare and Medicaid Services (CMS).

It is IPRO's intent to be as transparent as possible regarding any modifications to the current reporting process, content or structure. Therefore, as part of our preparation for the next reporting year, IPRO will provide Health Plans with an opportunity to comment and provide feedback regarding proposed changes. It is anticipated that these recommendations will be presented and discussed during the January 2015 Quality Work Group meeting. Feedback from the Health Plans regarding the feasibility and value of these recommendations are welcomed. Furthermore, any modification to the current ATR process will be made only with the full approval of DHS.

Recent efforts in reporting MCO data have focused on simplifying the report structure to focus on highlighting key findings that can be used to make comparisons across MCOs and to track progress over time.

One model for consideration is CMS' Quality Rating System (QRS), which is intended to provide information to Marketplace consumers regarding the quality of the services provided by Qualified Health Plans (QHP) offered in the Marketplace. Individual performance measures form the basis of the QRS hierarchical structure. Combinations of two or more individual indicators are grouped into composite scores and reported in a streamlined format that helps distinguish performance across Health Plans and is designed to make it easy for consumers to understand. Summary indicators are created that align with CMS priority areas: (1) Clinical Quality Management, (2) Member Experience and (3) Plan Efficiency, Affordability and Management. These composites are converted into performance scores, and Health Plans are rated using a star system that ranges from one to five stars.

Though the measures collected for Minnesota do not correspond directly to the CMS QRS, a similar approach can be undertaken for future ATRs. Indicators can be grouped into domains reflecting such areas as: Quality, Access and Member Experience and converted into a summary score or scores similar to the methodology employed for the QRS. The ATR can report the composite scores, an overall score, if appropriate, as well as the individual performance measure rates as currently reported.

An example of how composite indicators could be created and reported appears below. The "Quality of Care" indicator can be made up of such HEDIS® measures as *Comprehensive Diabetes Care*, *Use of Appropriate Medications for People With Asthma* and *Controlling High Blood Pressure*, for example. Similarly, the "Access to Care" indicator could be comprised of *Adults' Access to Preventive/Ambulatory Health Services*, *Adolescent Well-Care Visit* and *Chlamydia Screening in Women*. The "Member Experience" indicator can be drawn from the CAHPS® measure set.

Example of a Health Plan's Global Score Calculation

Composite Indicator	Example Composite Summary Indicator Score
Quality of Care	65
Access to Care	50
Member Experience	35
Global Score	50

Note: The Global Score equals the sum of the scores for each composite indicator divided by three (i.e., the number of composite indicators).

The ATR can report composite indicators, as indicated above, and can also be used to compute star ratings, if of interest. To accomplish this, each composite score can be converted to a star rating based upon percentile ranks of the scores, as follows:

Example of Composite Score to Categorical Rating Conversion

Composite Score	Categorical Rating
0< Score Value < 25	1★
25≤ Score Value<50	2★★
50≤ Score Value<75	3★★★
75≤ Score Value<90	4★★★★
90≤Score	5★★★★★

Using the example above, Health Plan XYZ would have a star rating for each composite, as follows:

Example of a Health Plan's Star Rating

Composite Indicator	Example Composite Summary Indicator Score
Quality of Care	★★★
Access to Care	★★★
Member Experience	★★

Another approach follows a model that is currently in use. For several states, IPRO has successfully employed a matrix approach for displaying performance measure results over time and in comparison to statewide benchmarks. This matrix approach provides a comparative look at selected performance measures by Health Plan. The matrix is multi-dimensional and compares a Health Plan's own performance for selected indicators over the two most recent reporting years and compares its current performance to the statewide Medicaid Managed Care (MMC) weighted average for these same

indicators. As such, the matrix provides for a graphic presentation of Health Plan performance using statistical analyses and trends over time. Using a simple scoring mechanism (such as Grade "A" to Grade "F"), indicators that fall either above or below the statewide averages, or are trending upward or downward, can be readily identified. This graphic approach offers advantages to the State regulator, consumers and Health Plan staff involved in quality improvement by allowing the reader to quickly grasp key findings and easily discern differences in performance.

An example of this matrix approach appears below. The horizontal comparison represents the Health Plan's current performance as compared to the most recent statewide average. When comparing a Health Plan's rate to the MMC weighted average for each respective measure, the Health Plan rate can be either above average, average or below average. Whether or not a Health Plan performed above or below average is determined by whether or not that Health Plan's 95% confidence interval for the rate included the weighted average for the specific indicator. When noted, the Health Plan's comparative differences represent statistically significant differences from the weighted average.

The vertical comparison represents the Health Plan's performance for each measure in relation to its prior year's rates for the same measure. The Health Plan's rate can trend up; have no changes or trend down. The matrix is color-coded to indicate when a Health Plan's performance rates for these measures are notable or whether there is cause for action:

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Example of a Health Plan's Measure Matrix

		MHCP Weighted Average Statistical Significance Comparison		
Year to Year Statistical Significance Comparison	Trend	Below Average	Average	Above Average
	↑	**C** Childhood Immunization Status: Combo 3	**B** Use of Appropriate Medications for People With Asthma	**A**
	No Change	**D** Breast Cancer Screening Chlamydia Screening in Women	**C** Adolescent Well-Care Visits Cervical Cancer Screening Controlling High Blood Pressure	**B** Prenatal and Postpartum Care- Timeliness of Prenatal Care Adult BMI Assessment
	↓	***F***	**D** Frequency of Ongoing Prenatal Care:≥81% of Expected Prenatal Care Visits Received	**C**

Key to the Measure Matrix

A. Performance is notable. No action required. MCOs may have internal goals to improve.
B. No action required. MCOs may identify continued opportunities for improvement.
C. No action required although MCOs should identify continued opportunities for improvement.
D. Root cause analysis and plan of action required.
F. Root cause analysis and plan of action required.

Regardless of the modification to the reporting process, IPRO recommends that statistical analyses, either significance testing or the use of confidence intervals, accompany any data that is used to draw comparisons among Health Plans. We recommend that these statistical tests be presented in the ATR along with any limitations to their use and interpretation, such as small sample sizes.

In addition to enhancing the reporting format, other areas affecting quality of care may be considered for inclusion in the ATR. For example, CMS has informed EQROs of two priority areas that they should consider addressing in the ATR: Health Plans' use of Health Informational Technology (HIT) and efforts to identify and reduce disparity of care issues. For other states' reporting, IPRO has disseminated a survey tool to Health Plans in advance of the ATR reporting period. This survey solicits information regarding health plan initiatives to incorporate HIT in their quality improvement efforts and how HIT has improved the quality, access to and timeliness of care for their members. The same survey can be used to ask Health Plans to present any strategies they've employed to reduce disparities of care; the types of disparities that have been uncovered, if any; and any success the Health Plans have experienced in reducing these disparities. Information about whether Health Plans collect specific data points to

identify health care disparities, or whether they stratify existing data to accomplish the same purpose, is also collected information, which IPRO can report in the ATR.

In addition to reporting on HIT and disparities, DHS could also consider including additional MCO-specific data that allow for a broader view of the MCO's performance in regard to the access of, quality of and timeliness of care. Examples of such data include: provider network data, results of appointment accessibility studies, results of GeoAccess studies, board certification rates, results of the HEDIS® Final Audit Reports, enrollment and disenrollment data, etc.

Measures beyond HEDIS® that are relevant to the Minnesota Medicaid population and evaluate outcomes can also be considered for inclusion. Minnesota Community Measurement (MNCM), creates and refines measures, and collects and reports health care data used to drive improvement in health care and can be a resource to identify measures of interest to Minnesota. Such measures as *C-Section Rate* and *NICU Stays* are examples of measures collected and reported by MNCM that can be reported in the ATR if health plans have access to the data sources necessary for their calculation. Some states have adapted the Agency of Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) measures for health plan reporting. Measures such as: *Uncontrolled Diabetes Admission Rate*, *Asthma in Younger Adults Admission Rate* and *Hypertension Admission Rate* can yield valuable information about members hospitalized for conditions that, if treated appropriately, can be managed in an outpatient setting.

Other Recommendations

As disparities in care among the different racial and ethnic groups enrolled in MHCP have been identified by DHS and are the subject matter for the 2015-2017 PIPs, it is important that DHS capture MCO initiatives that address these disparities. As the Transparency and Accountability Report has successfully allowed the MCOs to self-report quality improvement activities, it is recommended that the MCOs utilize a similar format to report initiatives and progress made in addressing racial and ethnic disparities in care.

Based on MCO response to previous years' ATRs, as well as the 2013 ATR, there appears to be dissatisfaction among some of the MCOs regarding DHS's chosen methodology for scoring CAHPS® measures and composites. Specifically, MCOs have disagreed with DHS's decision to use the "9-10" methodology over the "8-9-10" methodology. Although both scoring methodologies are accepted by the NCQA, this continues to be a major issue for the MCOs; and, as such, it is recommended that IPRO and DataStat, the DHS CAHPS®-certified vendor, collaborate to provide technical assistance to the MCOs regarding the CAHPS® process.