Minnesota PMAP+ Section 1115 Waiver Renewal Request

Project No. 11-W-00039/5

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Table of Contents

Section I – Program Description 1

Section II – Demonstration Eligibility 4

Section III – Demonstration Benefits and Cost Sharing Requirements 6

Section IV – Delivery System and Payment Rates for Services 7

Section V – Implementation of Demonstration 16

Section VI – Demonstration Financing and Budget Neutrality 18

Section VII – List of Proposed Waivers and Expenditure Authorities 18

Section VIII – Public Notice 20

Section IX – Demonstration Administration 23

Attachments

Attachment A Medical Education and Research Costs (MERC)

Attachment B Historical Budget Neutrality Information

Attachment C Budget Neutrality Worksheets

Attachment D PMAP+ Evaluation Report April 1, 2011

Attachment E PMAP+ Supplemental Evaluation Report June 17, 2013

Attachment F PMAP+ Evaluation Report August 20, 2014

Attachment G PMAP+ Waiver Evaluation Plan for 2011-2013 and 2014 Waiver Periods

Attachment H Minnesota State Register Notice

Attachment I PMAP+ Stakeholder Email List

Attachment J Public Comment

Attachment K Tribal Consultation Policy

Attachment L Tribal Letter May 19, 2014

Attachment M State Register Notice - Post-Award Public Forum

Attachment N Stakeholder Email Notice – Post-Award Public Forum

Section I – Program Description

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

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

Beginning in 2014, the Affordable Care Act made federal tax credits and cost sharing subsidies available to families to help purchase private insurance through MNsure, which is Minnesota's health insurance exchange. For lower-income families, however, that financial assistance may not be enough to purchase coverage comparable to what is available today through MinnesotaCare. Therefore, Minnesota continued MinnesotaCare as a Medicaid expansion under the PMAP+ demonstration to ensure the stability of health coverage for low-income families and adults. The program provided comprehensive health benefits and low out-of-pocket costs for people with incomes above Medicaid income standards.

In 2015, CMS will implement the basic health plan (BHP) option under section 1331 of the Affordable Care Act. Minnesota will request BHP authority through the blueprint process to continue to provide affordable and comprehensive health insurance and preserve the legacy of MinnesotaCare for Minnesotans.

Even though the PMAP+ Medicaid demonstration will no longer be necessary to continue the MinnesotaCare program because federal authority for that program will shift to BHP, several aspects of the PMAP+ Medicaid demonstration will continue to be necessary. Minnesota seeks to renew longstanding 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 adult to include people living with child(ren) under age 19, and allowing coverage of certain populations in managed care.

2) Include the rationale for the Demonstration.

The purpose of the renewal of this waiver is to continue longstanding 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 adult to include people living with child(ren) under age 19, and allowing coverage of certain populations in managed care.

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.

Objective: The objective of the waiver is to provide comparable access and quality of prevention and chronic disease care to caretaker adult and one year old waiver populations as compared to Minnesota's other Medicaid managed care enrollees. 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 recipients who are not enrolled under the PMAP+ Section 1115 demonstration.

Hypotheses:

1. **Providing health care coverage under the PMAP+ waiver will result in access and quality of prevention and chronic disease care for child and adult waiver populations that is comparable to national Medicaid averages.** Access and quality will be evaluated using HEDIS adult and childhood prevention measures for PMAP+ waiver populations and for a national Medicaid sample.

   2. **Providing health care coverage under the PMAP+ waiver will result in access and quality of prevention and chronic disease care for child and adult waiver populations that is comparable to access and quality of prevention and chronic disease care for Minnesota Health Care Program recipients who are not enrolled under the PMAP+ demonstration waiver.** Access and quality will be evaluated using HEDIS adult and childhood prevention measures for PMAP+ waiver populations and for Minnesota Medicaid enrollees. The proposed hypotheses are consistent with the demonstration hypotheses for the 2011-2013 demonstration period and the calendar year 2014 demonstration period. The difference in the evaluation for 2015-2017 is that the examination of access and quality will be performed on fewer waiver populations, in recognition of the fact that many current waiver populations will transition to Basic Health Plan authority. For this reason, we also will not be able to measure waiver satisfaction because the CAHPs survey is not administered in a way that will allow identification of the waiver populations remaining under this waiver. The hypotheses for the calendar year 2014 demonstration period comparing MinnesotaCare coverage for 19-20 year olds and adults between 133-200% FPL to marketplace coverage will not be repeated, because those groups will transition to coverage under Basic Health Plan authority.

   To compare access and quality, as in past years, the evaluation will be conducted by the state and will utilize HEDIS performance measures calculated by the Minnesota Department of Human Services for waiver and non-waiver managed care populations, using encounter data submitted by Medicaid MCOs. HEDIS measures for waiver populations are benchmarked against the rates published in the National Medicaid Quality Compass HEDIS 2013 database produced by the National Committee for Quality Assurance (NCQA).

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, 2015 through December 31, 2017. Some portions of the demonstration, such as authority to cover the MinnesotaCare expansion populations, are no longer necessary because the MinnesotaCare program is expected to operate under basic health plan authority as of January 1, 2015. Minnesota requests to continue other longstanding components of the demonstration such as graduate medical education and authorities relating to state plan eligible populations affected by the demonstration through 2017.

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 will transition to basic health plan authority, as described above. The requested demonstration renewal will impact eligibility for certain populations eligible under the state plan and will continue expenditure authorities relating to graduate medical education.

With respect to graduate medical education, Minnesota seeks to continue existing expenditure authorities and amend the language relating to the distribution formula to reflect legislative changes. See Attachment A. The changes requested that relate to the Medical Education and Research Costs Trust Fund include both a change in the source of public program revenue and the distribution formula. First, public program revenue for the distribution formula no longer includes revenue from general assistance medical care and prepaid general assistance medical care. This change is requested so that the terms and conditions accurately reflect that these two state-funded programs for adults without children have been repealed. Next, a change in the distribution formula is requested. This change adjusts the grant awards based on the proportion of public program revenues received by the awardee.

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
Medically needy MA recipients with only unvarying, unearned income *12 month eligibility period*		Aged, blind disabled at/below 75% FPL standard
MA Parents and Caretaker Adults *caring for child age 18*		At or below 133% FPL
MA One Year Olds (12-23 months) *Apply methods for MA infants*		At or below 283% FPL

<u>Definitions: State Plan Eligibility Groups</u>

- **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.

- **Medically needy MA recipients with only unvarying, unearned income.** Minnesota will perform income reviews annually for certain medically needy recipients who are applying under an aged, blind or disabled basis of eligibility and have only unvarying unearned income or whose sole income is from a source excluded by law, whereas other medically needy recipients applying under those bases of eligibility are subject to 6-month income reviews.

- **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, regardless of 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 Medicaid. Although income reviews will be conducted less often as would otherwise be required, medically needy MA recipients with unvarying, unearned income must meet the same income standard. 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):

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

Quality Strategy
The DHS Quality Strategy is developed in accordance with 42 CFR 438.202(a) and requires the state Medicaid agency to have a written strategy for assessing and improving the quality of health care services offered by MCOs. The Quality Strategy was developed to monitor and oversee the following publicly funded managed care Minnesota Health Care Programs:
- PMAP (Prepaid Medical Assistance Program)
- MinnesotaCare
- MSHO (Minnesota Senior Health Option)
- MSC+ (Minnesota Senior Care Plus)
- SNBC (Special Needs Basic Care)

The Quality Strategy assesses the quality and appropriateness of care and service provided by MCOs for all managed care program enrollees. It incorporates elements of current DHS/MCO contract requirements, Minnesota HMO licensing requirements (Minnesota Statues, Sections 62D, 62M, 62Q), and federal Medicaid managed care rules and regulations (42 CFR 438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) is the core of DHS' responsibility to ensure the delivery of quality care and services in publicly funded managed health care programs. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with 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).

The Quality Strategy will evolve over time as the External Quality Review activities continue. DHS intends to review the effectiveness of the Quality Strategy. Significant future modifications will be published in the State Register to obtain public comment, presented to the Medicaid Citizen's Advisory Committee and reported to CMS. The current version of the quality strategy can be accessed on the DHS website at: Quality Strategy, 2013 (PDF)

External Review Process

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

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

Where there is a finding that a requirement is not met, the MCO is expected to take corrective action to come into compliance with the requirement.

The External Quality Review Organization (EQRO) conducts an overall review of Minnesota's managed care system. The EQRO's charge is to identify areas of strength and weakness and to make recommendations for change. Where the ATR describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The EQRO follows up on the MCO's response to the areas identified in the past year's ATR. The Annual Technical Report is shared with all contracted MCOs and is published on the DHS website at: Annual Technical Report for 2012 (PDF)

Performance Improvement Projects

Managed care plans contracted with DHS must conduct performance improvement projects designed to improve care and services provided to Minnesota Health Care Program enrollees. A summary report is published on the DHS website at: Performance Improvement Projects Summary Report for 2012 (PDF),

Voluntary Changes in MCO Enrollment

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. These are the results of surveys of managed care public program enrollees who voluntary change from one managed care plan to another and include reasons for the change. 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: Voluntary changes in MCO enrollment, 2011 (PDF)

Consumer Satisfaction

DHS sponsors an annual satisfaction survey of public program managed care enrollees using the Consumer Assessment of Health Plans Survey (CAHPS®) instrument and methodology to assess and compare the satisfaction of enrollees with services and care provided by MCOs. DHS

contracts with a certified CAHPS vendor to administer and analyze the survey. Survey results are published on the DHS website at: Consumer satisfaction survey results, 2013 (PDF)

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: Summary of managed care grievance information for calendar years 2010-2012 (PDF)

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 Quality Assurance Examination. 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: Health Plan HEDIS reporting.

Other Relevant Reports

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 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. 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.

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. Value of MHCP Managed Care compared to Fee-For-Service

Self-reported MCO quality improvement initiatives
Minnesota Managed Care Organizations (MCO) have begun to 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

first set of reports is included here. 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
- Quality Program Transparency and Accountability HealthPartners
- Quality Program Transparency and Accountability Hennepin Health
- Quality Program Transparency and Accountability IMCare
- Quality Program Transparency and Accountability Medica
- Quality Program Transparency and Accountability MHP
- Quality Program Transparency and Accountability PrimeWest
- Quality Program Transparency and Accountability SCHA
- Quality Program Transparency and Accountability UCare

Annual Report of Managed Care in Minnesota Health Care Programs

This report was ordered as part of Governor Dayton's executive order in November 2006 providing for more oversight and transparency of Minnesota's state managed care programs. Annual report of managed care in Minnesota Health Care Programs – Health care services in 2011, January 2013 (PDF-large file)

CMS Form 416 EPSDT/CHIP Report

Please refer to CMS 416 Reports for Minnesota's annual reports on the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) or Child and Teen Checkups Program (C&TC) as it is called in Minnesota.

PMAP+ Evaluation Reports

The goal of the PMAP+ demonstration is to provide comparable access and quality of prevention and chronic disease care to child and adult waiver populations as compared to Minnesota's other managed care public program enrollees. The PMAP+ waiver evaluation utilizes a subset of HEDIS performance measures to compare, contrast and draw out differences between PMAP and MinnesotaCare populations compared to the National Medicaid rates. On April 1, 2011 DHS submitted a report on the findings of the evaluation conducted for calendar years 2008 and 2009. This document may be found at Attachment D. A supplemental report of evaluation activities and findings was been completed for calendar years 2010 and 2011 and is included at Attachment E. The HEDIS performance measures examined in the supplemental report compare the utilization of preventive and chronic disease care services, physical and mental health, and satisfaction of adults with contracted managed care health care services. A report of evaluation activities and findings for the PMAP+ waiver period July 1, 2011 through December 31, 2013 stratified by race and ethnicity is included at Attachment F.

PMAP+ Evaluation Plan

The PMAP+ waiver evaluation plan is included at Attachment G. This proposed evaluation plan relates to the PMAP+ demonstration periods July 1, 2011 through December 31, 2013 and January 1, 2014 through December 31, 2014.

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?

Minnesota requests the extension of longstanding federal authority to require managed care enrollment for certain Medicaid State Plan groups that would otherwise be exempt from mandatory managed care, including the following:

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

American Indians

In consultation with tribal governments, DHS has developed an approach to Medicaid purchasing for American Indian recipients that is different from the remainder of the Medicaid program. These approaches address issues related to tribal sovereignty, the application of Federal provisions that prevent Indian Health Services (IHS) facilities from entering into contract with managed care organizations (MCOs), and other issues unique to serving American Indian recipients. Minnesota will continue to abide by the terms of these agreements, as stipulated below.

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

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

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

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

Managed care 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.

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

County staff provides information to Medical Assistance recipients about their MCO options, including if enrollment in an MCO is required or voluntary.

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

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

After enrollment, there are opportunities and options for changing enrollment between MCOs. The following is a list of options for switching MCOs:

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

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

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

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

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

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

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

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

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

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

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

The Department of Human Services periodically issue procurements 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 managed care capitation rate because it is coordinated at the local level.

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

N/A

___ Yes ___ No

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

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

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

General Rate Setting Methodology

The Department of Human Services does not negotiate individual rates with each managed care organization or MCO. Base capitation rates are developed on a statewide basis using data from all of the plans, adjusted for various factors such as changes in benefits and pricing. Capitation rates are varied based on the age, gender and geographic location of the recipient. In addition, MCO capitation rates vary based on the health status of members in the plan.

Risk Adjustment

The state will transition to a diagnosis-based risk adjustment mechanism called Chronic Illness and Disability Payment System (CDPS+Rx). The state began making risk adjusted payments in

2000, and in 2014 most of the MCO's payments will be affected by risk adjustment. Pregnant women and newborns will not be risk adjusted.

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 2014 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, so Minnesota proposes implementation on 1/1/2015.

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 Medicaid in the state. If CMS approves this waiver extension, MA One-Year-Olds will continue to be enrolled into the Demonstration using existing eligibility processes.

This waiver extension does not request continuing authority for several groups who are currently enrolled in MinnesotaCare under the authority of this waiver. These groups will continue to be eligible for the MinnesotaCare program, but Minnesota is refinancing the existing MinnesotaCare program under Basic Health Plan authority. In practical terms, people who are currently enrolled in MinnesotaCare under this waiver will experience few changes due to the refinancing of the program under the Basic Health Plan authority. Technically, however, this represents a phase-down of currently approved Section 1115 waiver populations so a transition plan is required.

The phase-down plan is as follows:

The following groups were Medicaid expansion populations under this waiver and will be covered under the MinnesotaCare Program that is being refinanced under Basic Health Plan authority:

MinnesotaCare Caretaker Adults- This group includes adults with children with incomes above 138% and at or below 200% of the FPL.
MinnesotaCare Adults without Children – This group includes adults with incomes above 138% and at or below 200% of the FPL.
MinnesotaCare Children under 21 Years – This group includes children ages 19 and 20 with incomes above 138% and at or below 200% of the FPL.
Designated State Health Program – This group includes children under age 19 with incomes up to 200% of the FPL and people ages 19-64 with incomes over 138 percent of the FPL who are not otherwise eligible for Medicaid or MinnesotaCare.

Cost sharing and benefits will be the same as before, so the refinancing of the MinnesotaCare program is not a negative action for most enrollees. Some enrollees, however, may be affected by the change to income-counting rules because Medicaid rules for calculation of income are slightly different than the advanced premium tax credit rules. At least ten days in advance, Minnesota will notify all affected beneficiaries that their MinnesotaCare coverage is being refinanced under the Basic Health Plan authority in the Affordable Care Act. Beneficiaries will be informed that benefits and cost sharing will be the same as the current MinnesotaCare program. Beneficiaries will also be informed that some Medicaid laws will not apply under the Basic Health Plan, which may affect certain legal rights as of January 1, 2015. These include: federal EPSDT law does not apply under the Basic Health Plan, and the method for determining income will be slightly different, which will affect people with certain types of educational grant income or tribal income. The Basic Health Plan will use the Medicaid appeals process, so the appeals process will be the same. Beneficiaries may appeal the transition to the refinanced program if they feel that they are eligible for Medicaid.

Community outreach activities directing Minnesotans to MNsure will continue. Administrative renewals are being conducted on a rolling basis throughout 2014 as renewals are processed and cases are transitioned to the eligibility system run by MNsure, Minnesota's health care exchange. In 2015, Minnesota will continue to use the same streamlined application for all insurance affordability programs, including Medical Assistance and MinnesotaCare. The MNsure system will determine whether beneficiaries are eligible for MA or MinnesotaCare. People who are found eligible for Medical Assistance will be enrolled in Medical Assistance. Applicants determined eligible for BHP coverage under MinnesotaCare may enroll in MinnesotaCare. However, if the application indicates the person requested a full Medical Assistance determination or may be eligible for Medical Assistance as an individual who is age 65 or older, a person with a disability, medically needy, resides in a long-term care facility, or needs home and community-based waiver services, additional information will be collected and referred to the county social service agency for an evaluation of Medical Assistance eligibility under a non-MAGI basis of eligibility.

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. Minnesota law places a five-year limitation on the

procurement of grant contracts, including managed care contracts. DHS has adopted a rolling cycle of procurements that result in one-year contracts that can be renewed for up to five years. The state is divided into geographic regions. Procurement is conducted for each region at least once every five years.

Section VI – Demonstration Financing and Budget Neutrality

1) <u>Budget Neutrality</u>

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

In the Historic Data tab of the worksheet provide at Attachment B, we provided 5 years of data on the MA one year olds and MA parents of 18 year olds. Historical year five is anomalous because of certain timing issues in the way that managed care payments were made in that year. Therefore, we used historical year 4 data for the Without Waiver (WOW) and With Waiver (WW) PMPMs. 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 C 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 2015-2017 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

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

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

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

To the extent necessary to enable the state to require enrollment in managed care in order to receive benefits.

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. Specifically, this waiver enables the State to perform annual income reviews for certain medically needy recipients who have only unvarying unearned income or whose sole income is from a source excluded by law, whereas other medically needy recipients are subject to 6-month income reviews.

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 Medicaid, up to 283 percent of the Federal poverty level (FPL).

2. Expenditures for Medicaid 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 19, 2014. This notice announced a 30-day comment period from May 19, 2014 to June 18, 2014 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 19, 2014 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. The main page of the DHS public website includes a "Public Participation" link to help people quickly identify what comment periods are open. This page contained a link to the PMAP+ waiver web page during the public comment period. After the comment period, it will be updated to alert web visitors of the upcoming federal comment period on the PMAP+ extension request and to provide the link to the federal website when it is available. A copy of the final draft of the waiver request that includes modifications following the public input process will 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 May 21, 2014. Public testimony was not given at this hearing. There were five members of the public in attendance. The second public hearing was held at the DHS Lafayette location on May 28, 2014. There were no members of the public in attendance.

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

The State used an electronic mailing list or similar mechanism to notify the public. On May 19, 2014 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. Please refer to the stakeholder e-mail list at Attachment I.

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

DHS received two written comments from stakeholders regarding the proposed PMAP+ waiver extension during the comment period from May 19, 2014 to June 18, 2014. Copies of the two comments are included at Attachment J.

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

Both of the written comments received from stakeholders were supportive of DHS' request to renew the PMAP+ waiver.

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 K 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 19, 2014 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 the Minnesota State Register notice published on May 19, 2014. Please refer to Attachment L for a copy of the May 19, 2014 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 June 10, 2014 Tribal Health Work Group meeting. The transition to Basic Health Plan authority and managed care enrollment of tribal members was discussed.

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 May 21, 2014 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 April 21, 2014 informing the public of the date, time and location of the forum (Attachment M). 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 7, 2014 announcing the date, time and location of the forum (Attachment N). There were five members of the public in attendance at the forum. A link to the slides that were discussed at the forum was posted on the PMAP Waiver web page. Discussion at the forum included a question about the Basic Health Plan. Attendees were invited to the public meetings covering the Basic Health Plan to be held in June 2014 for stakeholders and other interested persons

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

N/A

Section IX – Demonstration Administration

Contact

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Attachment A: MEDICAL EDUCATION AND RESEARCH COSTS (MERC)

The items underlined below are proposed amendments to the existing PMAP+ special terms and conditions relating to MERC.

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

(a) Each demonstration year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009, and the distribution set forth in (c) below. This aggregate limit applies to all MERC payments authorized under this demonstration.

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

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

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

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

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

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

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

vi. Public program revenue for the distribution formula includes revenue from medical assistance and~~,~~ prepaid medical assistance.~~, general assistance medical care, and prepaid general assistance medical care~~. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. Training sites whose training site level grant is less than $5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph. For funds distributed in state fiscal years 2014 and 2015, ~~T~~the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training site's grant for funds distributed in fiscal year 2014 and 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For state fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described above.

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

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

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

i. A list of the sponsoring institutions and training sites receiving payments from the MERC Trust Fund under these provisions, the amount paid to each sponsoring institution/training site, the subparagraph of (c) above under which each payment was made, and the source of the non-Federal share for each payment (i.e., each payment from the MERC Trust Fund must be identified with a corresponding transfer into the fund to account for the non-Federal share). A blanket statement can be used if the source of the non-Federal share is the same for all or most of the payments. Sponsoring institutions are the entities that receive payments from the MERC Trust Fund under (c)(i) through (c)(iv) above. The amounts paid to sponsoring institutions, and by training sites under (c)(v), are the basis for Minnesota's claim of FFP.

ii. A description of the process used by the University of Minnesota Board of Regents to allocate funds they received from the MERC Trust Fund, a list of sub-grantees receiving these funds, and the amount each sub-grantee received;

iii. With respect to payments made under (c)(iii) above: (A) a description of the public process used to determine which potential sponsoring institutions will receive grants and the amount of each grant, and (B) if any of the sponsoring institutions made sub-grants, a list of the sub-grantees and the amount each received; and

iv. With respect to payments made under (c)(v) above: a description of the public process used to determine which potential training site will receive grants and the amount of each grant.

MinnesotaCare Pregnant Women

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

MinnesotaCare Children

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

MinnesotaCare Caretaker Adults

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

MinnesotaCare Adults without Children (>= 75% FPG)

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

MA One-Year-Olds

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

MA Parents With Youngest Child 18 Years Old

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

Annual ceiling less expenditures, all waiver groups

MinnesotaCare	MinnesotaCare	MinnesotaCare	MinnesotaCare	MA	MA Parents with Youngest Child

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

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

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

Total waiver expenditures, all waiver groups

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

NOTES

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

May 16, 2014

5 YEARS OF HISTORIC DATA

Attachment C

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

MA 1-year-olds	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
TOTAL EXPENDITURES	$ 13,774,134	$ 14,992,188	$ 14,566,789	$ 16,056,815	$ 12,697,852	$ 72,087,778
ELIGIBLE MEMBER MONTHS	50,617	55,023	56,530	57,729	54,916	
PMPM COST	$ 272.12	$ 272.47	$ 257.68	$ 278.14	$ 231.22	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		8.84%	-2.84%	10.23%	-20.92%	-2.01%
ELIGIBLE MEMBER MONTHS		8.70%	2.74%	2.12%	-4.87%	2.06%
PMPM COST		0.13%	-5.43%	7.94%	-16.87%	-3.99%

MA parents of 18 year olds	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
TOTAL EXPENDITURES	$ 3,239,425	$ 4,307,107	$ 4,531,486	$ 4,317,884	$ 4,006,362	$ 20,402,264
ELIGIBLE MEMBER MONTHS	6,439	8,578	9,375	9,061	8,945	
PMPM COST	$ 503.09	$ 502.11	$ 483.36	$ 476.54	$ 447.89	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		32.96%	5.21%	-4.71%	-7.21%	5.46%
ELIGIBLE MEMBER MONTHS		33.22%	9.29%	-3.35%	-1.28%	8.57%
PMPM COST		-0.20%	-3.73%	-1.41%	-6.01%	-2.86%
	FY2009	FY2010	FY2011	FY2012	FY2013	

Attachment D

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

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

Final Report
April 1, 2011

Table of Contents

Section One Information About the Demonstration 1
1.1 Demonstration Name and Effective Dates 1
1.2 Brief Description and History of the Demonstration 1
1.3 Overview of Current PMAP+ Waiver Authorities 2
1.4 Population Groups Impacted by the Demonstration 2
1.5 Purposes, Aims, Objectives, and Goals of the Demonstration 3
1.6 Lessons Learned – Observations from the Previous Waiver Period 4
1.7 Summary of the Evaluation Requirements in the Demonstration Special Terms and Conditions 4
Section Two Evaluation Design 6
2.1 Management and Coordination of the Evaluation 6
2.2 Performance Measures 6
2.3 Integration of the Quality Improvement Strategy 8
2.4 Plan for Analysis 9
2.5 Limitations and Opportunities 10
2.6 Conclusion, Best Practices, and Recommendations 10
Section Three Evaluation Findings 12
3.1 Evaluation Analysis 12
3.2 Evaluation Analysis Summary 17

Section One Information About the Demonstration

1.1 Demonstration Name and Effective Dates

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

1.2 Brief Description and History of the Demonstration

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

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

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

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

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

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

1.3 Overview of Current PMAP+ Waiver Authorities

MinnesotaCare Authorities

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

Medical Assistance Authorities

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

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

1.4 Population Groups Impacted by the Demonstration

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

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

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

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

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

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

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

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

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

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

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

1.6 Lessons Learned – Observations from the Previous Waiver Period

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

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

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

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

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

Section Two Evaluation Design

2.1 Management and Coordination of the Evaluation

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

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

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

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

2.2 Performance Measures

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

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

Evaluation populations will consist of three subgroups:

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

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

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

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

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

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

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

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

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

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

2.3 Integration of the Quality Improvement Strategy

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

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

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

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

2.4 Plan for Analysis

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

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

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

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

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

2.5 Limitations and Opportunities

The following limitations may impact the results of this evaluation:

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

2.6 Conclusion, Best Practices, and Recommendations

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

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

Section Three Evaluation Findings

3.1 Evaluation Analysis

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

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

Table A: HEDIS Performance Measures[4]

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

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

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

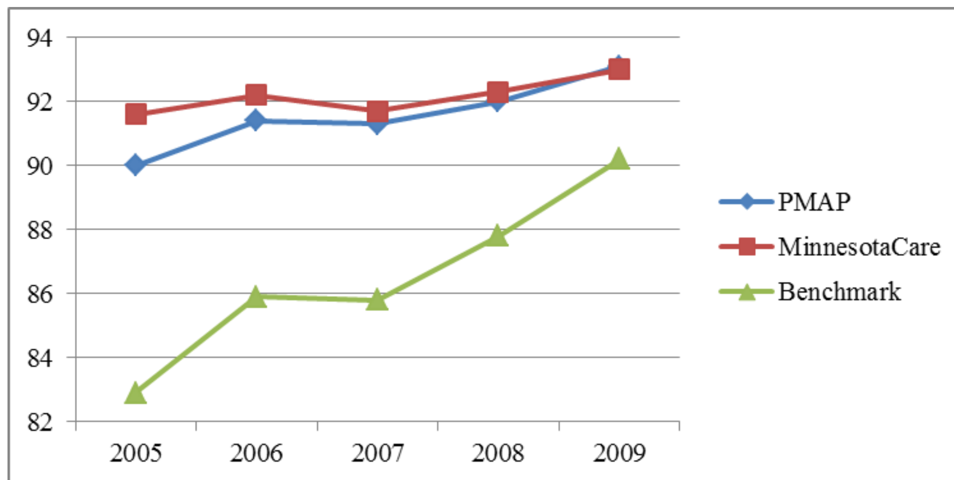
- Children age 0 to 19 years in MinnesotaCare with income at or below 275% FPG. Fourteen performance measures have been calculated and reviewed to identify improvements in care and services that have occurred since calendar year 2005.
- Parents (caretakers) with income at or below 275% FPG with children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

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

MinnesotaCare Children

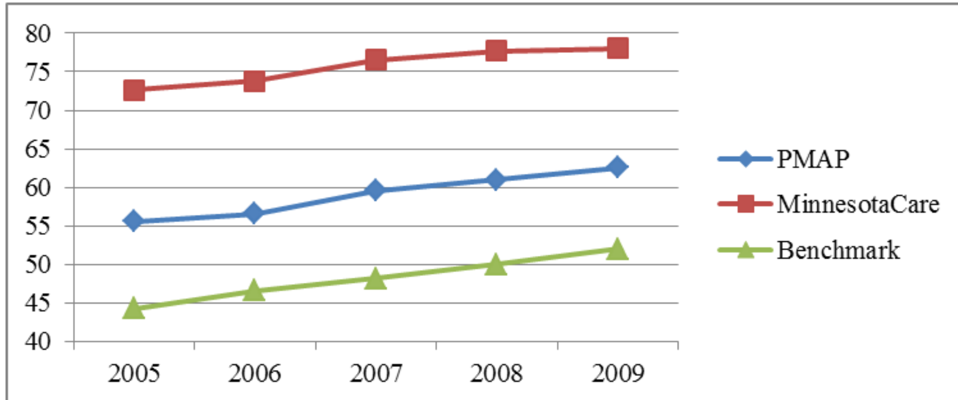
As demonstrated in Attachment A's Childhood Prevention Tables (1-14), the majority (9 out of 14) of PMAP and MinnesotaCare rates from calendar years 2005 through 2009 are above the national Medicaid average. These nine measures (child access and dental visits) confirm PMAP and MinnesotaCare children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

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



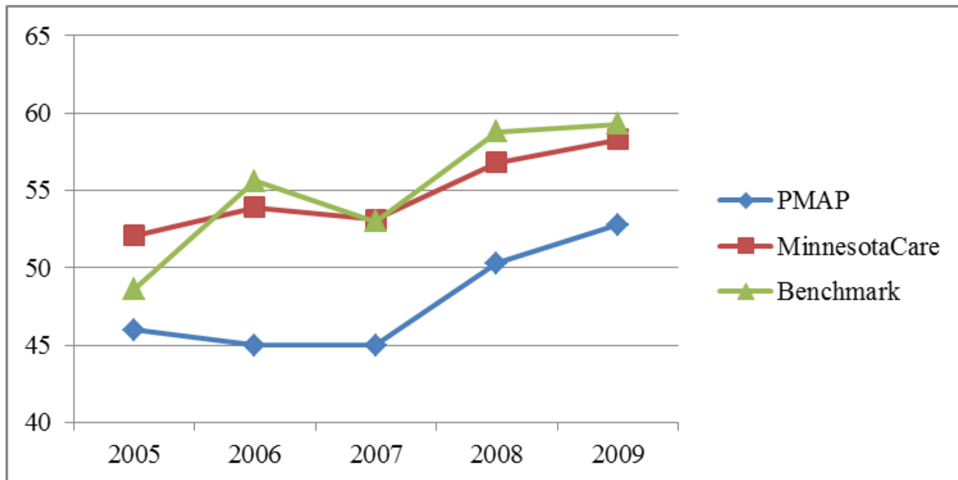
Graph 2 demonstrates that one of the strengths of Minnesota's managed care public programs is ensuring low-income children have greater access to dental care than other state Medicaid programs.

Graph 2: Annual Dental Visit 11-14 yrs.



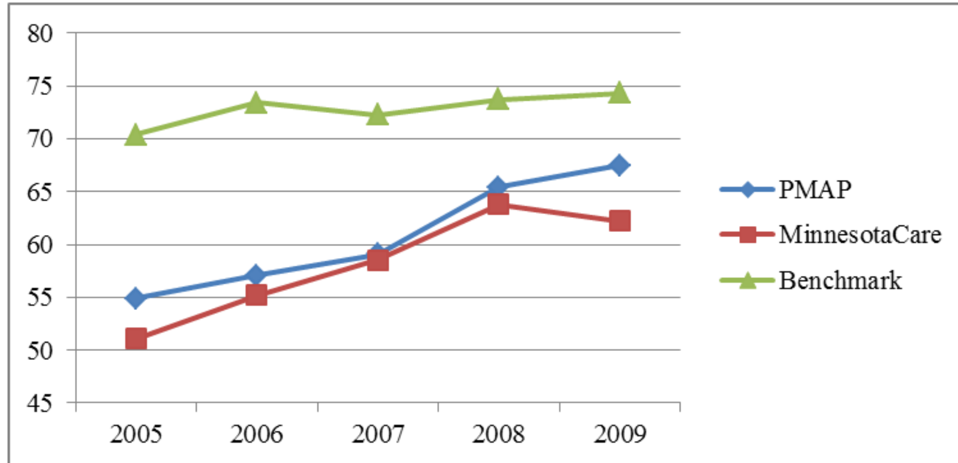
In addition, Graphs 2 and 3 point out the long standing recognition that PMAP and MinnesotaCare enrollees utilize services somewhat differently when measured by certain performance measures as seen in these two graphs.

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



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

Graph 4: Childhood Immunizations (combo #2)



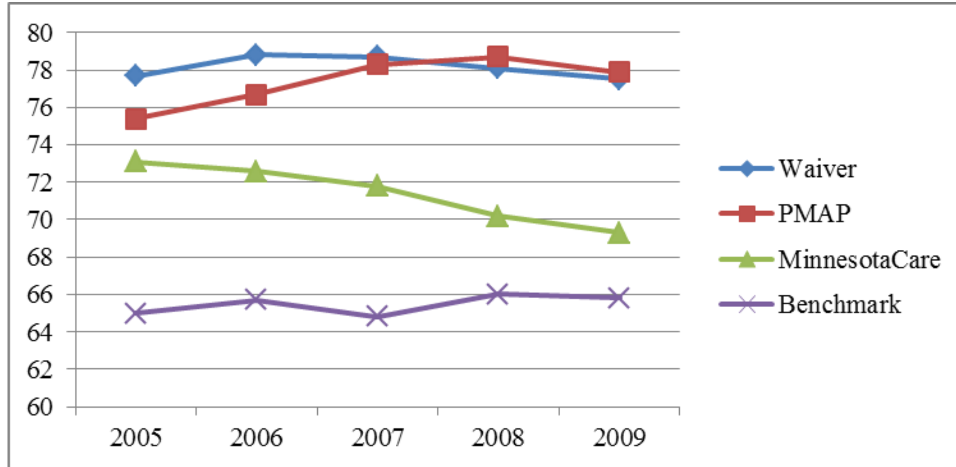
A very straightforward review of Appendix A: Tables 1-14 reveals the majority (9 of 14 measures) of the primary and dental care children's PMAP and MinnesotaCare rates have remained, across all age groups, higher than the national Medicaid average rates.[5] The remaining 5 measures (Immunizations and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

Parents of MinnesotaCare Children (Waiver Population)

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

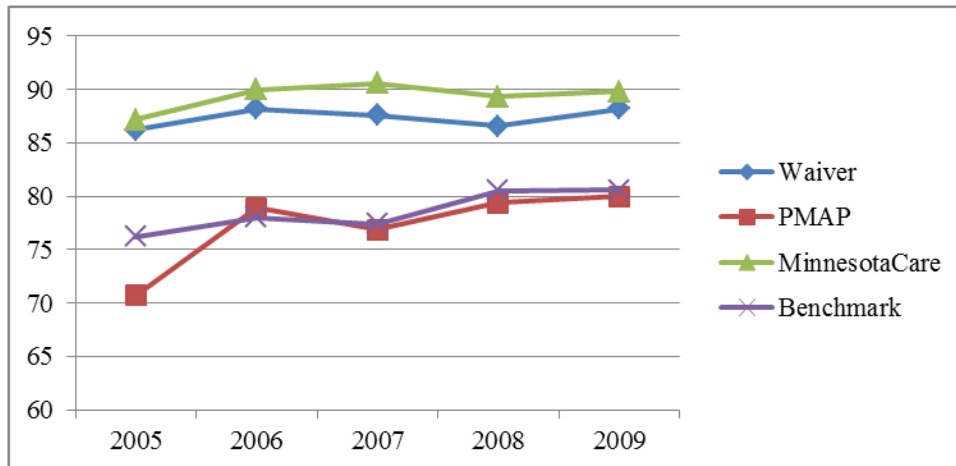
[5] Child access (12-24 mos.; 25mos.-6yrs; 7-11yrs; 12-19 yrs), Annual dental visit (2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14yrs; 15-18yrs)
[6] PMAP Diabetes LDL screening rates are the only exceptions with rates much lower than the benchmark.

Graph 5: Cervical Cancer Screening



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

Graph 6: Diabetes A1c Screening

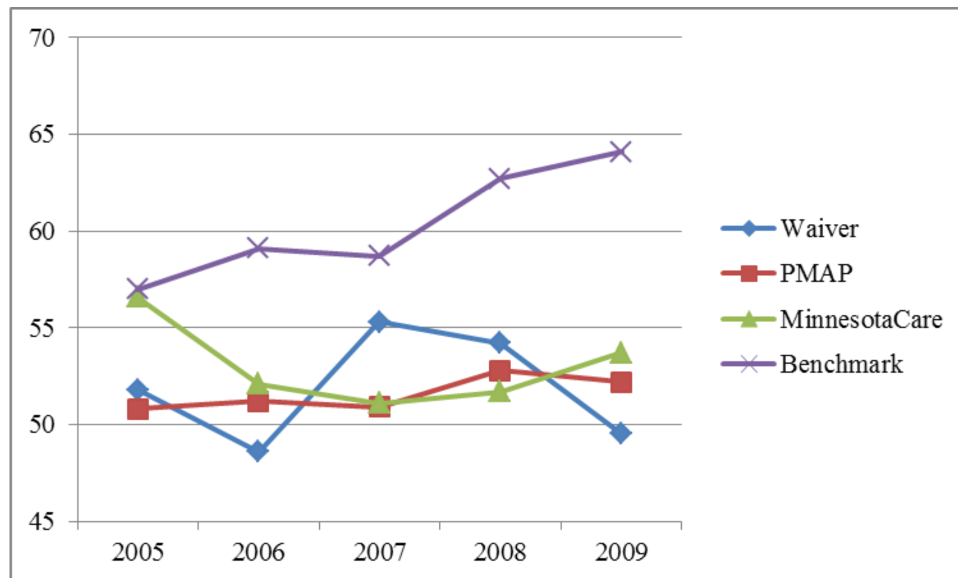


The five measures analyzed demonstrate waiver adults are accessing and receiving services consistent with the entire MinnesotaCare population and often at rates greater then all PMAP enrollees. When waiver adult rates are compared to the national Medicaid benchmark rates they are noticeably higher.

Pregnant Women Care

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

Graph 7: Postpartum Care



3.2 Evaluation Analysis Summary

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

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

[7] See Appendix A: Table 21.

Attachment E

Minnesota's PMAP+ 1115 Waiver Evaluation
Performance Measurement

Update

June 17, 2013

Evaluation Analysis Update – June 13, 2013

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

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

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

Summary of Comparison Population Results- Calendar Years 2010 through 2011

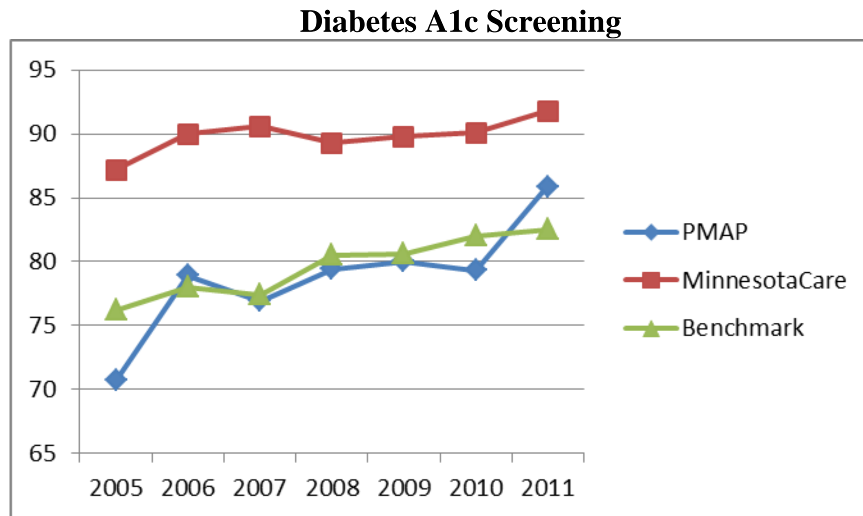
1. **PMAP and MinnesotaCare vs. National Medicaid Averages.** The first comparison is of how well Minnesota's public program enrollees are doing when compared to the National Medicaid average.
   a) As seen in the Childhood Prevention Tables (1-14), the majority (10 out of 14 measures) PMAP and MinnesotaCare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

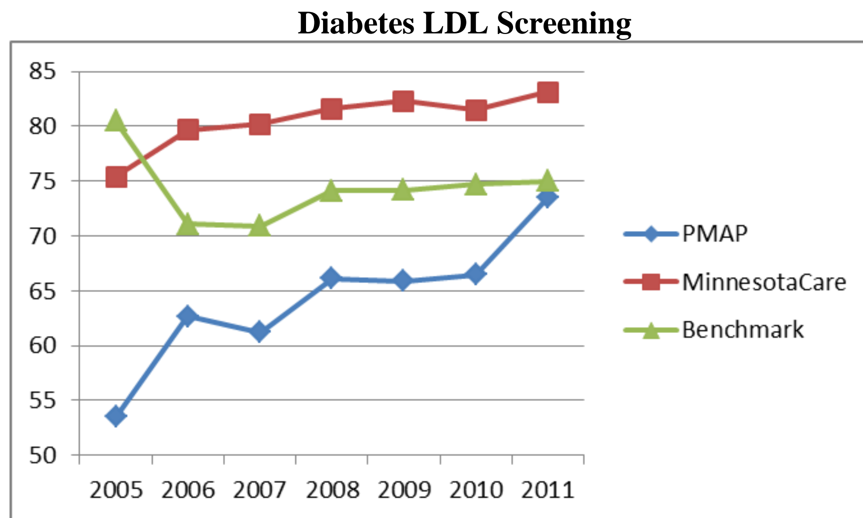
2. **PMAP vs. MinnesotaCare.** It has been a general understanding, PMAP and MinnesotaCare enrollees utilize services somewhat differently when measured by certain performance measures. It is important to recognize these differences and acknowledge these two sub-populations may utilize certain services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

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

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

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

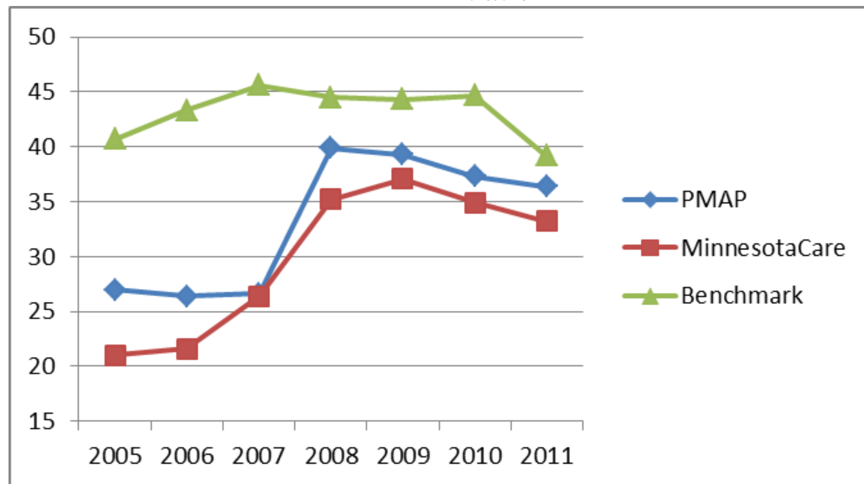




c) PMAP and MinnesotaCare satisfaction rates have not changed much, but there is a slight indication that MinnesotaCare may be somewhat more satisfied with managed care services. The higher MinnesotaCare disenrollment rates reflect the structural auto-assignment process in the MinnesotaCare program.

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

IET Initiation



IET Engagement

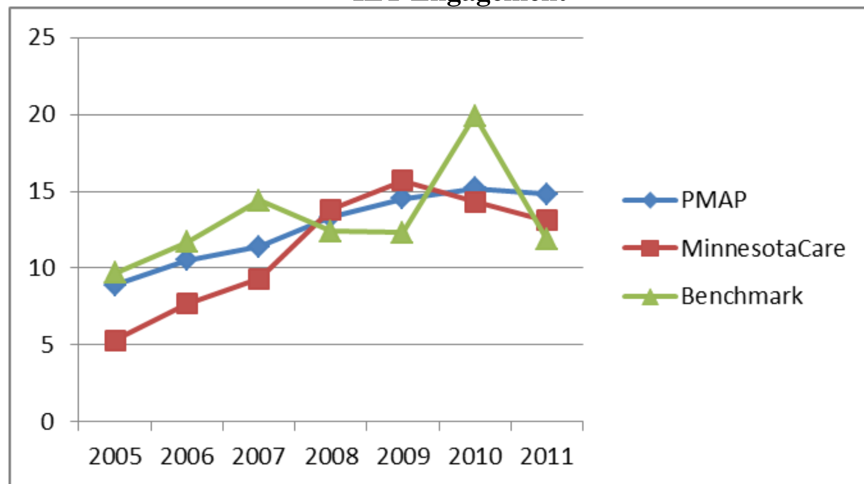


Table # 1

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

Table # 2

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

Table # 3

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

Table # 4

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

Table # 5

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

Table # 6

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

Table # 7

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

Table # 8

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

Table # 9

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

Table # 10

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

Table # 11

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

Table # 12

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

Table # 13

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

Table # 14

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

Table # 15

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

Table # 16

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

Table # 17

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

Table # 18

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

Table # 19

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

Table # 20

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

Table # 21

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

Table # 22

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

Table # 23

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

Table # 24

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

Attachment F

Minnesota Department of Human Services

Minnesota's Prepaid Medical Assistance Project Plus (PMAP+)

Evaluation of 2011-2013 Waiver Periods

Stratified by Race and Ethnicity

August 20, 2014

Table of Content

1. Demonstration History and Description 3

2. Evaluation Objective and Plan for Analysis 4

3. HEDIS 2013 Performance Measures 5

4. Analysis Findings 7

5. Analysis Limitations 9

6. Principle Conclusions and Opportunities 10

7. Appendixes:

Appendix A: Stratification Rate Data and Graphs 12

Appendix B: Measure Analysis 48

Appendix C: Overview of the Race/Ethnicity Disparity Trends 66

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Evaluation of HEDIS 2013 Performance Data
Calendar Years 2012 through 2009
Stratified by Race and Ethnicity

Demonstration History and Description

This report is an evaluation of HEDIS 2013 performance measures for calendar years 2012 through 2009. The evaluation covers the demonstration period July 1, 2011 through December 31, 2013 for the Prepaid Medicaid Assistance Project Plus (PMAP+) Section 1115 waiver. 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. In addition, the waiver has allowed Minnesota to enroll American Indians in managed care for many years, with a number of protections to ensure that American Indians may access culturally appropriate providers. For adult enrollees, MinnesotaCare requires payment of a monthly premium and higher cost sharing than Medicaid. MinnesotaCare 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. A new feature of the demonstration during this period was coverage of nondisabled adults without children. On August 1st, 2011, Minnesota received authority to add coverage for this category of adults to the MinnesotaCare program under the Affordable Care Act (PPACA). Over 30,000 adults received coverage under the waiver every month during this period. This group was previously covered under state-funded programs.

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

a) 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.

b) 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.

c) 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.

d) 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.

e) MinnesotaCare Adults without Dependent Children. This group includes adults age 21 to 64 without dependent children ages 21-64 with incomes above 75 percent and at or below 250 percent of the FPG. MinnesotaCare 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 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 (a) through (h) below are excluded and inpatient hospital services are limited for certain participants as described in (i) below.

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 (except that mental health targeted case management services are provided);
g) Nursing facility services; and
h) ICF/MR services.
i) Inpatient Hospital Limit: MinnesotaCare Caretaker Adults 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.

Evaluation Objective and Plan for Analysis

The objective of the waiver is to provide access and quality comparable to national Medicaid averages, as well as to provide access and quality comparable to Minnesota Medicaid managed care enrollees who are not eligible under the waiver. Due to limitations on the availability of data, the evaluation utilizes data on MinnesotaCare enrollees as those enrolled in the waiver and PMAP+ enrollees as the Minnesota Medicaid managed care population. A limitation of the data used for this evaluation is that a small number of waiver MA One-Year-Olds is included in the PMAP+ data for this evaluation. Subsequent waiver evaluations for this period will separate out these populations, thereby more accurately addressing these concerns. However, it is useful to look at the general program experience by looking at the entire PMAP+ and MinnesotaCare programs.

A positive feature of the data utilized in this evaluation is that it is stratified by race. Race data was obtained by voluntary report of the enrollee. In light of the longstanding authority to enroll American Indians in managed care under the waiver, stratification by race is appropriate.

To compare access and quality, this evaluation utilized selected calendar year (CY) 2012 through 2009 HEDIS 2013 performance measures calculated by the Minnesota Department of Human Services (DHS) for Minnesota Medicaid managed care program for families and children ("MA" or "F&C MA") and MinnesotaCare managed care populations which are funded through the waiver. Comparisons between these two managed care populations are benchmarked against the rates published in the National Medicaid Quality Compass HEDIS 2013 database produced by the National Committee for Quality Assurance (NCQA).

The analysis plan consists of comparisons of 18 HEDIS 2013 performance measurement results between MA and MinnesotaCare managed care populations to demonstrate the ongoing improvement in care for all publicly funded program enrollees. HEDIS prevention and utilization performance measurement rates have been stratified by race and ethnicity to also identify potential health care delivery system disparities over the four year period.

DHS compares results between MA and MinnesotaCare programs to demonstrate that waiver enrollees in MinnesotaCare are receiving/utilizing health care services similar to F&C MA populations. In addition, rates stratified by race and ethnicity will be compared between programs and determine if there are trends and patterns of change over time.

HEDIS 2013 Performance Measures

Eighteen HEDIS 2013 performance measures were calculated by DHS staff based on managed care plan submitted encounter data and validated reportable by MetaStar, Inc., a certified HEDIS auditor. Each measure was stratified by race and ethnicity, and then graphically compared over the four year period for tends and patterns to reveal potential health care delivery system disparities. The table below provides a list of measures that were analyzed.

HEDIS 2013 Measure	Measure Description
1. Adult' Access to Preventive/Ambulatory Health Services: 20-44 years	The percentage of managed care enrollees 20-44 years old who had one or more ambulatory or preventive care visit during the measurement year
2. Adult' Access to Preventive/Ambulatory Health Services: 45-64 years	The percentage of managed care enrollees 45-64 years old who had one or more ambulatory or preventive care visit during the measurement year
3. Antidepressant Medication Management: Effective Acute Phase Treatment	The percentage of managed care enrollees 18-64 years old newly diagnosed (major depression) and treated with antidepressant medication, who remained on an antidepressant medication for at least 12 weeks. The intake period was a 12 month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year
4. Antidepressant Medication Management: Effective Continuation Phase Treatment	The percentage of managed care enrollees 18-64 years old newly diagnosed (major depression) and treated with antidepressant medication who remained on an antidepressant medication for at least 6 months. The intake period was a 12 month window starting on May 1 of the year prior to the measurement year and

	ending on April 30 of the measurement year
5. Use of Appropriate Medications for People with Asthma: Total 5-64 years	The percentage of managed care enrollees 5-64 years old during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications.
6. Adolescent Well-Child: 12-21 years	The percentage of managed care enrollees 12-21 years old who had at least one comprehensive well-care visit with a primary care or OB/GYN provider during the measurement year.
7. Breast Cancer Screening: 40-64 years	The percentage of managed care women 40-64 years old who had a mammogram to screen for breast cancer during measurement year and year prior to the measurement year.
8. Children and Adolescents' Access to Primary Care Practitioners: 12-24 Months	The percentage of managed care children 12-24 months old who had a visit with a primary care provider during the measurement year.
9. Children and Adolescents' Access to Primary Care Practitioners: 25 Months- 6 Yrs.	The percentage of managed care children 25 months to 6 years old who had a visit with a primary care provider during the measurement year.
10. Children and Adolescents' Access to Primary Care Practitioners: 7-11 Yrs.	The percentage of managed care children 7 to 11 years old who had a visit with a primary care provider during the measurement year.
11. Children and Adolescents' Access to Primary Care Practitioners: 12-19 Yrs	The percentage of managed care children 12-19 years months old who had a visit with a primary care provider during the measurement year.
12. Cervical Cancer Screening: 21-64 Yrs	The percentage of managed care women 21-64 years old who received one or more Pap test to screen for cervical cancer during the measurement year.
13. Comprehensive Diabetes Care: Hemoglobin A1c Testing	The percentage of managed care enrollees, 18-64 years old with diabetes who had a Hemoglobin A1c (A1c) test during the measurement year.
14. Comprehensive Diabetes Care: LDL-C Screening	The percentage of managed care enrollees, 18-64 years old with diabetes who had a LDL-C screening test during the measurement year.
15. Chlamydia Screening in Women	The percentage of women, 16-24 years old, who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
16. Childhood Immunization Status	The percentage of children, two year of age during the measurement year, who had four DTaP, three IPV, one MMR, three Hib, three HepB and one VZV vaccinations by their second birthday.
17. Well-Child Visits in the First 15 Months of Life	The percentage of children, who turned 15 months old during the measurement year and had six or more well-child visits with a primary care provider during their first 15 months.
18. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	The percentage of children, 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year.

All of these measures are calculated from MCO submitted encounter data on an annual basis. Stratification of results based on race/ethnicity has been performed to determine if there were disparities that could be quantified. Race/ethnicity determination is based on DHS enrollment information. U.S. Census race and ethnicity categories are used (six categories: White, Black, Asian & Pacific Islanders, American Indian, Others and Hispanic). The "Other" category includes those of multiple racial/ethnicity origins or those enrollees in which race or ethnicity are unknown.

These same HEDIS measures were analyzed in the Annual Technical Report (ATR) for several years to identify potential public program and MCO trends over rolling four year periods. Generally, DHS has seen MCO and program rates increasing steadily, demonstrating increased utilization of health care services. There have been a few exceptions, such as cervical cancer screening.

Analysis Findings

DHS' analysis of HEDIS performance measures over the past several years indicates that there are differences in access and utilization of health care services between MA and MinnesotaCare enrollees. These differences may be small, often inconsistent over time, but enrollees in these two programs make difference choices. Likewise when public program results are stratified by race and ethnicity, these sub-populations also access and utilize health care services differently. As a public purchaser of health care services, DHS works to ensure Minnesota Health Care Programs (MHCP) services are delivered in a culturally competent manner and easily used by all enrollees especially if they may have limited English proficiency. DHS expects contracted managed care organizations to participate in the State's efforts to promote the delivery of health care services that meet the needs of all public program enrollees.

Appendix A contains the stratified rates and summary four year graphs of MA and MinnesotaCare rates for the performance measures. Appendix B narrows the focus, to identify differences in program level averages and highlight the most recent year of rates stratified by race/ethnicity. Appendix C provides a useful summary comparison of how minority populations compare to the white subgroup in CY 2012.

MA and MinnesotaCare Average Comparisons and Benchmarks.

Over the four year period:

a) Eight out of 18 MinnesotaCare measures were higher than MA rates and
b) Five were approximately the same as MA.
c) Thirteen MinnesotaCare measures were above the National Medicaid average and twelve were within the 75th or 90th percentiles.

When comparing MinnesotaCare to MA performance rates, MinnesotaCare performance rates were the same or greater than that achieved in MA on 13 out of the 18 measures. When comparing MHCP performance rates to national performance outcomes, it's clear that MHCP enrollees in either MinnesotaCare or MA programs out-perform the national averages and frequently are ranked within the national 75th or 90th percentiles

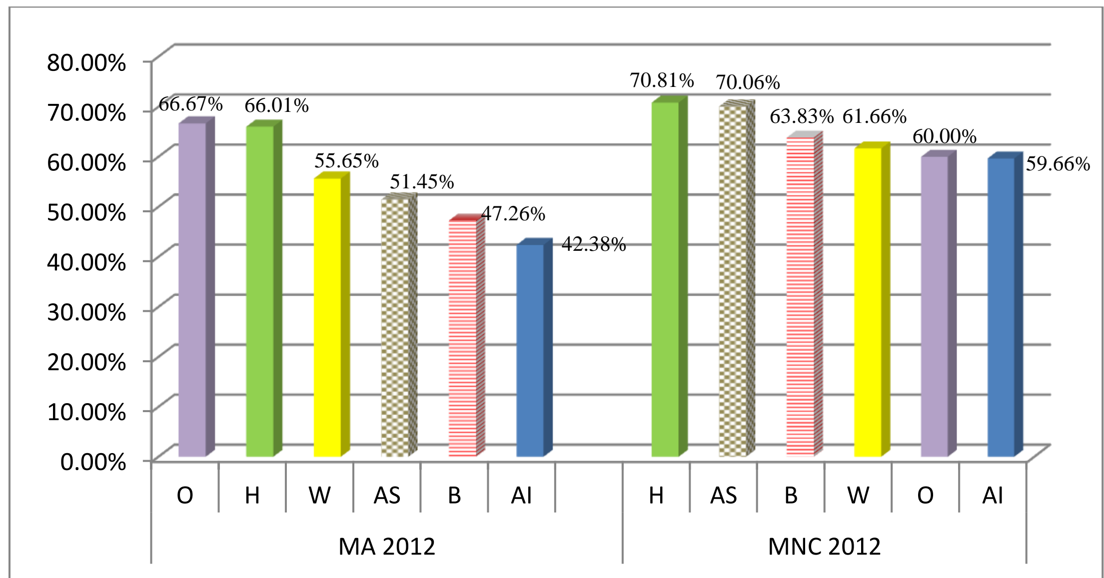
Stratification Comparisons and Benchmarks. Over the four year period examined:

a) The gap between highest and lowest racial/ethnic subgroups within the MinnesotaCare program was on average about 10 percentage points.
b) There were patterns in 9 MinnesotaCare measures over time, indicating potential disparities may exist in:

i. Antidepressant Medication Management: Effective Acute Phase Treatment and Effective Continuation Phase Treatment (measures # 3 and 4). The Black subgroup consistently had the lowest rates and while the White subgroup had the highest rates.

ii. Adolescent Well-Child (measure # 6). The White subgroup had the lowest Adolescent Well-Child rate over the 4 years.

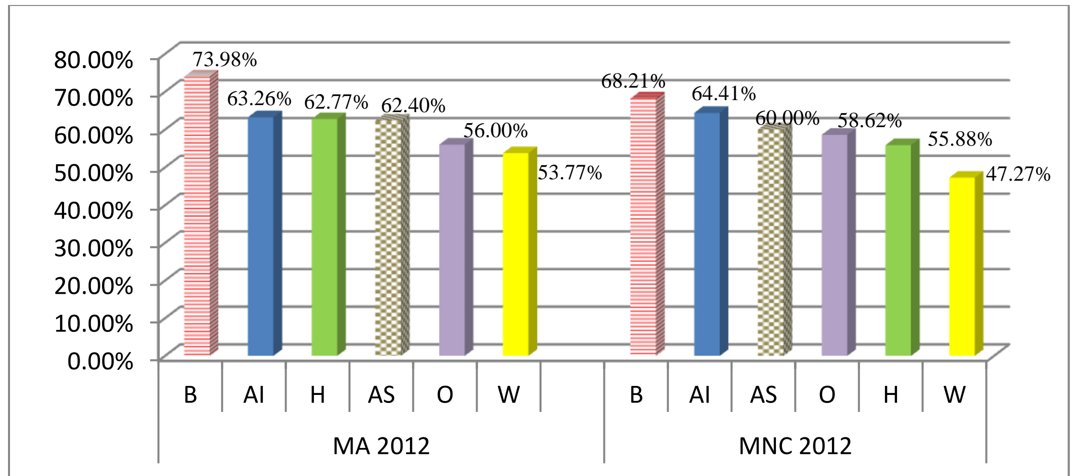
iii. Breast Cancer Screening (measure # 7). The American Indian subgroup rates were consistently the lowest (50 to 59%) each year compared to the Hispanic population with the highest rates (74 to 70%).



iv. Cervical Cancer Screening (measure #12). American Indian rates were consistently 10 percentage points lower than the Asian, Black and Hispanic subgroups.

v. Comprehensive Diabetes Care: Hemoglobin A1c Testing and LDL-C Screening (measures # 13 & 14). The American Indian subgroup rates over the four years of results had the lowest rates for both the A1c testing and LDL screenings

vi. Chlamydia Screening in Women (measure # 15). The White subgroup had the lowest rate of screening of young women for Chlamydia (35 to 48%) while the Black subgroup had the highest rates (66 to 71%). In calendar year 2009 the difference was 31 percentage points.



vii. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (measure # 18). The White subgroup rates for well-child visits between the ages of 3 to 6 were always the lowest at about 64% while the highest rates were approximately 72%.

Analysis Limitations

This evaluation presents a graphic comparison of a subset of HEDIS performance measure. The measures are both simple process measures and measures of utilization which do not attempt to aggregate results up to one overall rate that is risk adjusted for social/demographic factors. Therefore, each measure will have its own set of limitations that must be considered independently. Below are analysis factors that should be considered in reviewing these 18 individual measures before drawing conclusions or making summary judgments on the quality of health care services being provided to MHCP managed care enrollees, or the potential for disparities in care and services.

a) HEDIS continuous enrollment criteria. 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 can provide a deeper understanding of the motivational forces behind the complex relationships of how enrollees value and utilize health care services.

b) Small racial and ethnic group population bias. A closer review of the data tables in Appendix A (example see Table 16) will show that for some measures, especially for MinnesotaCare, the number of eligible minority enrollees is very small (< 50). Consideration must be used when comparing rates based on small denominators, recognizing that a relatively small change in the numerator could result in a very large change in the rate. (Subgroups with less than 50 peoplehave been removed from the graphic analysis).

Table 16: MinnesotaCare-Childhood Immunizations Combo 2

	2012		2011		2010		2009	
	N	D	N	D	N	D	N	D
White	346	556	371	608	318	543	192	633
Black	48	72	54	87	56	77	55	99
Asian	38	47	44	58	42	57	25	52
Amer Indian	4	6	3	4	2	2	1	4
Other	129	211	143	237	138	212	70	210
Hispanic	22	29	36	49	27	34	18	40

Additionally, in some measures (Table 15) there may be more than 50 total eligible enrollees, but the number of the minority subgroups is very small compared to the White subgroup. Therefore, relatively small changes in minority subgroup rates could result in large changes in the rate, introducing a bias in the average rates for MA and MinnesotaCare. For the measures used over the four year period, the proportion of the minority population remained consistent inMA and MinnesotaCare (approximately 49% and 27% respectively).

c) Measures with high rates may show only small changes or remain stable over time. Some of the visit utilization measures have rates close to 100% (Table 8). Rate changes over time or differences between subgroups may only be one or two percentage points. These measures should only be considered as indications of failing or negative events and not indicators that demonstrate real improvements.

Principle Conclusions and Opportunities

MA and MinnesotaCare Comparison. Enrollees in these two publicly funded health care programs often utilize services differently when measured by certain performance measures (Table 7). It is important to recognize the social and economic factors that influence and contribute to these differences in service utilization and acknowledge enrollees may utilize services differently based upon slight but important racial and ethnic preference and expectations. These slight differences have not been sufficiently explored and understood and require more specific analyzes based upon a qualitative approach rather than quantitative methods.

Race and Ethnicity Comparisons. Utilization performance measures suggest there are no consistent disparities between managed care public program racial and ethnic populations of color and the white population. Utilization variation is dependent on the specific measure and for at least these measures, results show racial/ethnic groups often utilize services more appropriately than white public program enrollees. The American Indian subgroup more consistently appears across multiple measures as a lower performing minority population. This may be explained due to American Indian enrollee's unique dual citizenship status enabling them to receive services at a federal Indian Health Service clinic whose services information may be incompletely submitted to DHS.

Where utilization differences occur, the differences have persisted over the past four years. With few exceptions, when there is increasing or decreasing utilization rate movement, all racial/ethnic groups followed a similar direction. It should not be assumed that even the White subgroup utilization rates are optimal even though populations of color were compared to the Whites as in

Appendix C. There is a need to improve utilization rates for all public program enrollees as well as to narrow the existing race/ethnicity gaps in rates.

The socioeconomic status of enrollees is a significant determinate in the utilization of services and the enrollee's perceived value of available health care services. The perceived value of prevention may be the common link between all racial/ethnic groups' less than optimal utilization. One of the limitations in this analysis of performance measures is the significant variation between measures that may be based on an individual's perception of value. Some MCOs have learned that value perceptions can be altered by the addition of a financial incentive. However, to ensure improved utilization, sustained consideration must be given to which incentive (or how much) and what is considered culturally appropriate.

Program comparisons and stratification by race and ethnicity provides an initial method to assess differences. More intense and detailed quantitative and qualitative methods may reveal reasons for the observed differences. At this level of analysis, suggesting reasons for the differences would only be based on conjecture and not actual facts.

Appendixes

Appendix A: Stratification Rate Data and Graphs

Appendix B: Measure Analysis

Appendix C: Overview of the Race/Ethnicity Disparity Trends

Appendix A: Stratification Rate Data and Graphs

Table #1: Adult Ambulatory or Preventive Visit 20−44 Years

Measure Description: The percentage of managed care enrollees 20-44 years old who had one or more ambulatory or preventive care visit during the measurement year.

F+C MA

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	29,142	32,119	90.73%	29,652	32,599	90.96%	23,658	25,641	92.27%	22,199	23,916	92.82%
Black	11,623	13,056	89.02%	11,067	12,285	90.09%	9,119	9,922	91.91%	8,780	9,557	91.87%
Asian	3,407	4,176	81.59%	3,443	4,246	81.09%	2,590	3,124	82.91%	2,355	2,850	82.63%
Amer Indian	2,097	2,303	91.06%	1,739	1,913	90.90%	1,442	1,576	91.50%	1,533	1,670	91.80%
Other	350	425	82.35%	346	405	85.43%	153	175	87.43%	137	165	83.03%
Hispanic	1,988	2,195	90.57%	2,018	2,237	90.21%	1,796	1,951	92.06%	1,681	1,814	92.67%
Total	**48,607**	**54,274**	**89.56%**	**48,265**	**53,685**	**89.90%**	**38,758**	**42,389**	**91.43%**	**36,685**	**39,972**	**91.78%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	18,292	20,743	88.18%	20,967	23,688	88.51%	24,555	28,046	87.55%	19,270	22,015	87.53%
Black	1,925	2,124	90.63%	1,971	2,191	89.96%	2,532	2,888	87.67%	1,807	2,019	89.50%
Asian	1,462	1,825	80.11%	1,563	1,913	81.70%	1,655	2,059	80.38%	1,298	1,576	82.36%
Amer Indian	314	355	88.45%	310	342	90.64%	350	404	86.63%	253	276	91.67%
Other	723	858	84.27%	806	959	84.05%	890	1,072	83.02%	779	936	83.23%
Hispanic	637	704	90.48%	687	765	89.80%	723	795	90.94%	540	592	91.22%
Total	**23,353**	**26,609**	**87.76%**	**26,304**	**29,858**	**88.10%**	**30,705**	**35,264**	**87.07%**	**23,947**	**27,414**	**87.35%**

Graph # 1: Adult' Access to Preventive/Ambulatory Health Services: 20-44 Years

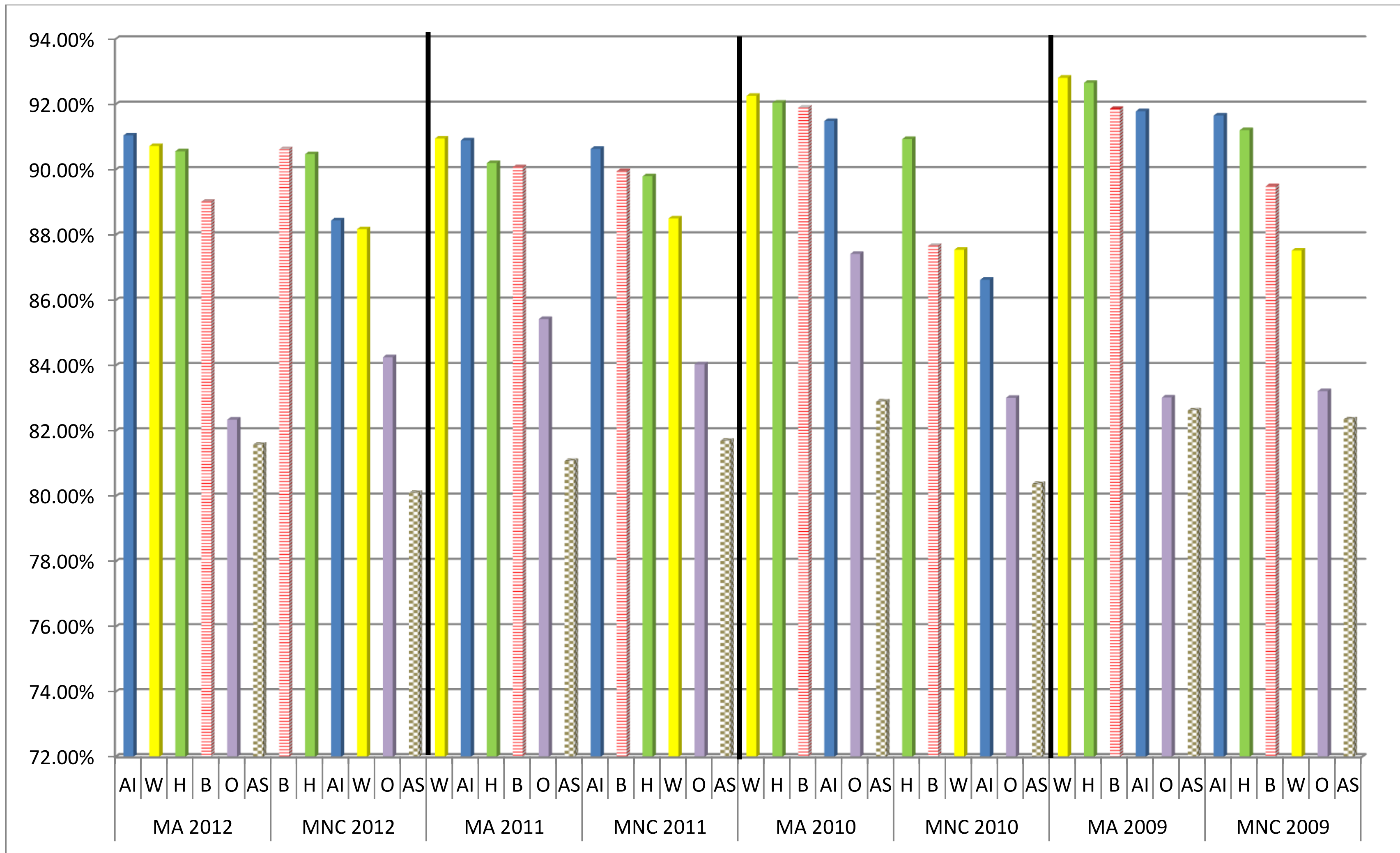


Table #2: Adult Ambulatory or Preventive Visit 45−64 Years

Measure Description: The percentage of managed care enrollees 45-64 years old who had one or more ambulatory or preventive care visit during the measurement year

F+C MA

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	12,865	14,544	88.46%	9,994	11,131	89.79%	3,292	3,636	90.54%	5,628	6,164	91.30%
Black	3,998	4,403	90.80%	2,560	2,781	92.05%	1,537	1,640	93.72%	2,834	3,071	92.28%
Asian	1,360	1,503	90.49%	1,095	1,228	89.17%	619	691	89.58%	703	808	87.00%
Amer Indian	722	788	91.62%	436	466	93.56%	182	197	92.39%	494	517	95.55%
Other	252	299	84.28%	198	219	90.41%	19	20	95.00%	22	27	81.48%
Hispanic	587	629	93.32%	478	515	92.82%	250	270	92.59%	333	361	92.24%
Total	**19,784**	**22,166**	**89.25%**	**14,761**	**16,340**	**90.34%**	**5,899**	**6,454**	**91.40%**	**10,014**	**10,948**	**91.47%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	17,641	19,390	90.98%	19,132	21,004	91.09%	21,841	24,254	90.05%	16,634	18,430	90.26%
Black	1,295	1,386	93.43%	1,310	1,396	93.84%	1,584	1,712	92.52%	1,077	1,147	93.90%
Asian	1,131	1,277	88.57%	1,102	1,231	89.52%	1,099	1,238	88.77%	849	943	90.03%
Amer Indian	310	326	95.09%	295	308	95.78%	319	350	91.14%	239	250	95.60%
Other	671	793	84.62%	759	870	87.24%	803	921	87.19%	665	767	86.70%
Hispanic	481	515	93.40%	448	486	92.18%	566	597	94.81%	400	437	91.53%
Total	**21,529**	**23,687**	**90.89%**	**23,046**	**25,295**	**91.11%**	**26,212**	**29,072**	**90.16%**	**19,864**	**21,974**	**90.40%**

Graph 2: Adult' Access to Preventive/Ambulatory Health Services: 45-64 Years

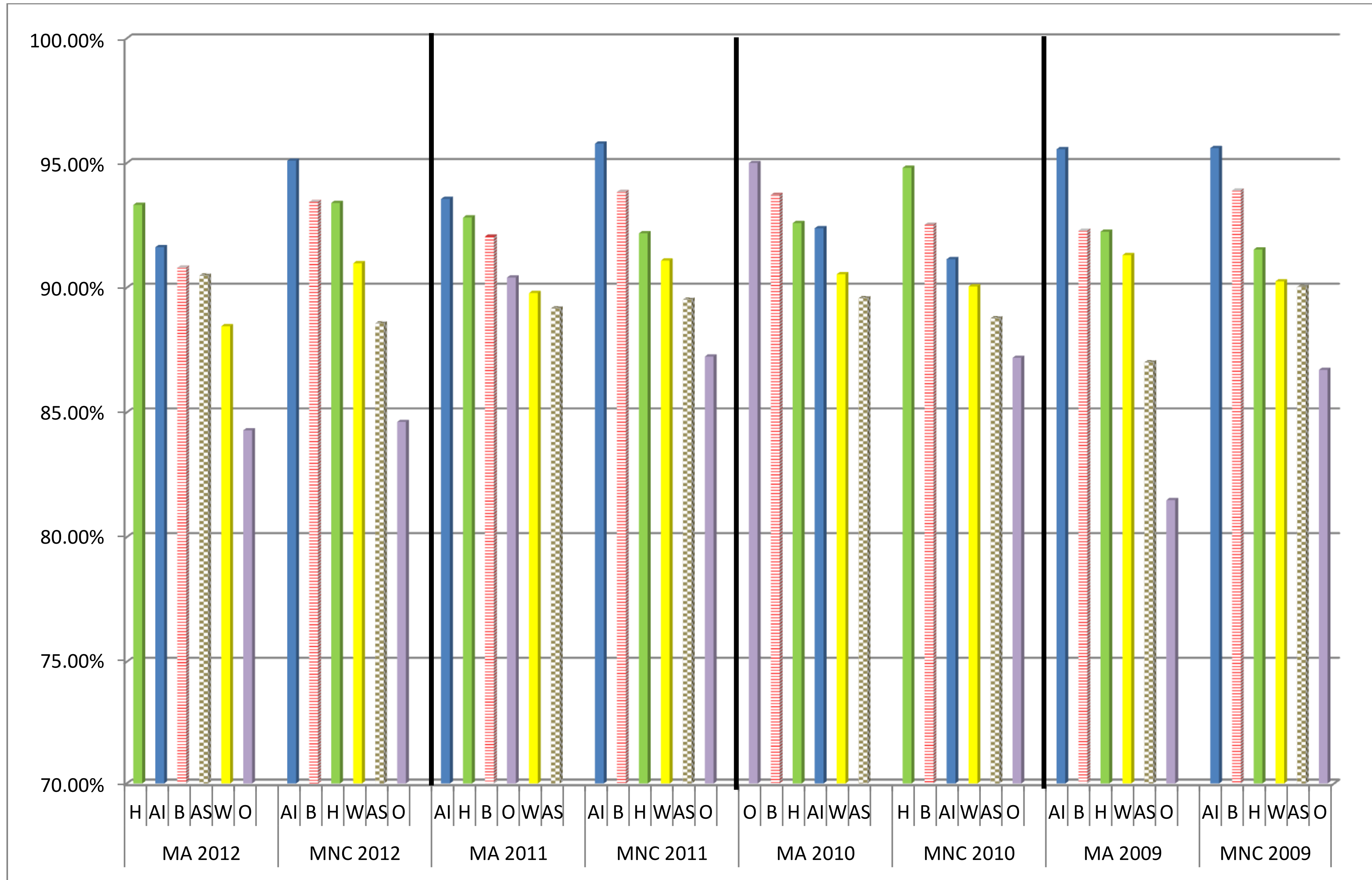


Table #3: Antidepressant Medication Management: Effective Acute Phase Treatment 18-64 Years

Measure Description: The percentage of managed care enrollees 18-64 years old newly diagnosed (major depression) and treated with antidepressant medication, who remained on an antidepressant medication for at least 12 weeks. The intake period was a 12 month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.

F+C MA

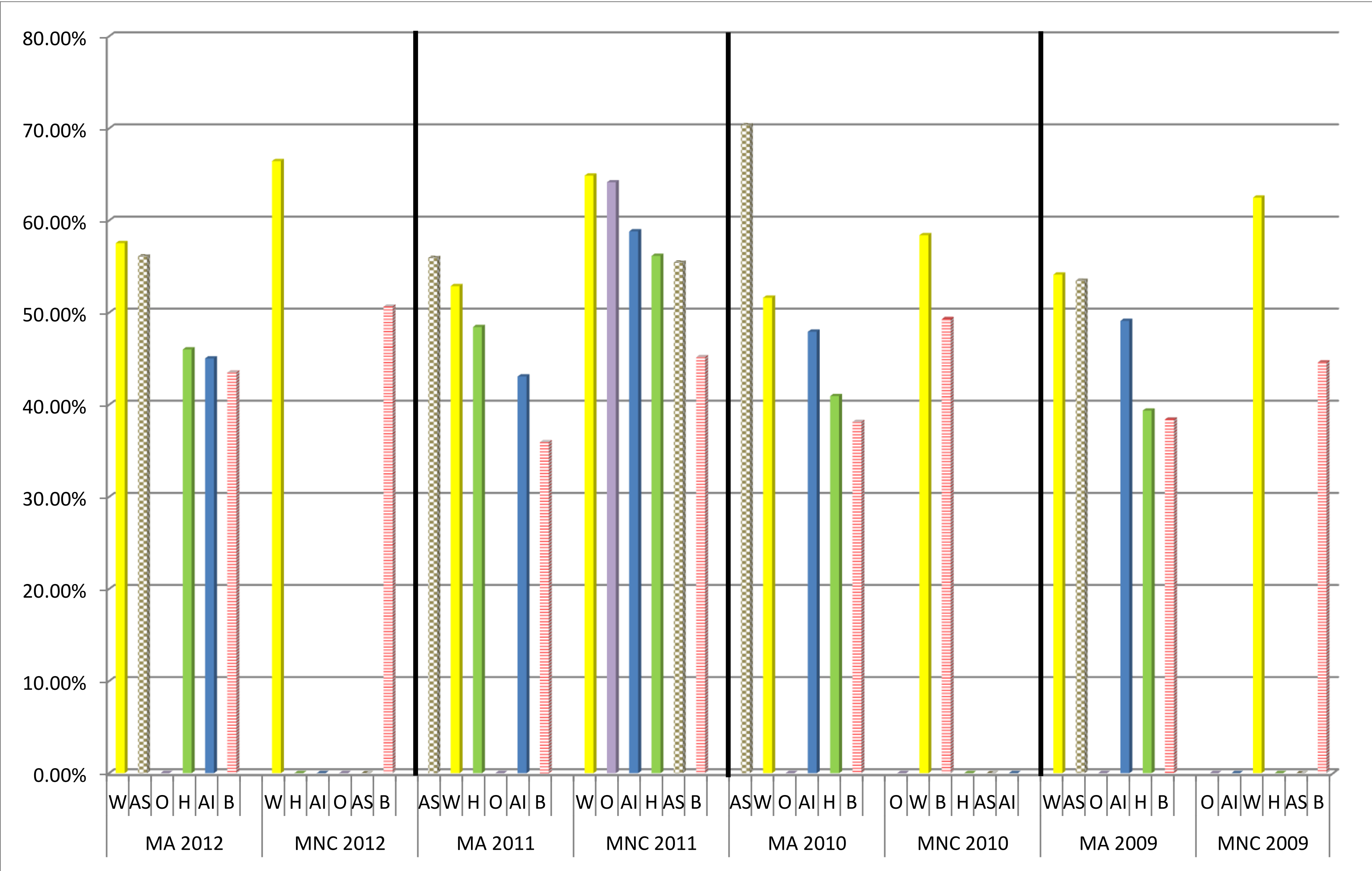
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	1,124	1,953	57.55%	954	1,804	52.88%	905	1,753	51.63%	955	1,764	54.14%
Black	254	584	43.49%	212	590	35.93%	236	619	38.13%	237	617	38.41%
Asian	92	164	56.10%	80	143	55.94%	102	145	70.34%	77	144	53.47%
Amer Indian	77	171	45.03%	59	137	43.07%	81	169	47.93%	82	167	49.10%
Other	6	13	46.15%	5	11	45.45%	3	6	50.00%	3	6	50.00%
Hispanic	69	150	46.00%	78	161	48.45%	61	149	40.94%	50	127	39.37%
Total	**1,622**	**3,035**	**53.44%**	**1,388**	**2,846**	**48.77%**	**1,388**	**2,841**	**48.86%**	**1,404**	**2,825**	**49.70%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	755	1,136	66.46%	1,317	2,030	64.88%	809	1,385	58.41%	718	1,149	62.49%
Black	38	75	50.67%	56	124	45.16%	35	71	49.30%	33	74	44.59%
Asian	20	37	54.05%	49	90	54.44%	21	45	46.67%	22	43	51.16%
Amer Indian	20	32	62.50%	20	34	58.82%	5	17	29.41%	10	16	62.50%
Other	14	24	58.33%	34	53	64.15%	23	39	58.97%	23	32	71.88%
Hispanic	29	44	65.91%	41	73	56.16%	20	41	48.78%	11	20	55.00%
Total	**876**	**1,348**	**64.99%**	**1,517**	**2,404**	**63.10%**	**913**	**1,598**	**57.13%**	**817**	**1,334**	**61.24%**

Graph 3: Antidepressant Medication Management: Effective Acute Phase Treatment 18-64 Years



MA 2012-2009 O; MNC 2012, 2010, 2009; H, AI, O, AS < 50 enrollees

Table #4 Antidepressant Medication Management: Effective Continuation Phase Treatment 18-64 Years

Measure Description: The percentage of managed care enrollees 18-64 years old newly diagnosed (major depression) and treated with antidepressant medication, who remained on an antidepressant medication for at least 6 months. The intake period was a 12 month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.

F+C MA

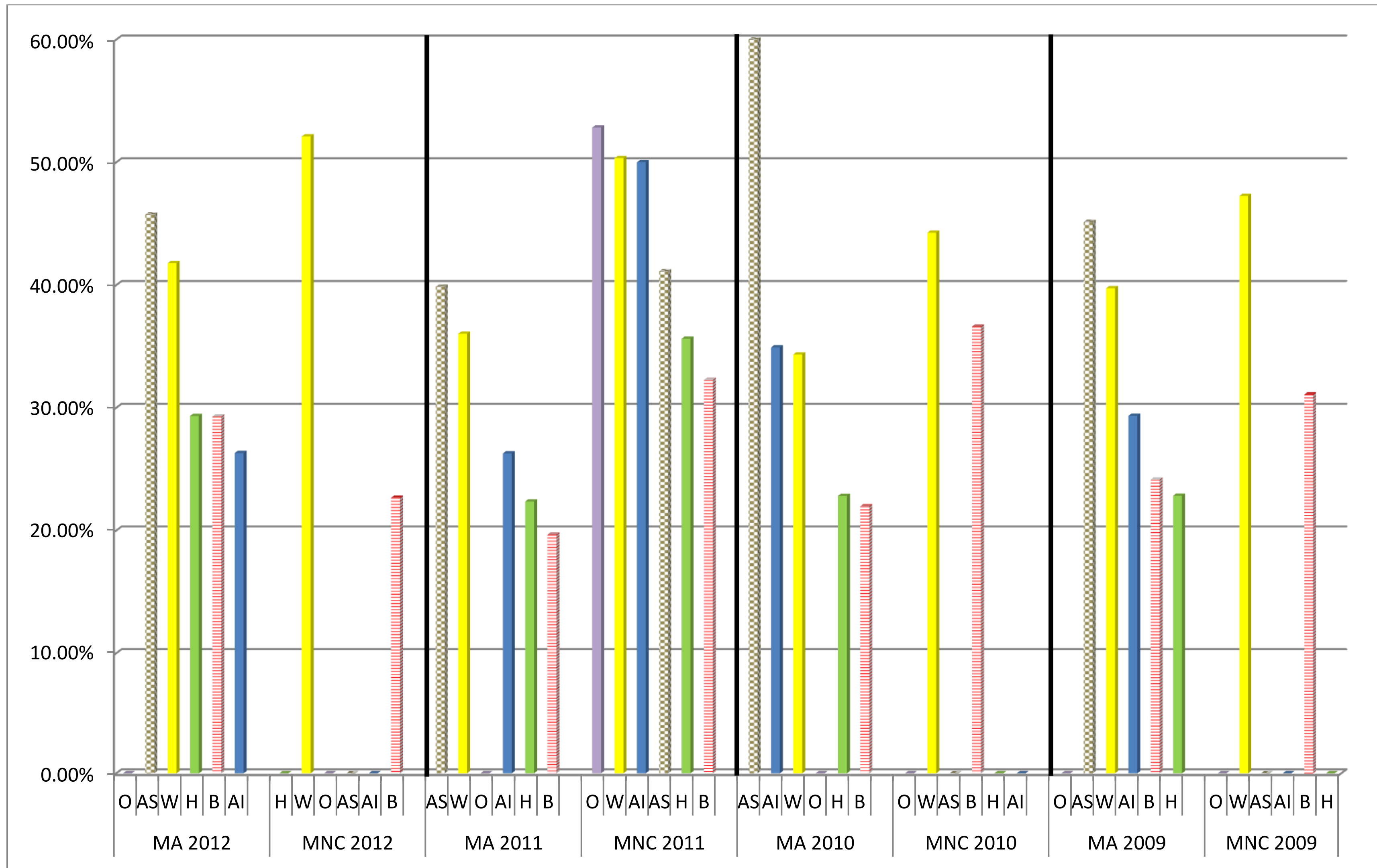
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	816	1,953	41.78%	650	1,804	36.03%	602	1,753	34.34%	701	1,764	39.74%
Black	171	584	29.28%	116	590	19.66%	136	619	21.97%	149	617	24.15%
Asian	75	164	45.73%	57	143	39.86%	87	145	60.00%	65	144	45.14%
Amer Indian	45	171	26.32%	36	137	26.28%	59	169	34.91%	49	167	29.34%
Other	6	13	46.15%	3	11	27.27%	2	6	33.33%	3	6	50.00%
Hispanic	44	150	29.33%	36	161	22.36%	34	149	22.82%	29	127	22.83%
Total	**1,157**	**3,035**	**38.12%**	**898**	**2,846**	**31.55%**	**920**	**2,841**	**32.38%**	**996**	**2,825**	**35.26%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	592	1,136	52.11%	1,022	2,030	50.34%	613	1,385	44.26%	543	1,149	47.26%
Black	17	75	22.67%	40	124	32.26%	26	71	36.62%	23	74	31.08%
Asian	16	37	43.24%	37	90	41.11%	18	45	40.00%	17	43	39.53%
Amer Indian	13	32	40.63%	17	34	50.00%	2	17	11.76%	5	16	31.25%
Other	12	24	50.00%	28	53	52.83%	20	39	51.28%	19	32	59.38%
Hispanic	23	44	52.27%	26	73	35.62%	15	41	36.59%	5	20	25.00%
Total	**673**	**1,348**	**49.93%**	**1,170**	**2,404**	**48.67%**	**694**	**1,598**	**43.43%**	**612**	**1,334**	**45.88%**

Graph 4: Antidepressant Medication Management: Effective Continuation Phase Treatment 18-64 Years



MA: 2012-2009 O; MNC: 2012, 2010, 2009 AI; O, AS and H < 50 enrollees

Table #5 Asthma Medication Management Total 5-64 Years

Measure Description: The percentage of managed care enrollee's 5-64 years old during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications. The 5-11, 12-18, 19-50, 51-64 years age groups were not analyzed because of the small number of eligible.

F+C MA

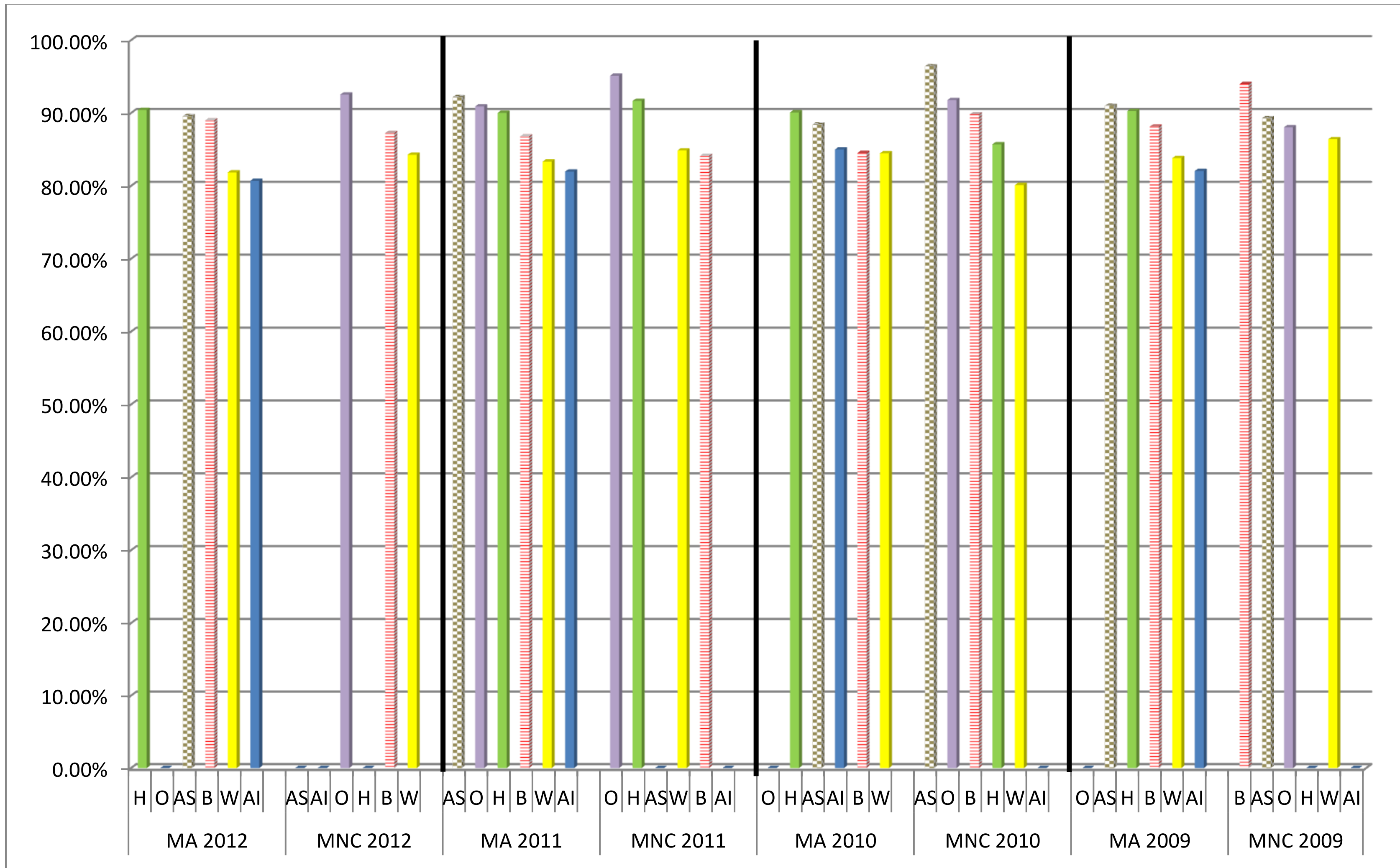
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	1,299	1,587	81.85%	1,476	1,771	83.34%	1,122	1,328	84.48%	1,109	1,323	83.82%
Black	806	906	89.00%	933	1,075	86.79%	789	892	84.52%	736	835	88.14%
Asian	103	115	89.56%	106	115	92.17%	84	95	88.42%	91	100	91.00%
Amer Indian	92	114	80.70%	100	122	81.96%	85	100	85.00%	96	117	82.05%
Other	43	48	89.58%	50	55	90.90%	46	48	95.83%	27	27	100.00%
Hispanic	217	240	90.41%	244	271	90.03%	209	232	90.08%	167	185	90.27%
Total	**2,560**	**3,010**	**85.04%**	**2,909**	**3,409**	**85.33%**	**2,335**	**2,695**	**86.64%**	**2,226**	**2,587**	**86.04%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	976	1,158	84.28%	1,110	1,308	84.86%	1,177	1,394	80.12%	1,037	1,200	86.41%
Black	89	102	87.25%	106	126	84.12%	115	128	89.84%	94	100	94.00%
Asian	31	33	93.93%	41	45	91.11%	54	56	96.42%	50	56	89.28%
Amer Indian	26	28	92.85%	17	22	77.27%	19	28	67.85%	11	15	73.33%
Other	62	67	92.53%	78	82	95.12%	67	73	91.78%	59	67	88.05%
Hispanic	36	40	90.00%	55	60	91.66%	48	56	85.71%	42	48	87.50%
Total	**1,220**	**1,428**	**85.43%**	**1,407**	**1,643**	**85.63%**	**1,480**	**1,735**	**85.30%**	**1,293**	**1,486**	**87.01%**

Graph 5: Use of Appropriate Medications for People with Asthma: Total 5-64 Years



MA: 2012, 2010, 2009 O < 50 enrollees; MNC: 2012 AS, AI, H; 2011 AS, AI; 2010 AI; 2009 H, AI < 50 enrollees

Table #6 Adolescent Well−Care Visits 12-21 Years

Measure Description: The percentage of managed care enrollees 12-21 years old who had at least one comprehensive well-care visit with a primary care or OB/GYN provider during the measurement year.

F+C MA

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	6,291	19,650	32.02%	6,597	20,436	32.28%	6,494	20,163	32.21%	5,948	17,894	33.24%
Black	4,611	12,312	37.45%	4,755	12,792	37.17%	4,802	12,156	39.50%	4,695	11,082	42.37%
Asian	2,110	6,096	34.61%	2,230	6,426	34.70%	2,515	6,121	41.09%	2,279	6,006	37.95%
Amer Indian	551	1,645	33.50%	543	1,654	32.83%	524	1,569	33.40%	473	1,480	31.96%
Other	140	434	32.26%	144	419	34.37%	126	342	36.84%	119	306	38.89%
Hispanic	1,758	4,461	39.41%	1,661	4,207	39.48%	1,523	3,808	39.99%	1,301	3,155	41.24%
Total	**15,461**	**44,598**	**34.67%**	**15,930**	**45,934**	**34.68%**	**15,984**	**44,159**	**36.20%**	**14,815**	**39,923**	**37.11%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	4,110	12,536	32.79%	4,177	13,219	31.60%	4,024	12,713	31.65%	3,567	11,312	31.53%
Black	516	1,284	40.19%	535	1,300	41.15%	484	1,125	43.02%	392	942	41.61%
Asian	426	1,219	34.95%	438	1,275	34.35%	391	1,036	37.74%	300	879	34.13%
Amer Indian	68	201	33.83%	62	185	33.51%	53	159	33.33%	44	123	35.77%
Other	240	715	33.57%	260	696	37.36%	232	610	38.03%	162	481	33.68%
Hispanic	325	857	37.92%	302	731	41.31%	248	562	44.13%	195	454	42.95%
Total	**5,685**	**16,812**	**33.82%**	**5,774**	**17,406**	**33.18%**	**5,432**	**16,205**	**33.52%**	**4,660**	**14,191**	**32.84%**

Graph 6: Adolescent Well-Child: 12-21 Years

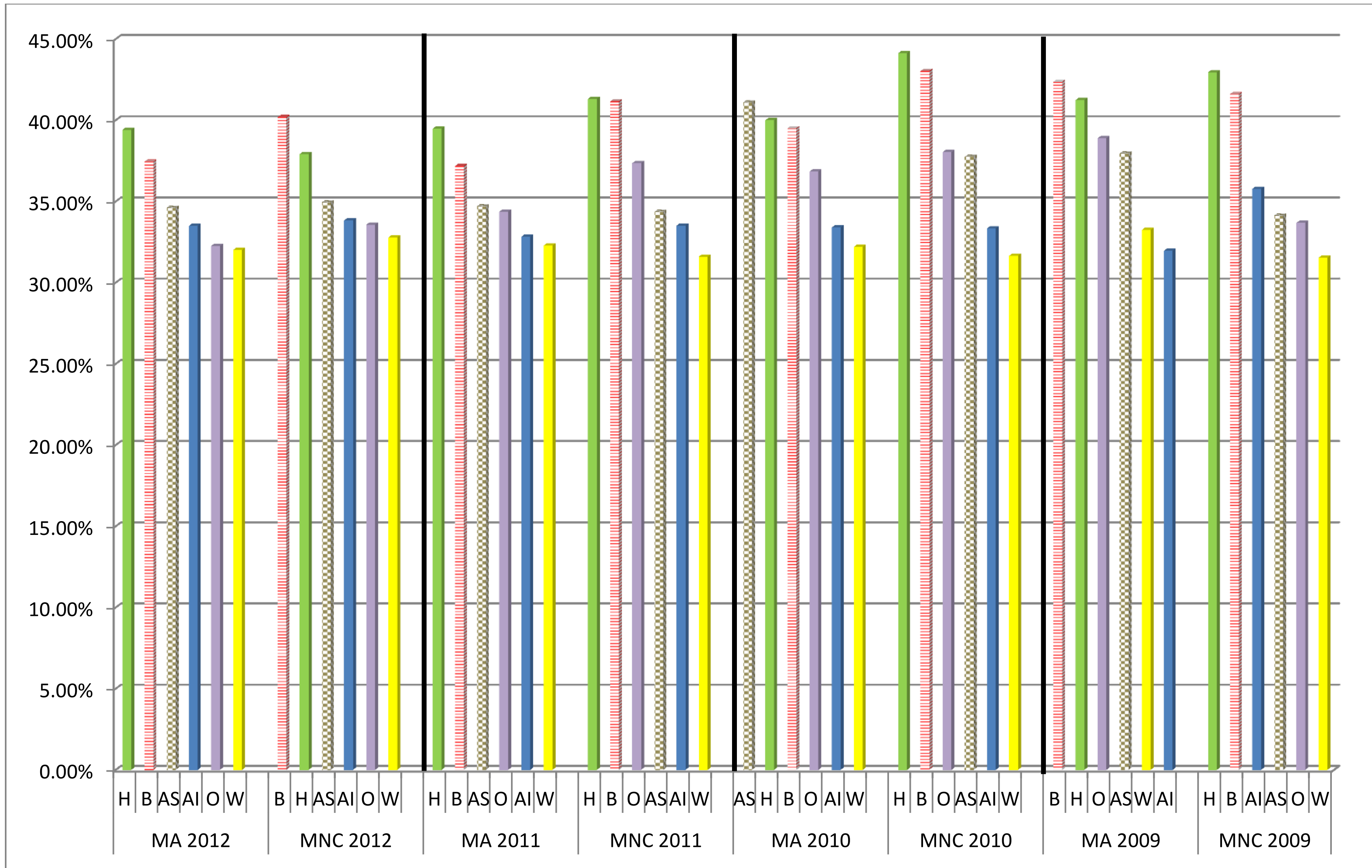


Table #7 Breast Cancer Screening 40-64 Years

Measure Description: The percentage of managed care women 40-64 years old who had a mammogram to screen for breast cancer during measurement year and year prior to the measurement year.

F+C MA

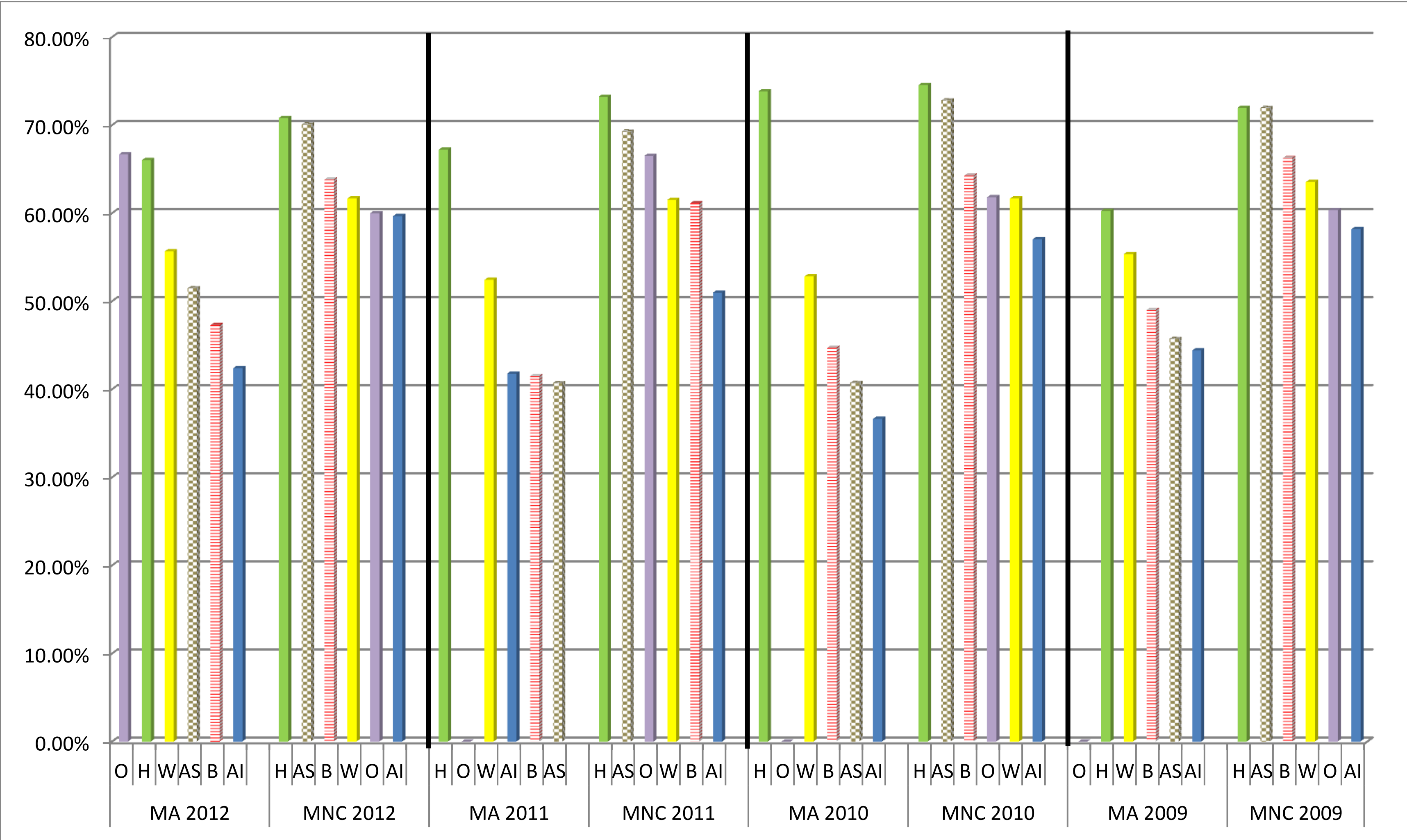
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,448	4,399	55.65%	1,385	2,642	52.42%	1,264	2,394	52.80%	1,513	2,733	55.36%
Black	534	1,130	47.26%	444	1,070	41.50%	400	895	44.69%	545	1,112	49.01%
Asian	266	517	51.45%	138	339	40.71%	125	307	40.72%	160	350	45.71%
Amer Indian	89	210	42.38%	61	146	41.78%	52	142	36.62%	95	214	44.39%
Other	38	57	66.67%	9	15	60.00%	8	11	72.73%	7	10	70.00%
Hispanic	134	203	66.01%	123	183	67.21%	113	153	73.86%	94	156	60.26%
Total	**3,509**	**6,516**	**53.85%**	**2,160**	**4,395**	**49.15%**	**1,962**	**3,902**	**50.28%**	**2,414**	**4,575**	**52.77%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	5,491	8,905	61.66%	7,319	11,900	61.50%	6,395	10,372	61.66%	5,539	8,719	63.53%
Black	307	481	63.83%	462	756	61.11%	365	568	64.26%	275	415	66.27%
Asian	358	511	70.06%	464	670	69.25%	388	533	72.80%	328	456	71.93%
Amer Indian	71	119	59.66%	79	155	50.97%	77	135	57.04%	57	98	58.16%
Other	189	315	60.00%	278	418	66.51%	246	398	61.81%	219	363	60.33%
Hispanic	131	185	70.81%	186	254	73.23%	167	224	74.55%	131	182	71.98%
Total	**6,547**	**10,516**	**62.26%**	**8,788**	**14,153**	**62.09%**	**7,638**	**12,230**	**62.45%**	**6,549**	**10,233**	**64.00%**

Graph 7: Breast Cancer Screening: 40-64 years



MA 2011, 2010, 2009 O < 50 enrollees

Table #8 Children and Adolescents' Access to Primary Care Practitioners 12-24 Months

Measure Description: The percentage of managed care children 12-24 months old who had a visit with a primary care provider during measurement year.

F+C MA

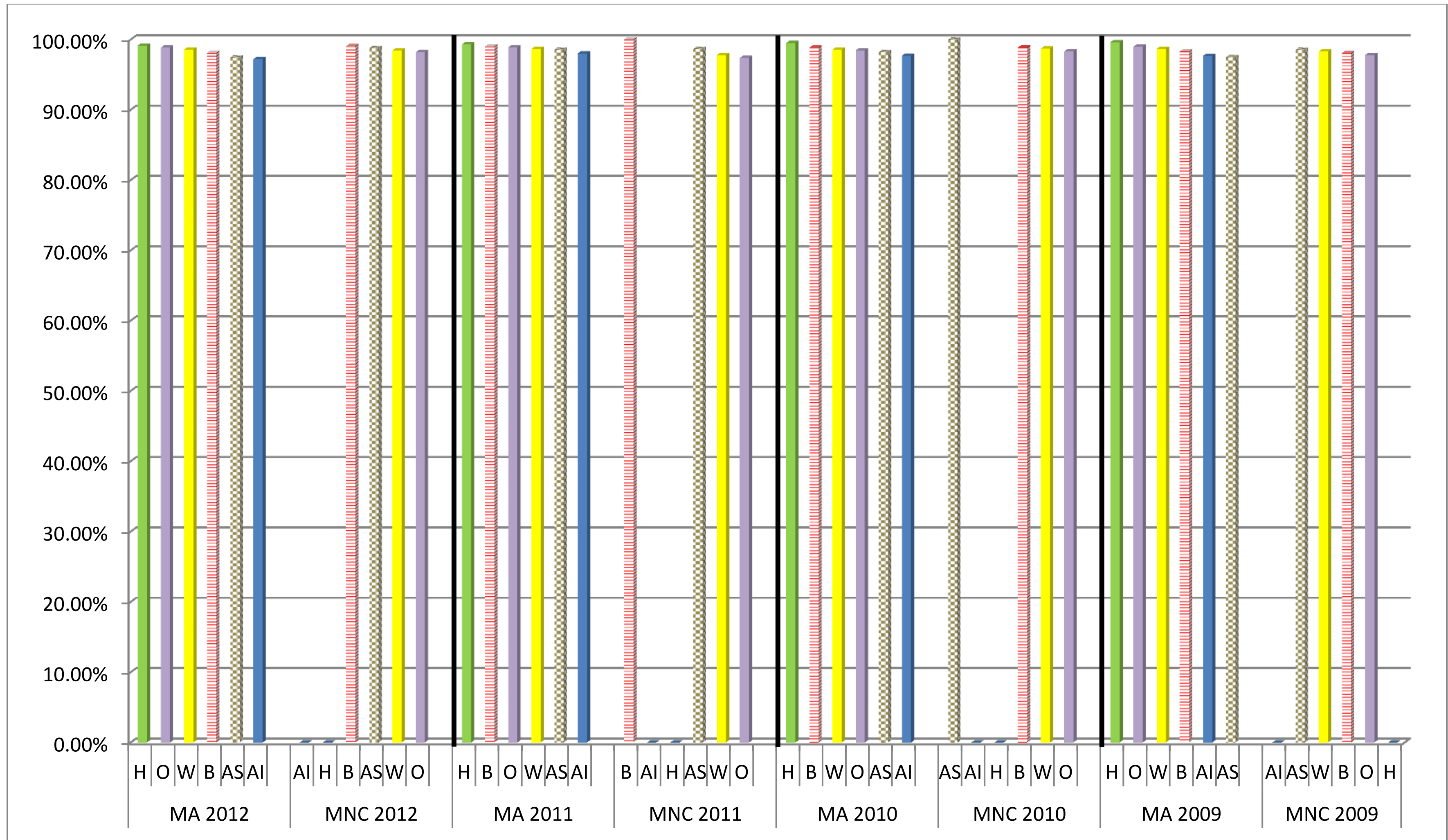
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	5,737	5,821	98.56%	6,153	6,238	98.64%	6,606	6,704	98.54%	6,043	6,124	98.68%
Black	3,225	3,287	98.11%	3,450	3,484	99.02%	3,541	3,583	98.83%	3,259	3,315	98.31%
Asian	1,139	1,169	97.43%	1,038	1,053	98.58%	1,037	1,056	98.20%	890	913	97.48%
Amer Indian	452	465	97.20%	447	456	98.03%	508	520	97.69%	544	557	97.67%
Other	850	860	98.84%	619	626	98.88%	440	447	98.43%	486	491	98.98%
Hispanic	1,824	1,840	99.13%	2,101	2,116	99.29%	2,363	2,375	99.49%	2,252	2,261	99.60%
Total	**13,227**	**13,442**	**98.40%**	**13,808**	**13,973**	**98.82%**	**14,495**	**14,685**	**98.71%**	**13,474**	**13,661**	**98.63%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	629	639	98.44%	659	674	97.77%	613	621	98.71%	577	587	98.30%
Black	103	104	99.04%	100	100	100.00%	85	86	98.84%	102	104	98.08%
Asian	79	80	98.75%	74	75	98.67%	60	60	100.00%	67	68	98.53%
Amer Indian	5	5	100.00%	5	5	100.00%	3	3	100.00%	3	3	100.00%
Other	322	328	98.17%	297	305	97.38%	287	292	98.29%	265	271	97.79%
Hispanic	38	38	100.00%	42	42	100.00%	43	43	100.00%	39	40	97.50%
Total	**1,176**	**1,194**	**98.49%**	**1,177**	**1,201**	**98.00%**	**1,091**	**1,105**	**98.73%**	**1,053**	**1,073**	**98.14%**

Graph 8: Children and Adolescents' Access to Primary Care Practitioners: 12-24 Months



MNC 2012-2009 AI, H < 50 enrollees

Table #9 Children and Adolescents' Access to Primary Care Practitioners 25 Months-6 Years

Measure Description: The percentage of managed care children 25 months to 6 years old who had a visit with a primary care provider during measurement year.

F+C MA

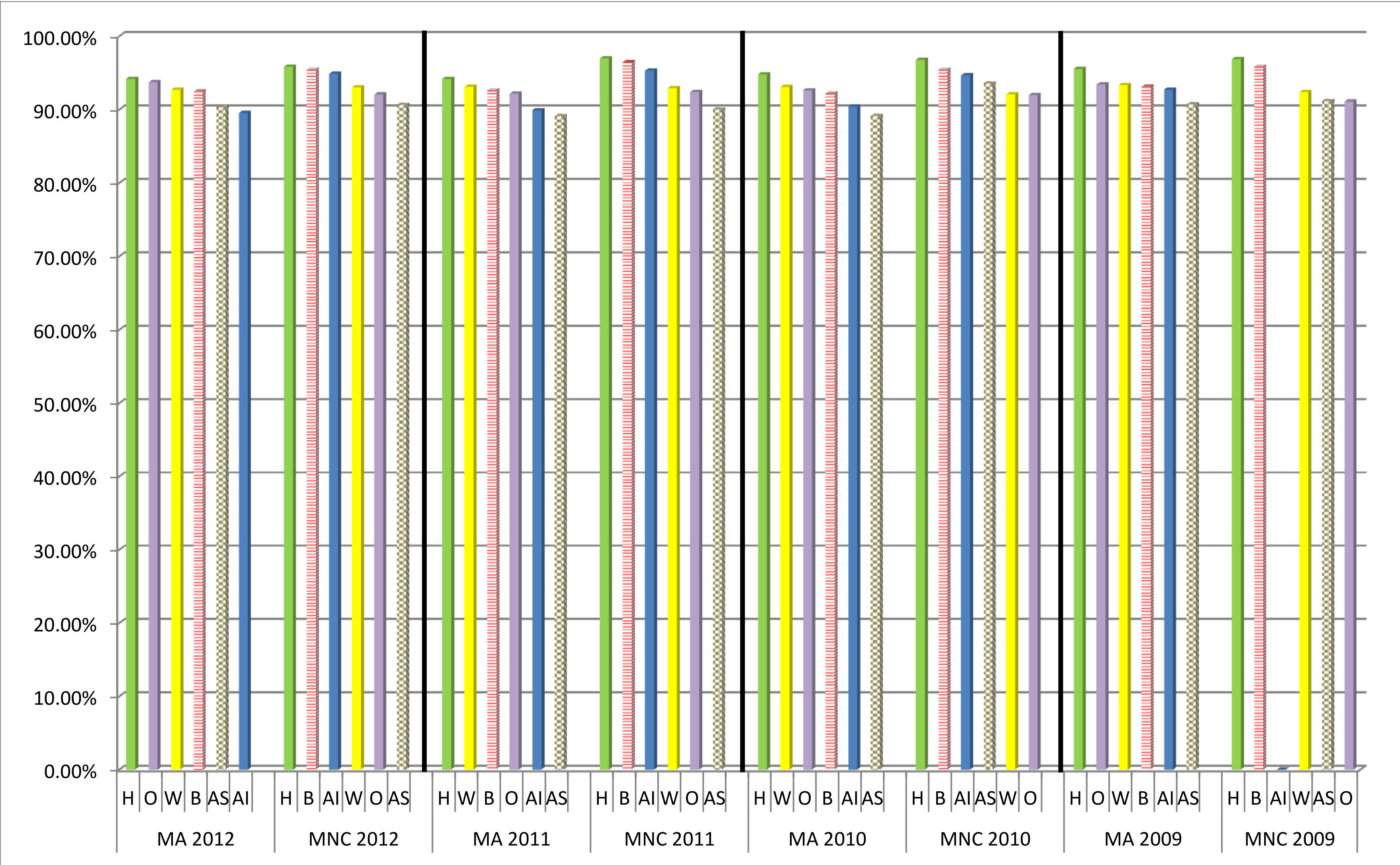
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	14,968	16,147	92.70%	16,275	17,485	93.08%	16,250	17,460	93.07%	14,433	15,460	93.36%
Black	9,959	10,774	92.44%	10,812	11,674	92.62%	10,137	10,998	92.17%	8,966	9,634	93.07%
Asian	2,772	3,069	90.32%	2,925	3,283	89.10%	2,527	2,836	89.10%	2,288	2,523	90.69%
Amer Indian	1,350	1,508	89.52%	1,409	1,567	89.92%	1,497	1,656	90.40%	1,287	1,388	92.72%
Other	997	1,064	93.70%	939	1,019	92.15%	866	935	92.62%	763	817	93.39%
Hispanic	6,108	6,485	94.19%	6,552	6,959	94.15%	6,745	7,116	94.79%	5,801	6,071	95.55%
Total	**36,154**	**39,047**	**92.59%**	**38,912**	**41,987**	**92.68%**	**38,022**	**41,001**	**92.73%**	**33,538**	**35,893**	**93.44%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	4,853	5,219	92.99%	4,943	5,320	92.91%	4,417	4,799	92.04%	3,949	4,275	92.37%
Black	686	719	95.41%	726	753	96.41%	627	657	95.43%	601	627	95.85%
Asian	436	481	90.64%	476	529	89.98%	391	418	93.54%	329	361	91.14%
Amer Indian	74	78	94.87%	81	85	95.29%	53	56	94.64%	44	47	93.62%
Other	1,005	1,092	92.03%	1,055	1,142	92.38%	960	1,044	91.95%	838	920	91.09%
Hispanic	575	600	95.83%	576	594	96.97%	452	467	96.79%	401	414	96.86%
Total	**7,629**	**8,189**	**93.16%**	**7,857**	**8,423**	**93.28%**	**6,900**	**7,441**	**92.73%**	**6,162**	**6,644**	**92.75%**

Graph 9: Children and Adolescents' Access to Primary Care Practitioners: 25 Months-6 Years



MNC 2009 AI < 50 enrollees

Table #10 Children and Adolescents' Access to Primary Care Practitioners 7-11 Years

Measure Description: The percentage of managed care children 7 to 11 years old who had a visit with a primary care provider during measurement year.

F+C MA

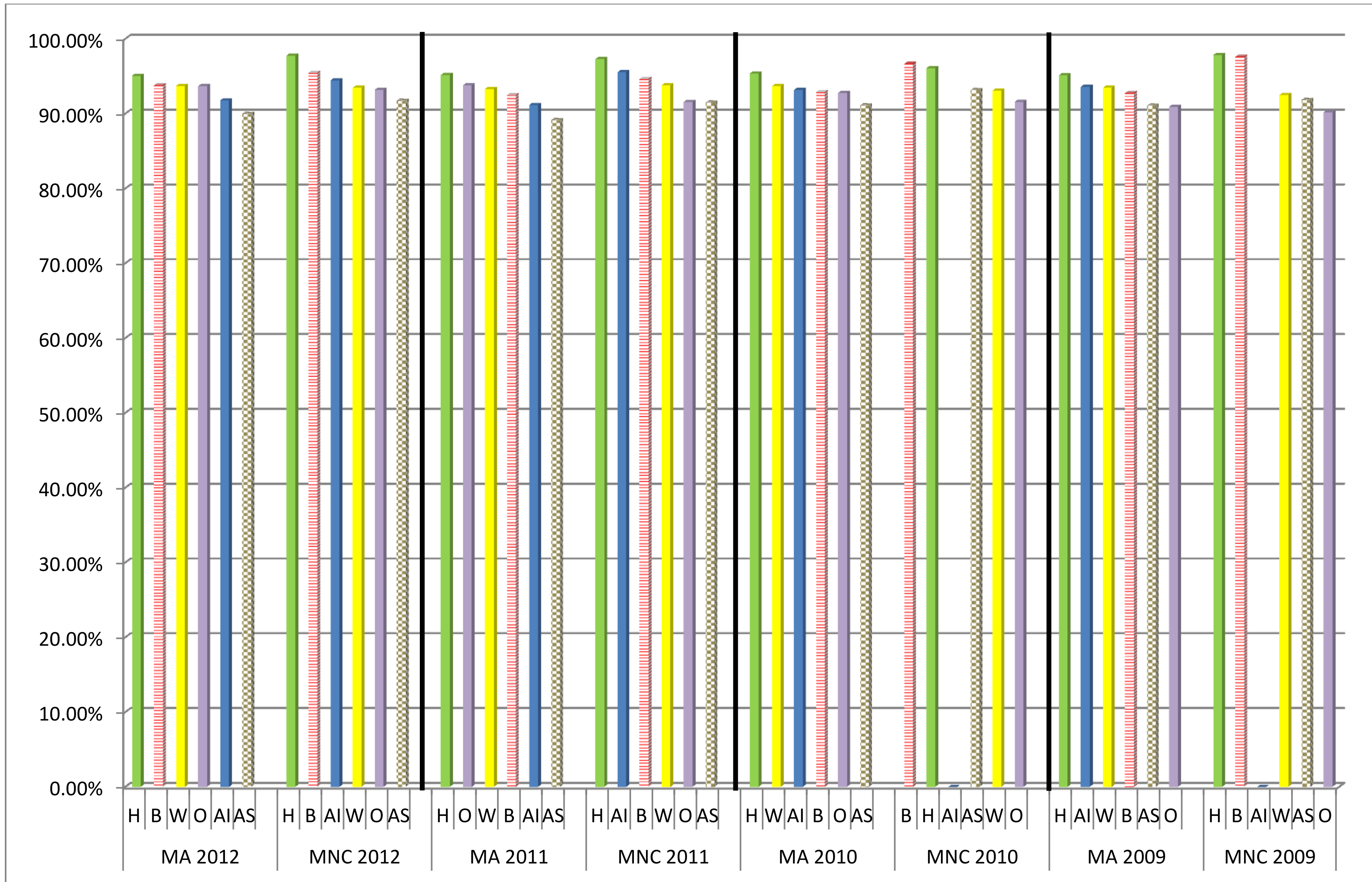
	2012			2011			2010			2009		
	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate
White	8,122	8,668	93.70%	9,368	10,041	93.30%	9,004	9,614	93.66%	7,817	8,365	93.45%
Black	4,820	5,140	93.77%	6,037	6,528	92.48%	5,209	5,609	92.87%	4,456	4,805	92.74%
Asian	1,758	1,954	89.97%	1,953	2,191	89.14%	1,861	2,043	91.09%	1,792	1,968	91.06%
Amer Indian	702	765	91.76%	710	779	91.14%	735	789	93.16%	598	639	93.58%
Other	326	348	93.68%	347	370	93.78%	295	318	92.77%	220	242	90.91%
Hispanic	2,691	2,831	95.05%	3,545	3,725	95.17%	2,986	3,131	95.37%	2,333	2,453	95.11%
Total	**18,419**	**19,706**	**93.47%**	**21,960**	**23,634**	**92.92%**	**20,090**	**21,504**	**93.42%**	**17,216**	**18,472**	**93.20%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate
White	3,876	4,148	93.44%	4,392	4,683	93.79%	3,990	4,287	93.07%	3,828	4,139	92.49%
Black	420	440	95.45%	492	520	94.62%	462	478	96.65%	405	415	97.59%
Asian	310	338	91.72%	375	410	91.46%	352	378	93.12%	337	367	91.83%
Amer Indian	68	72	94.44%	64	67	95.52%	44	47	93.62%	35	37	94.59%
Other	601	645	93.18%	618	675	91.56%	510	557	91.56%	468	519	90.17%
Hispanic	391	400	97.75%	394	405	97.28%	342	356	96.07%	315	322	97.83%
Total	**5,666**	**6,043**	**93.76%**	**6,335**	**6,760**	**93.71%**	**5,700**	**6,103**	**93.40%**	**5,388**	**5,799**	**92.91%**

Graph 10: Children and Adolescents' Access to Primary Care Practitioners: 7-11 Years



MNC 2010, 2009 AI < 50 enrollees

Table #11 Children and Adolescents' Access to Primary Care Practitioners 12-19 Years

Measure Description: The percentage of managed care children 12-19 years old who had a visit with a primary care provider during measurement year.

F+C MA

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	10,104	10,693	94.49%	11,609	12,293	94.44%	11,168	11,819	94.49%	10,056	10,642	94.49%
Black	5,672	6,048	93.78%	7,161	7,700	93.00%	6,566	7,036	93.32%	5,882	6,277	93.71%
Asian	3,276	3,676	89.12%	3,619	4,094	88.40%	3,590	4,072	88.16%	3,588	4,060	88.37%
Amer Indian	776	819	94.75%	872	934	93.36%	876	922	95.01%	659	706	93.34%
Other	242	263	92.02%	255	278	91.73%	224	235	95.32%	205	222	92.34%
Hispanic	1,968	2,106	93.45%	2,463	2,593	94.99%	2,047	2,129	96.15%	1,687	1,778	94.88%
Total	**22,038**	**23,605**	**93.36%**	**25,979**	**27,892**	**93.14%**	**24,471**	**26,213**	**93.35%**	**22,077**	**23,685**	**93.21%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	7,354	7,753	94.85%	8,091	8,567	94.44%	7,543	7,987	94.44%	7,465	7,908	94.40%
Black	575	599	95.99%	684	720	95.00%	607	644	94.25%	523	547	95.61%
Asian	569	663	85.82%	633	708	89.41%	525	573	91.62%	501	554	90.43%
Amer Indian	98	103	95.15%	89	100	89.00%	77	82	93.90%	78	83	93.98%
Other	448	479	93.53%	475	506	93.87%	407	438	92.92%	338	356	94.94%
Hispanic	396	421	94.06%	398	413	96.37%	321	331	96.98%	290	302	96.03%
Total	**9,440**	**10,018**	**94.23%**	**10,370**	**11,014**	**94.15%**	**9,480**	**10,055**	**94.28%**	**9,195**	**9,750**	**94.31%**

Graph 11: Children and Adolescents' Access to Primary Care Practitioners: 12-19 Years

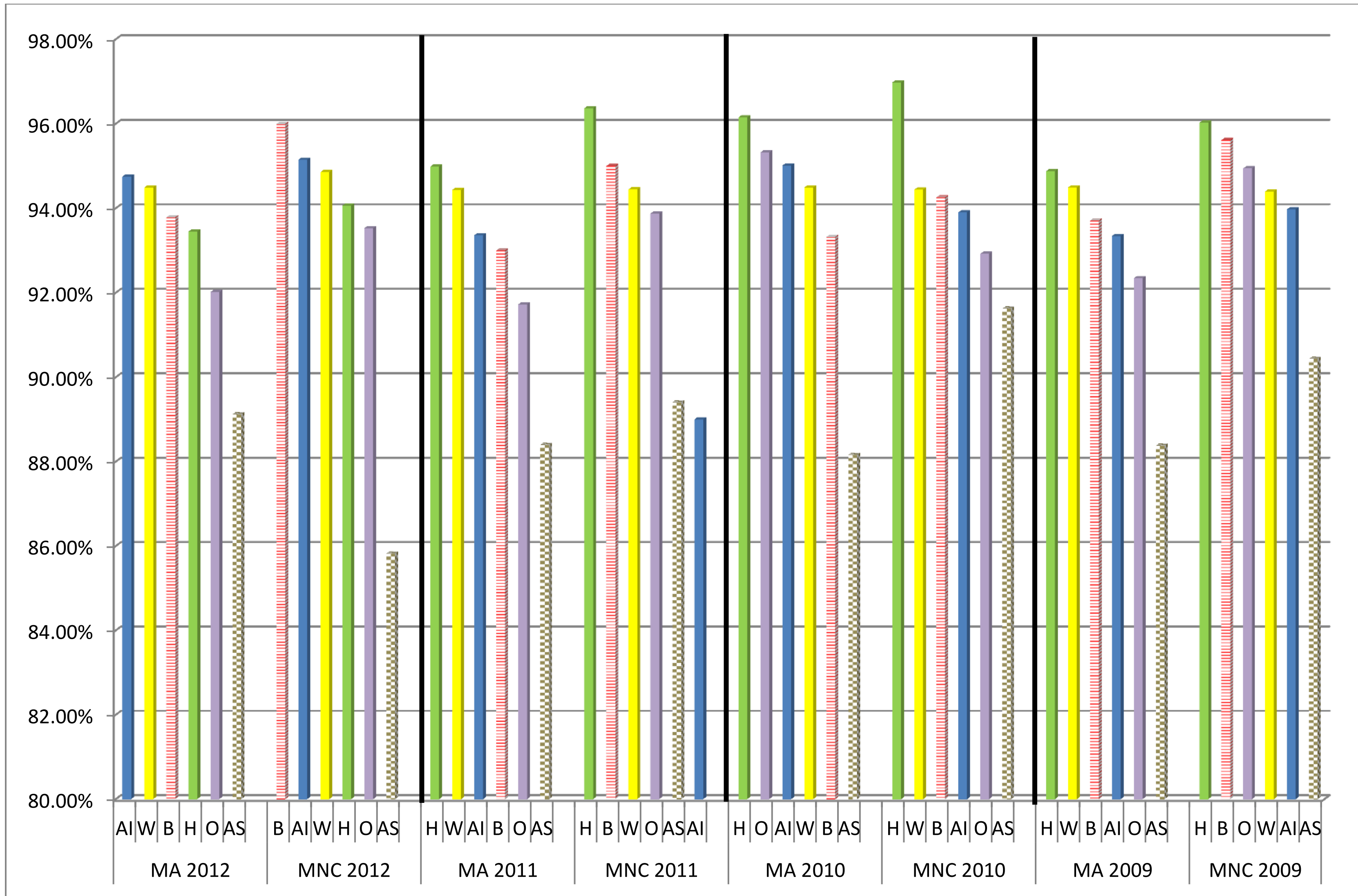


Table #12 Cervical Cancer Screening 24-64 Years

Measure Description: The percentage of managed care women 21-64 years old who were screened for cervical cancer as of December 31 of the measurement year.

F+C MA

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	17,839	24,961	71.47%	17,924	24,501	73.16%	14,725	19,033	77.37%	13,792	18,037	76.47%
Black	6,854	9,142	74.97%	7,059	8,927	79.07%	6,089	7,472	81.49%	5,611	7,164	78.32%
Asian	1,877	2,769	67.79%	1,769	2,595	68.17%	1,314	1,870	70.27%	1,184	1,755	67.46%
Amer Indian	1,056	1,621	65.14%	921	1,316	69.98%	833	1,100	75.73%	902	1,244	72.51%
Other	175	266	65.79%	176	253	69.57%	88	107	82.24%	81	94	86.17%
Hispanic	1,163	1,507	77.17%	1,240	1,547	80.16%	1,120	1,361	82.29%	1,030	1,292	79.72%
Total	**28,964**	**40,266**	**71.93%**	**29,089**	**39,139**	**74.32%**	**24,169**	**30,943**	**78.11%**	**22,600**	**29,586**	**76.39%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	14,091	21,171	66.56%	15,695	23,337	67.25%	16,851	24,955	67.53%	13,936	19,916	69.97%
Black	1,307	1,797	72.73%	1,317	1,811	72.72%	1,368	2,011	68.03%	1,034	1,451	71.26%
Asian	1,191	1,607	74.11%	1,165	1,575	73.97%	1,123	1,565	71.76%	882	1,207	73.07%
Amer Indian	204	336	60.71%	210	355	59.15%	236	373	63.27%	160	257	62.26%
Other	499	759	65.74%	573	841	68.13%	590	856	68.93%	509	738	68.97%
Hispanic	430	597	72.03%	436	609	71.59%	432	630	68.57%	345	468	73.72%
Total	**17,722**	**26,267**	**67.47%**	**19,396**	**28,528**	**67.99%**	**20,600**	**30,390**	**67.79%**	**16,866**	**24,037**	**70.17%**

Graph 12: Cervical Cancer Screening: 21-64 Year

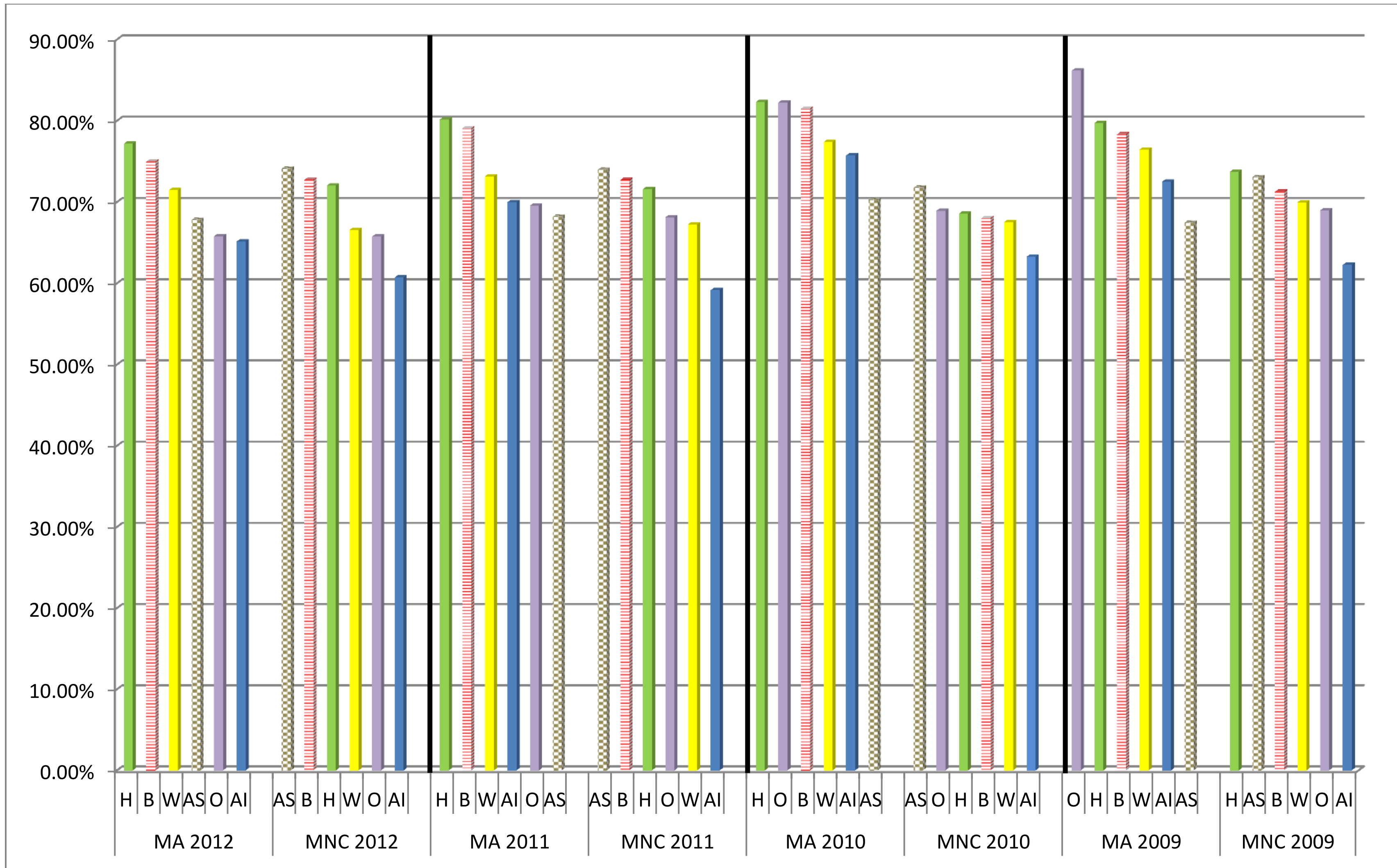


Table #13: Comprehensive Diabetes Care-Screening A1c Testing 18-64 Years

Measure Description: The percentage of managed care enrollees, 18-64 years old with diabetes who had a Hemoglobin A1c (A1c) test during measurement year.

F+C MA

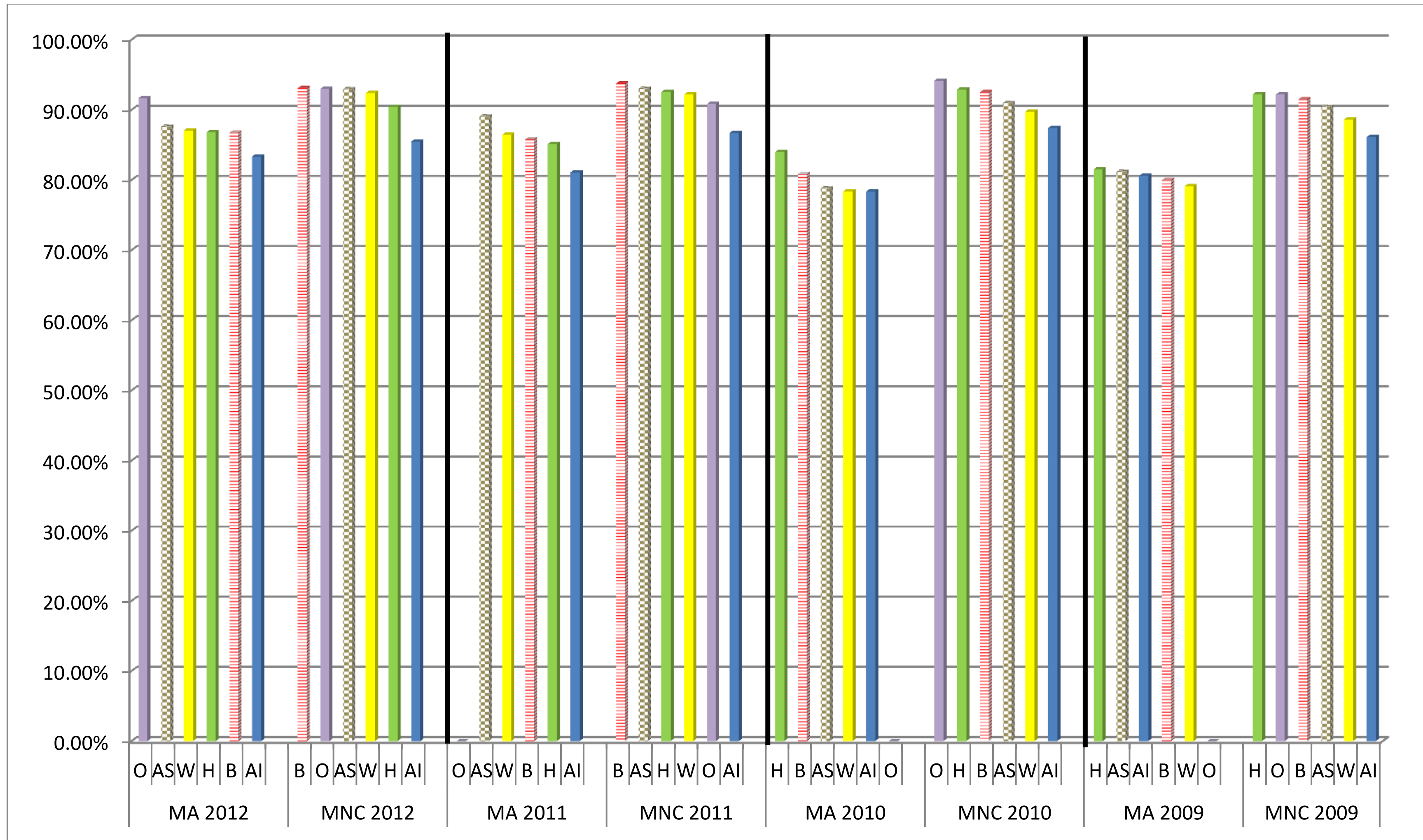
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,934	3,370	87.06%	2,429	2,810	86.44%	1,048	1,337	78.38%	1,404	1,775	79.10%
Black	1,354	1,561	86.74%	1,074	1,252	85.78%	688	851	80.85%	915	1,144	79.98%
Asian	388	443	87.58%	333	374	89.04%	182	231	78.79%	198	244	81.15%
Amer Indian	385	462	83.33%	266	328	81.10%	170	217	78.34%	245	304	80.59%
Other	55	60	91.67%	34	35	97.14%	2	4	50.00%	2	5	40.00%
Hispanic	329	379	86.81%	286	336	85.12%	194	231	83.98%	207	254	81.50%
Total	**5,445**	**6,275**	**86.77%**	**4,422**	**5,135**	**86.11%**	**2,284**	**2,871**	**79.55%**	**2,971**	**3,726**	**79.74%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,998	3,245	92.39%	3,222	3,495	92.19%	3,801	4,235	89.75%	2,833	3,197	88.61%
Black	403	433	93.07%	420	448	93.75%	518	560	92.50%	365	399	91.48%
Asian	250	269	92.94%	240	258	93.02%	251	276	90.94%	180	199	90.45%
Amer Indian	106	124	85.48%	111	128	86.72%	125	143	87.41%	93	108	86.11%
Other	106	114	92.98%	109	120	90.83%	129	137	94.16%	106	115	92.17%
Hispanic	189	209	90.43%	174	188	92.55%	236	254	92.91%	166	180	92.22%
Total	**4,052**	**4,394**	**92.22%**	**4,276**	**4,637**	**92.21%**	**5,060**	**5,605**	**90.28%**	**3,743**	**4,198**	**89.16%**

Graph 13: Comprehensive Diabetes Care: Hemoglobin A1c Testing 18-64 Years



MA 2011, 2010, 2009 O < 50 enrollees

Table #14: Comprehensive Diabetes Care-Screening LDL Screening 18-64 Years

Measure Description: The percentage of managed care enrollees, 18-64 years old with diabetes who had a LDL-C screening test during measurement year.

F+C MA

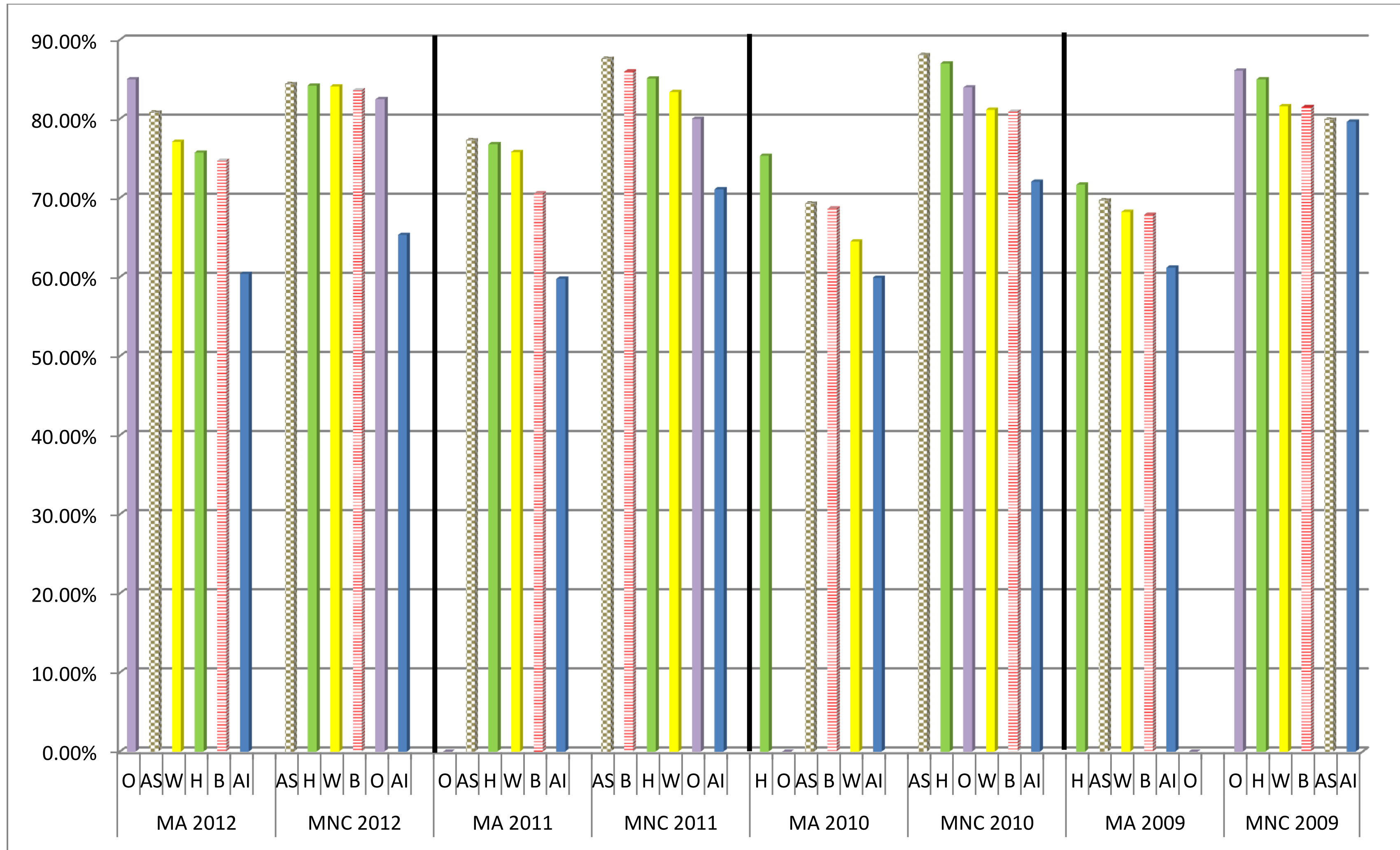
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,598	3,370	77.09%	2,130	2,810	75.80%	862	1,337	64.47%	1,211	1,775	68.23%
Black	1,166	1,561	74.70%	883	1,252	70.53%	584	851	68.63%	776	1,144	67.83%
Asian	358	443	80.81%	289	374	77.27%	160	231	69.26%	170	244	69.67%
Amer Indian	279	462	60.39%	196	328	59.76%	130	217	59.91%	186	304	61.18%
Other	51	60	85.00%	28	35	80.00%	3	4	75.00%	3	5	60.00%
Hispanic	287	379	75.73%	258	336	76.79%	174	231	75.32%	182	254	71.65%
Total	**4,739**	**6,275**	**75.52%**	**3,784**	**5,135**	**73.69%**	**1,913**	**2,871**	**66.63%**	**2,528**	**3,726**	**67.85%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,729	3,245	84.10%	2,913	3,495	83.35%	3,436	4,235	81.13%	2,609	3,197	81.61%
Black	362	433	83.60%	385	448	85.94%	453	560	80.89%	325	399	81.45%
Asian	227	269	84.39%	226	258	87.60%	243	276	88.04%	159	199	79.90%
Amer Indian	81	124	65.32%	91	128	71.09%	103	143	72.03%	86	108	79.63%
Other	94	114	82.46%	96	120	80.00%	115	137	83.94%	99	115	86.09%
Hispanic	176	209	84.21%	160	188	85.11%	221	254	87.01%	153	180	85.00%
Total	**3,669**	**4,394**	**83.50%**	**3,871**	**4,637**	**83.48%**	**4,571**	**5,605**	**81.55%**	**3,431**	**4,198**	**81.73%**

Graph 14: Comprehensive Diabetes Care: LDL-C Screening 18-64 Years



MA 2011, 2010, 2009 O < 50 enrollees

Table #15: Chlamydia Screening in Women 16-24 Years

Measure Description: The percentage of managed care women, 16-24 years old, who were identified as sexually active and who had at least one test for chlamydia during the measurement year

F+C MA

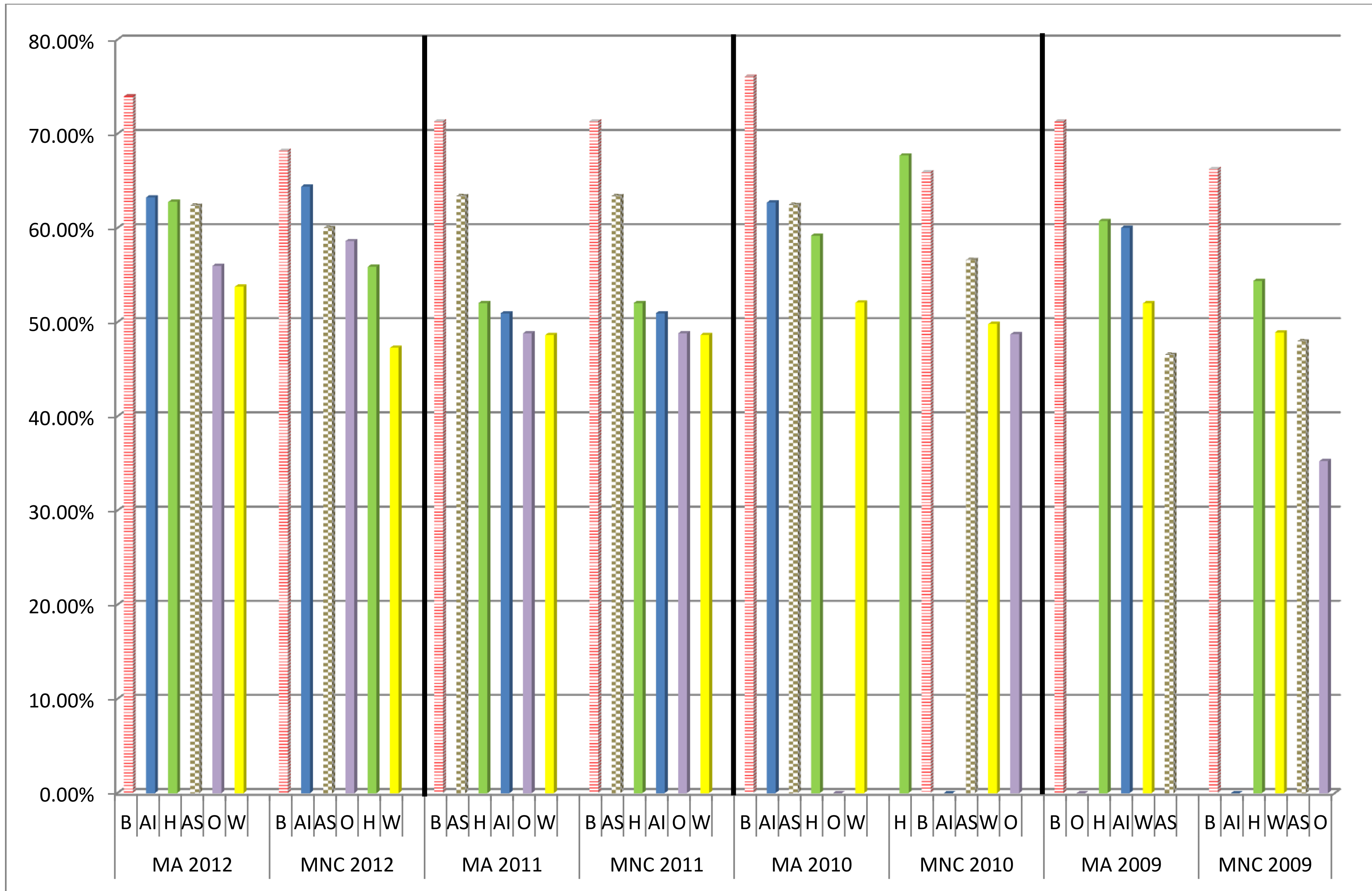
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,956	5,498	53.77%	3,343	6,282	53.22%	3,143	6,036	52.07%	3,019	5,806	52.00%
Black	2,127	2,875	73.98%	2,333	3,116	74.87%	2,284	3,003	76.06%	1,993	2,795	71.31%
Asian	526	843	62.40%	568	943	60.23%	521	834	62.47%	363	780	46.54%
Amer Indian	334	528	63.26%	309	518	59.65%	321	512	62.70%	291	485	60.00%
Other	28	50	56.00%	19	51	37.25%	26	47	55.32%	20	31	64.52%
Hispanic	435	693	62.77%	463	740	62.57%	406	686	59.18%	396	652	60.74%
Total	**6,406**	**10,487**	**61.09%**	**7,035**	**11,650**	**60.39%**	**6,701**	**11,118**	**60.27%**	**6,082**	**10,549**	**57.65%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	1,499	3,171	47.27%	1,799	3,700	48.62%	2,052	4,120	49.81%	1,661	3,395	48.92%
Black	191	280	68.21%	199	279	71.33%	209	317	65.93%	169	255	66.27%
Asian	108	180	60.00%	142	224	63.39%	137	242	56.61%	94	196	47.96%
Amer Indian	38	59	64.41%	27	53	50.94%	23	36	63.89%	20	33	60.61%
Other	51	87	58.62%	41	84	48.81%	57	117	48.72%	37	105	35.24%
Hispanic	76	136	55.88%	64	123	52.03%	86	127	67.72%	56	103	54.37%
Total	**1,963**	**3,913**	**50.17%**	**2,272**	**4,463**	**50.91%**	**2,564**	**4,959**	**51.70%**	**2,037**	**4,087**	**49.84%**

Graph 15: Chlamydia Screening in Women 16-24 Years



MA 2010 & 2009 O; MNC AI < 50 enrollees

Table # 16: Childhood Immunizations Combo 2

Measure Description: The percentage of managed care children, two years of age during the measurement year, who had four DTaP, three IPV, one MMR, three Hib, three HepB and one VZV vaccinations by their second birthday.

F+C MA

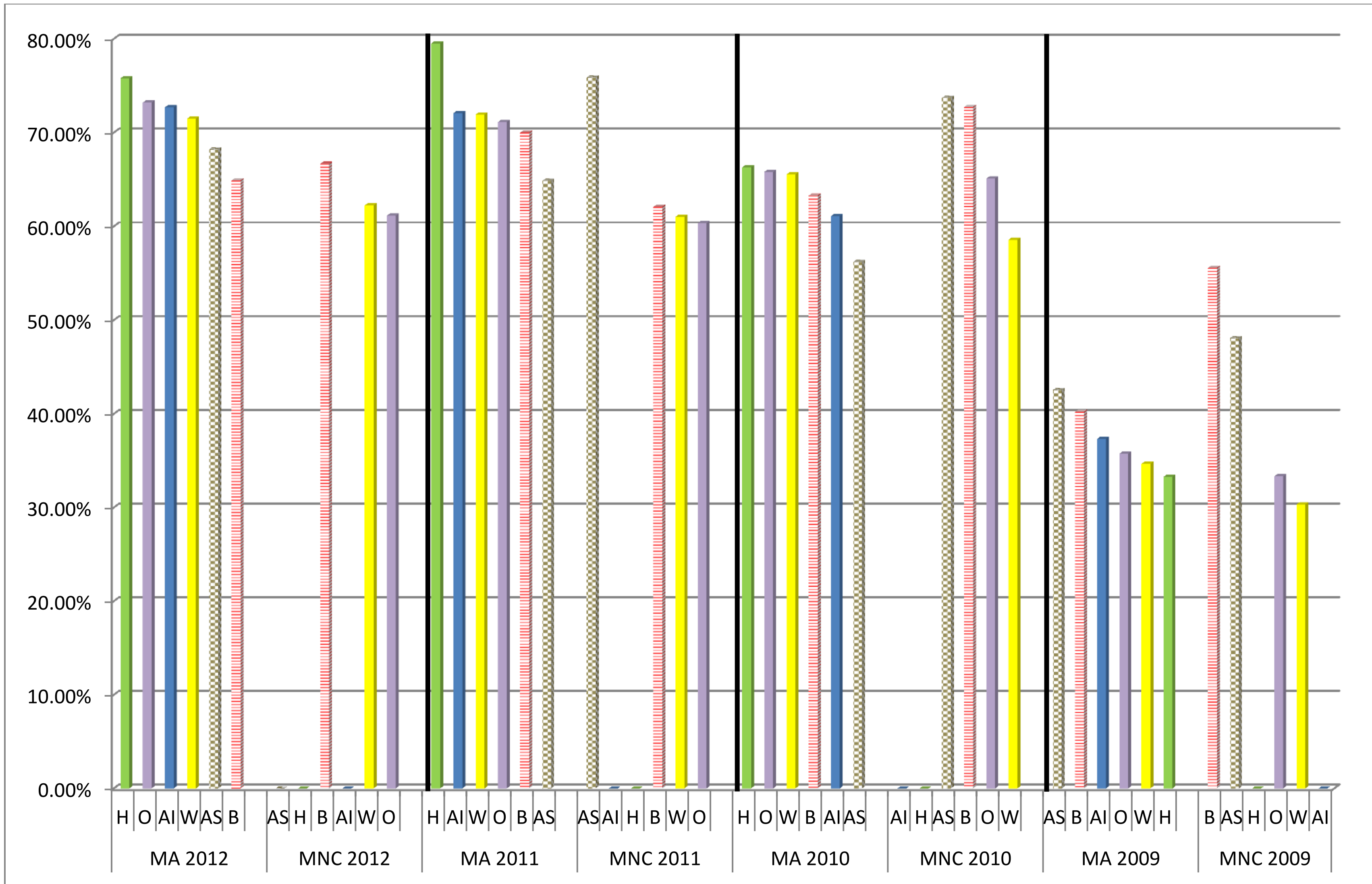
	2012			2011			2010			2009		
	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate
White	2,519	3,524	71.48%	3,157	4,389	71.93%	2,847	4,344	65.54%	1,380	3,981	34.66%
Black	1,212	1,868	64.88%	1,691	2,416	69.99%	1,504	2,377	63.27%	856	2,129	40.21%
Asian	412	604	68.21%	476	734	64.85%	377	671	56.18%	248	583	42.54%
Amer Indian	189	260	72.69%	253	351	72.08%	237	388	61.08%	109	292	37.33%
Other	213	291	73.20%	197	277	71.12%	204	310	65.81%	104	291	35.74%
Hispanic	792	1,045	75.79%	1,238	1,557	79.51%	1,034	1,560	66.28%	441	1,325	33.28%
Total	**5,337**	**7,592**	**70.30%**	**7,012**	**9,724**	**72.11%**	**6,203**	**9,650**	**64.28%**	**3,138**	**8,601**	**36.48%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate	Num	Demom	Rate
White	346	556	62.23%	371	608	61.02%	318	543	58.56%	192	633	30.33%
Black	48	72	66.67%	54	87	62.07%	56	77	72.73%	55	99	55.56%
Asian	38	47	80.85%	44	58	75.86%	42	57	73.68%	25	52	48.08%
Amer Indian	4	6	66.67%	3	4	75.00%	2	2	100.00%	1	4	25.00%
Other	129	211	61.14%	143	237	60.34%	138	212	65.09%	70	210	33.33%
Hispanic	22	29	75.86%	36	49	73.47%	27	34	79.41%	18	40	45.00%
Total	**587**	**921**	**63.74%**	**651**	**1,043**	**62.42%**	**583**	**925**	**63.03%**	**361**	**1,038**	**34.78%**

Graph 16: Childhood Immunization Status: Combo 2



MNC 2012 AS, H, AI; 2011 - 2009: AI, H; < 50 enrollees

Table #17 Well-Child Visits in the First 15 Months of Life 6+ Visits

Measure Description: The percentage of managed care children, who turned 15 months old during the measurement year and had six or more well-child visits with a primary care provider during their first 15 months

F+C MA

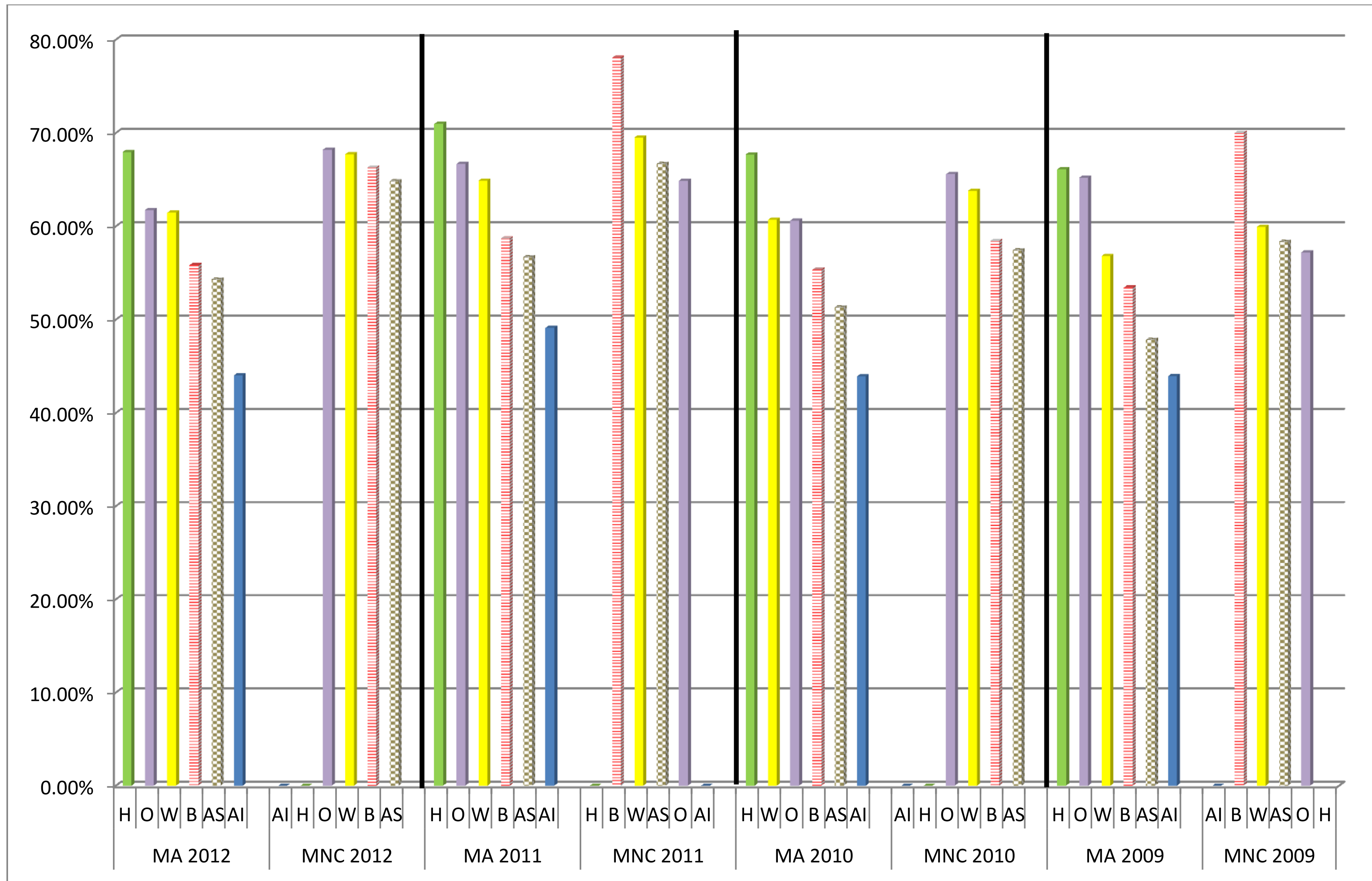
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,667	4,341	61.44%	3,450	5,317	64.89%	3,113	5,130	60.68%	2,691	4,738	56.80%
Black	1,348	2,415	55.82%	1,780	3,033	58.69%	1,670	3,018	55.33%	1,462	2,737	53.42%
Asian	499	919	54.30%	517	912	56.69%	454	885	51.30%	373	780	47.82%
Amer Indian	125	284	44.01%	192	391	49.10%	169	385	43.90%	163	371	43.94%
Other	350	567	61.73%	308	462	66.67%	223	368	60.60%	268	411	65.21%
Hispanic	882	1,298	67.95%	1,385	1,952	70.95%	1,437	2,123	67.69%	1,323	2,002	66.08%
Total	**5,871**	**9,824**	**59.76%**	**7,632**	**12,067**	**63.25%**	**7,066**	**11,909**	**59.33%**	**6,280**	**11,039**	**56.89%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	369	545	67.71%	392	564	69.50%	335	525	63.81%	347	579	59.93%
Black	59	89	66.29%	64	82	78.05%	52	89	58.43%	70	100	70.00%
Asian	35	54	64.81%	46	69	66.67%	31	54	57.41%	35	60	58.33%
Amer Indian	4	5	80.00%	3	5	60.00%	4	4	100.00%	2	2	100.00%
Other	178	261	68.20%	181	279	64.87%	179	273	65.57%	143	250	57.20%
Hispanic	26	34	76.47%	32	38	84.21%	31	39	79.49%	21	39	53.85%
Total	**671**	**988**	**67.91%**	**718**	**1,037**	**69.24%**	**632**	**984**	**64.23%**	**618**	**1,030**	**60.00%**

Graph 17: Well-Child Visits in the First 15 Months of Life 6+ Visits



MNC: 2012, 2009 AI, H < 50 enrollees

Table # 18 Well−Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Measure Description: The percentage of managed care children, 3-6 years of age who had one or more will-child visits with a primary care provider during the measurement year

F+C MA

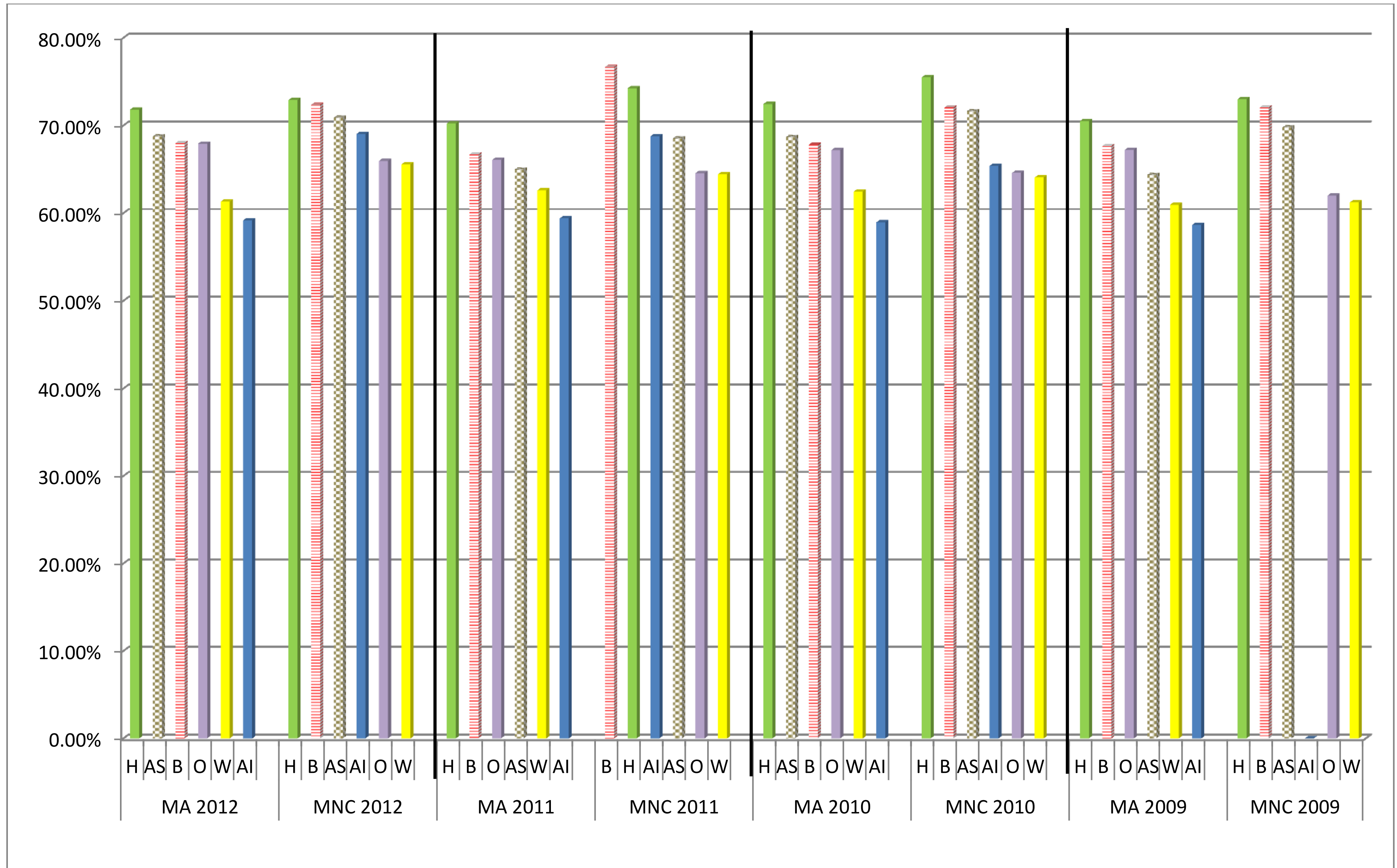
	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	8,034	13,105	61.30%	8,733	13,952	62.59%	8,645	13,840	62.46%	7,305	11,987	60.94%
Black	6,035	8,877	67.98%	6,356	9,531	66.69%	5,996	8,846	67.78%	5,190	7,671	67.66%
Asian	1,741	2,532	68.76%	1,714	2,638	64.97%	1,546	2,251	68.68%	1,281	1,990	64.37%
Amer Indian	744	1,257	59.19%	761	1,281	59.41%	767	1,301	58.95%	646	1,101	58.67%
Other	540	795	67.92%	541	819	66.06%	487	725	67.17%	402	598	67.22%
Hispanic	3,862	5,377	71.82%	3,946	5,619	70.23%	4,167	5,752	72.44%	3,391	4,810	70.50%
Total	**20,956**	**31,943**	**65.60%**	**22,051**	**33,840**	**65.16%**	**21,608**	**32,715**	**66.05%**	**18,215**	**28,157**	**64.69%**

Race "Other" includes missing and multiple races.

MinnesotaCare

	2012			2011			2010			2009		
	Num	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**	**Num**	**Demom**	**Rate**
White	2,971	4,531	65.57%	2,967	4,604	64.44%	2,639	4,119	64.07%	2,203	3,598	61.23%
Black	450	622	72.35%	506	660	76.67%	407	565	72.04%	387	537	72.07%
Asian	297	419	70.88%	318	464	68.53%	255	356	71.63%	217	311	69.77%
Amer Indian	49	71	69.01%	55	80	68.75%	34	52	65.38%	30	45	66.67%
Other	587	890	65.96%	605	937	64.57%	540	836	64.59%	455	734	61.99%
Hispanic	409	561	72.91%	395	532	74.25%	311	412	75.49%	262	359	72.98%
Total	**4,763**	**7,094**	**67.14%**	**4,846**	**7,277**	**66.59%**	**4,186**	**6,340**	**66.03%**	**3,554**	**5,584**	**63.65%**

Graph 18: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



MNC: 2009 AI < 50 enrollees

Appendix B: Measure Analysis

Measure 1: **Adult' Access to Preventive/Ambulatory Health Services: 20-44 years**

HEDIS 2013 Technical Specifications: the percentage of managed care enrollees 20-44 years old who had one or more ambulatory or preventive care visit during the measurement year (see Table 1 in the Appendix for more detailed results).

Table 1a

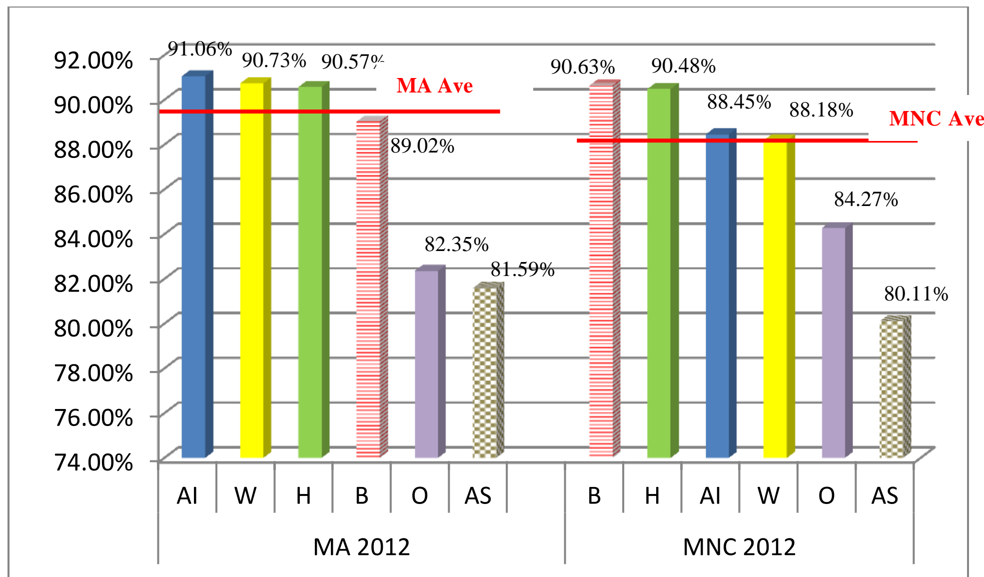
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	89.56%	89.90%	91.43%	91.78%
MinnesotaCare (MNC)	87.76%	88.10%	87.07%	87.35%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 1 in the Appendix A for more detailed results):

1. MinnesotaCare rates were approximately 2 to 3 percentage points lower than the rates for F&C MA over the 4 year period. Both MinnesotaCare and F&C MA rates were above the national Medicaid HMO HEDIS (Quality Compass) benchmark rate of 80.37%, and in the 75th (85.27) and 90th (88.32) percentiles.
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity demonstrate no consistent race/ethnicity disparities patterns over the 4 year period, with the exception of the Other (O) and Asian (AS) subgroup rates are the lowest two subgroup rates over the measurement period. The range between the highest to lowest racial/ethnic performance subgroups was approximately10 percentage points over the 4 calendar years. The Other and Asian subgroup lower performance would need to be explored with more focused qualitative methods to determine if there are racial/ethnic disparities.

Figure 1a



Measure 2:

Adult' Access to Preventive/Ambulatory Health Services: 45-64 years

HEDIS 2013 Technical Specifications: the percentage of managed care enrollees 45-64 years old who had one or more ambulatory or preventive care visit during the measurement year (see Table 2 in the Appendix A for more detailed results).

Table 2a

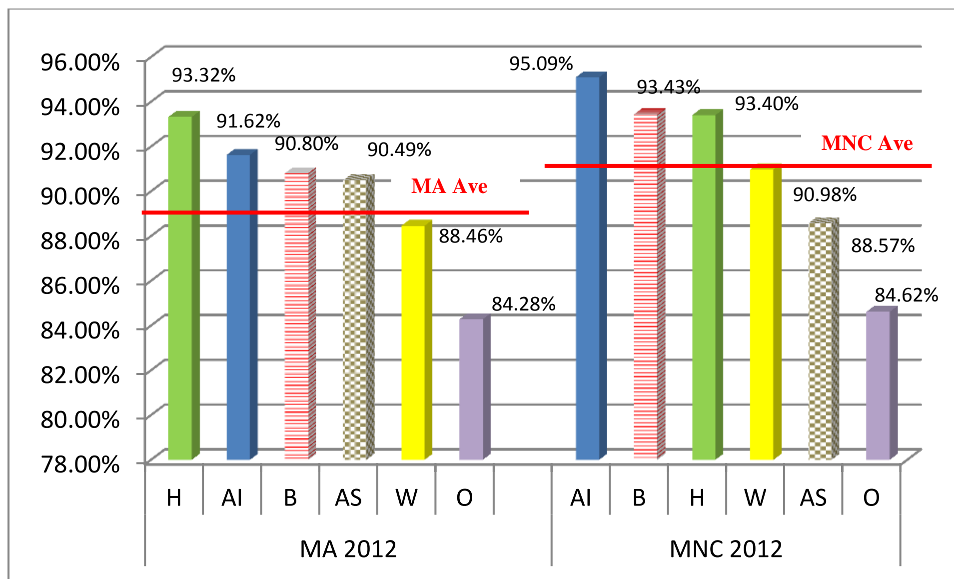
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	89.25%	90.34%	91.40%	91.47%
MinnesotaCare (MNC)	90.89%	91.11%	90.16%	90.40%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 2 in the Appendix A for more detailed results):

1. MinnesotaCare rates were approximately the same as F&C MA rates over the measurement period and were substantially above the national Medicaid HMO HEDIS (Quality Compass) benchmark rate of 86.54%, and in the 75th (90.3) and 90th (91.14) percentiles.
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity indicated no pattern of disparities over the measurement period. However in contrast to the younger adults, when stratified by race/ethnicity, Minnesota Care older adult rates were consistently slightly higher than F&C MA rates for the 4 year period. The range of difference over the 4 years, between the high and low subgroups, has more variation (range from 5 to 14 percentage points) then in the younger adults but is not consistent between racial/ethnic subgroups.

Figure 2a



Measure 3

Antidepressant Medication Management: Effective Acute Phase Treatment

HEDIS 2013 Technical Specifications: the percentage of managed care enrollees 18-64 years old newly diagnosed (major depression) and treated with antidepressant medication, who remained on an antidepressant medication for at least 12 weeks. The intake period was a 12 month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year (see Table 3 in the Appendix A for more detailed results).

Table 3a

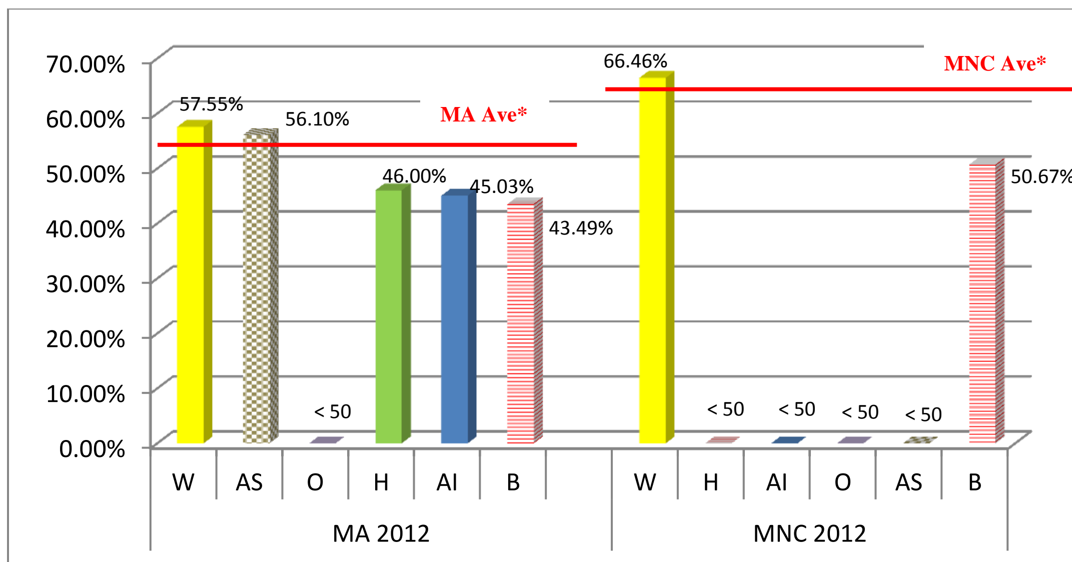
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	53.44%	48.77%	48.86%	49.70%
MinnesotaCare (MNC)	64.99%	63.10%	57.13%	61.24%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 3 in the Appendix for more detailed results):

1. MinnesotaCare rates were approximately 10 percentage points higher than F&C MA rates (higher difference in CYs 2010 & 2009) over the measurement period, and MinnesotaCare rates were substantially above the national Medicaid HMO HEDIS (Quality Compass) benchmark rate of 52.79%, and within the 75th (56.05) and 90th (61.03) percentiles.
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity indicated no consistent pattern of disparities over the measurement period, but the Black subgroup had the lowest rates throughout the measurement period except in CY 2010. Over the 4 year period, MinnesotaCare race/ethnic subgroups had higher rates than their F&C MA comparisons.

Figure 3a



* MA Ave: Other > 50 enrollees; MNC Ave.: Asian, Am Indian, Other & Hispanic > 50 enrollees

Measure 4

Antidepressant Medication Management: Effective Continuation Phase Treatment

HEDIS 2013 Technical Specifications: the percentage of managed care enrollees 18-64 years old newly diagnosed (major depression) and treated with antidepressant medication, who remained on an antidepressant medication for at least 6 months. The intake period was a 12 month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year (see Table 4 in the Appendix A for more detailed results).

Table 4a

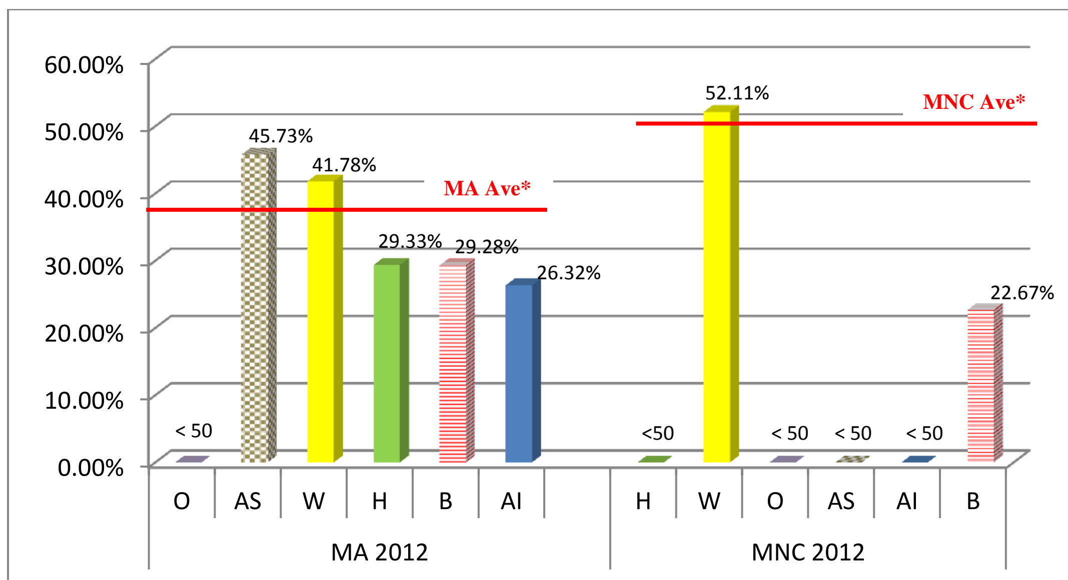
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	38.12%	31.55%	32.38%	35.26%
MinnesotaCare (MNC)	49.93%	48.67%	43.43%	45.88%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 4 in the Appendix A for more detailed results):

1. MinnesotaCare rates were higher (10 to 15 percentage points) than F&C MA rates over the measurement period, and were substantially above the national Medicaid HMO HEDIS (Quality Compass) benchmark rate of 36.65%, and within the 75th (40.06) and 90th (45.86) percentiles.
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity show no pattern of disparities over the 4 year period. However in contrast to the younger adults, when stratified by race/ethnicity, Minnesota Care older adult rates were frequently higher than F&C MA rates for the 4 year period.

Figure 4a



* MA Ave: Other > 50 enrollees; MNC Ave.: Asian, Am Indian, Other & Hispanic > 50 enrollees

Measure 5

Use of Appropriate Medications for People with Asthma: Total 5-64 years

HEDIS 2013 Technical Specifications: the percentage of managed care enrollee's 5-64 (5-11, 12-18, 19-50, 51-64 yrs. age groups were not analyzed because of the small number of eligibles) years old during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications. (see Table 5 in the Appendix A for more detailed results).

Table 5a

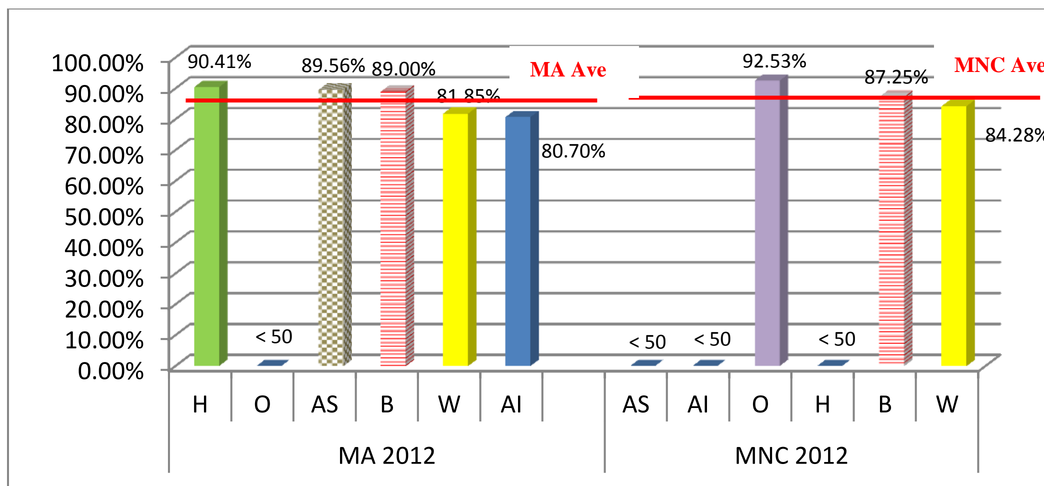
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	85.04%	85.33%	86.64%	86.04%
MinnesotaCare (MNC)	85.43%	85.63%	85.30%	87.01%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 5 in the Appendix for more detailed results):

1. MinnesotaCare rates were approximately the same as F&C MA rates over the measurement period, and both were below the national Medicaid HMO HEDIS (Quality Compass) benchmark rate of 89.59%, and near the 50th (85.88) percentiles.
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity show no pattern of disparities over the 4 year period. However, rates for some of the minority subgroups are within the 75th (88.99) and 90th (92.16) national percentiles. It is the White subgroup performance that bias the overall program averages due to the small proportion of minority enrollees.

Figure 5a



Measure 6:

Adolescent Well-Child: 12-21 years

HEDIS 2013 Technical Specifications: the percentage of managed care enrollees 12-21 years old who had at least one comprehensive well-care visit with a primary care or OB/GYN provider during the measurement year. (see Table 6 in the Appendix for more detailed results).

Table 6a

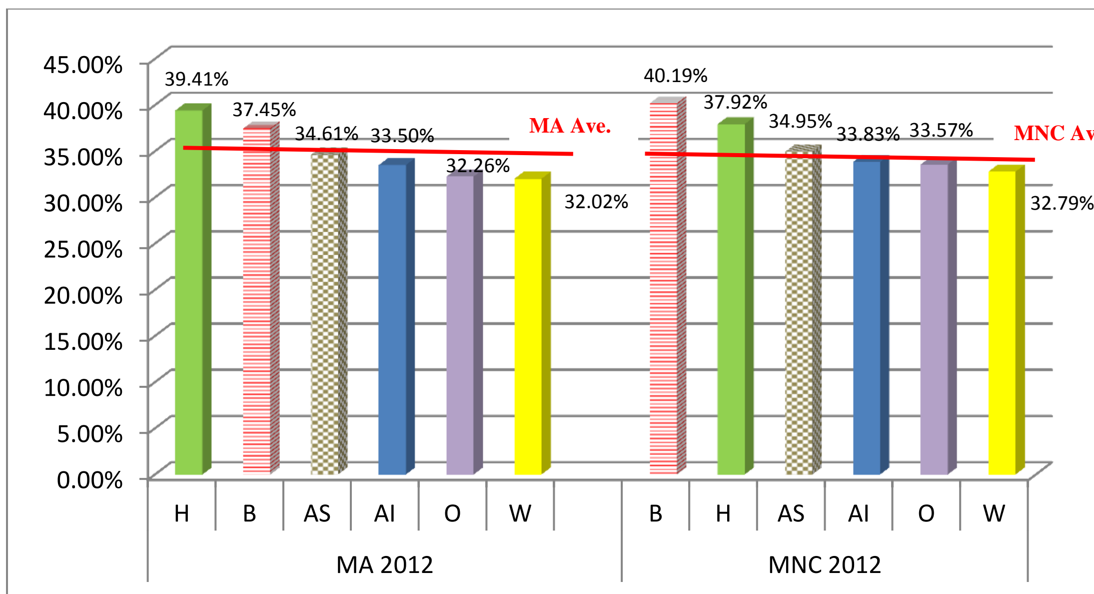
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	34.76%	34.68%	36.20%	37.11%
MinnesotaCare (MNC)	33.82%	33.17%	33.52%	32.84%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 6 in the Appendix A for more detailed results):

1. MinnesotaCare rates were slightly lower (1 to 5 percentage points) than F&C MA rates over the 4 year period, both appear to be trending downward over the past 3 years. MinnesotaCare and F&C MA were substantially below the national Medicaid HMO HEDIS (Quality Compass) average benchmark rate of 49.69%, and only within the 10th (37.27) percentile.
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity show an unanticipated disparities pattern over the 4 year period. The White subgroup over almost every year has the lowest performance. There is a significant numerical bias within this measure where the minority populations represent only one-third of the total eligible adolescents, as such the F&C MA and MinnesotaCare averages are much lower and do not actually represent the performance of the minority populations.

Figure 6a



Measure 7:

Breast Cancer Screening: 40-64 years

HEDIS 2013 Technical Specifications: the percentage of managed care women 40-64 years old who had a mammogram to screen for breast cancer during measurement year and year prior to the measurement year. (see Table 7 in the Appendix A for more detailed results).

Table 7a

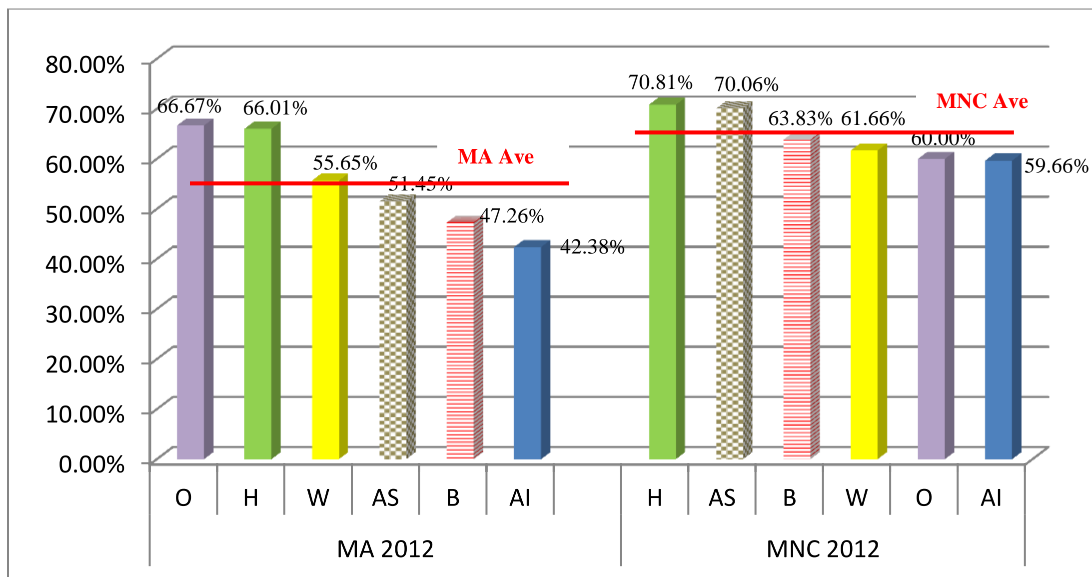
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	53.85%	49.15%	50.28%	52.77%
MinnesotaCare (MNC)	62.26%	62.09%	62.45%	64.00%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 7 in the Appendix for more detailed results):

1. MinnesotaCare rates were significantly higher (10 to 12 percentage points) than F&C MA rates over the 4 year period, both appear to be trending downward over the past 3 years. MinnesotaCare were substantially above the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 51.82%, and both programs were within the 50th (51.32) to 90th percentile (62.88).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity show over the 4 year period that American Indians (AI) subgroup has had consistently the lowest rates while the Hispanic (H) subgroup has the highest performance within both MinnesotaCare and F&C MA programs. The range from highest to lowest subgroup for MinnesotaCare, over the last 4 years, is much smaller than in F&C MA with ranges that are 10 to 20 percentage points wider.

Figure 7a



Measure 8:

Children and Adolescents' Access to Primary Care Practitioners: 12-24 Months

HEDIS 2013 Technical Specifications: the percentage of managed care children 12-24 months old who had a visit with a primary care provider during measurement year. (see Table 8 in the Appendix A for more detailed results).

Table 8a

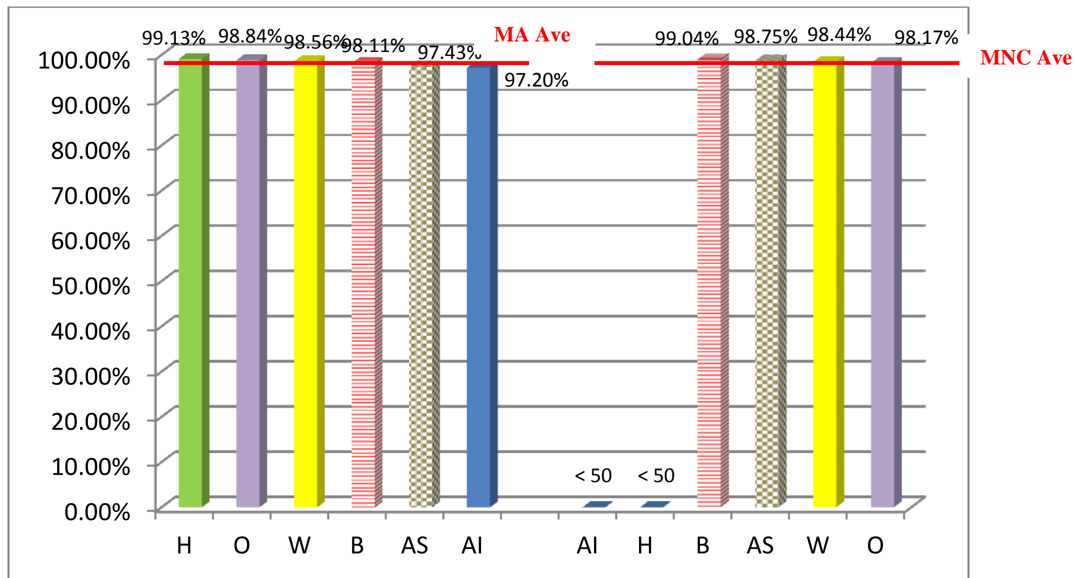
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	98.40%	98.82%	98.71%	98.63%
MinnesotaCare (MNC)	98.49%	98.00%	98.73%	98.14%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 8 in the Appendix for more detailed results):

1. Program rates over the 4 year period have remained the same. F&C MA and MinnesotaCare rates were above the national Medicaid Quality Compass average rate of 95.97% and within the 75th (97.84) and 90th (98.49) percentiles.
2. Stratification of the F&C MA and MinnesotaCare show rates that are approximately the same for all subgroups.

Figure 8a



Measure 9:

Children and Adolescents' Access to Primary Care Practitioners: 25 Months- 6 Yrs.

HEDIS 2013 Technical Specifications: the percentage of managed care children 25 months to 6 years old who had a visit with a primary care provider during measurement year. (see Table 9 in the Appendix A for more detailed results).

Table 9a

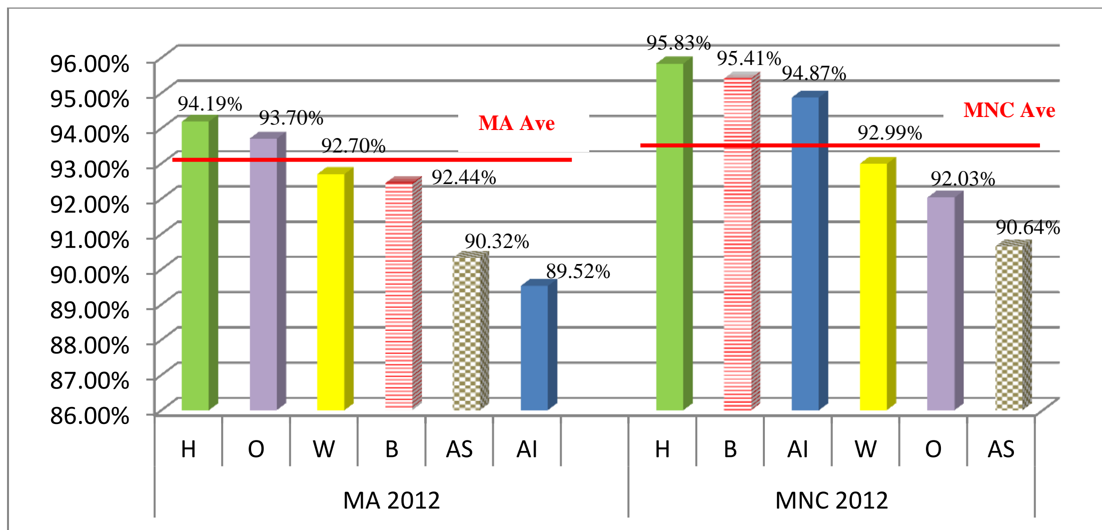
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	92.59%	92.68%	92.73%	93.44%
MinnesotaCare (MNC)	93.16%	93.28%	92.73%	92.75%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 9 in the Appendix for more detailed results):

1. MinnesotaCare rates were slightly higher over the 4 year period with consistently high rates in both public programs. MinnesotaCare and F&C MA were substantially higher than national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 88.32%, and consistently in the 90th percentile (93.6).
2. Stratification of the F&C MA and MinnesotaCare rates show that the Hispanic (H) subgroup was always the highest, and the Asian (AS) race/ethnicity subgroup always the lowest with a range of 4 to 6 percentage point difference. MinnesotaCare rates were slightly higher for all racial/ethnic subgroups over the 4 year period.

Figure 9a



Measure 10:

Children and Adolescents' Access to Primary Care Practitioners: 7-11 Yrs.

HEDIS 2013 Technical Specifications: the percentage of managed care children 7 to 11 years old who had a visit with a primary care provider during measurement year. (see Table 10 in the Appendix A for more detailed results).

Table 10a

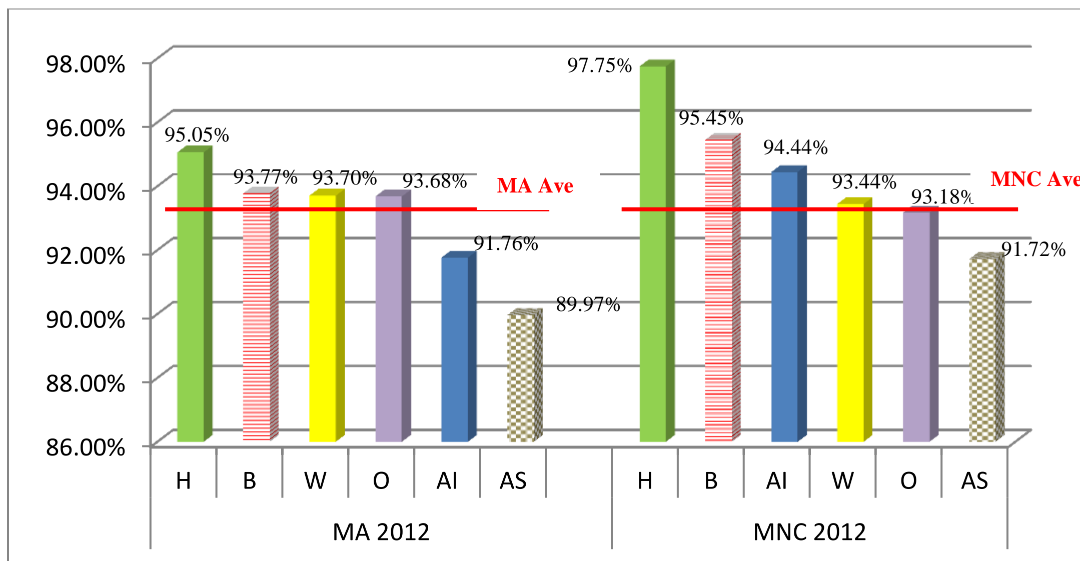
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	93.47%	92.92%	93.42%	93.20%
MinnesotaCare (MNC)	93.76%	93.71%	93.40%	92.91%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 10 in the Appendix for more detailed results):

1. MinnesotaCare and F&C MA rate were consistently the same over the 4 year period, but all rates were very high as seen in the other age groups. MinnesotaCare and F&C MA were substantially above the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 89.88%, and within the 75th (93.26) but below the 90th percentile (95.25).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity show over the 4 year period a similar pattern to the other three age groups in this measure, the Hispanic (H) subgroup most often is the highest racial/ethnic subgroup, while the Asian subgroup is the lowest. The range from highest to lowest in all subgroups is very small.

Figure 10a



Measure 11:

Children and Adolescents' Access to Primary Care Practitioners: 12-19 Yrs.

HEDIS 2013 Technical Specifications: the percentage of managed care children 12-19 years months old who had a visit with a primary care provider during measurement year. (see Table 11 in the Appendix A for more detailed results).

Table 11a

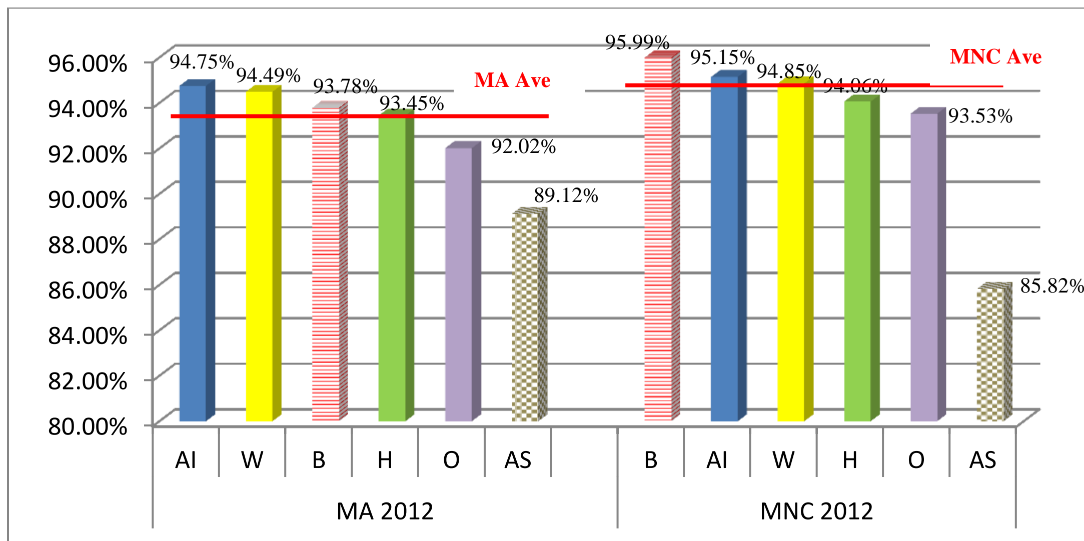
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	93.36%	93.14%	93.35%	93.21%
MinnesotaCare (MNC)	94.23%	94.15%	94.28%	94.31%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 11 in the Appendix for more detailed results):

1. MinnesotaCare rates are slightly higher than F&C MA rates over the 4 year period, but the range between programs is very small. MinnesotaCare and F&C MA were substantially above the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 88.38%, and within the 75th (91.85) and 90th percentile (93.77).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity over the 4 year period reveal no patterns other than the Asian (AS) subgroup almost always has the lowest rate by 5 to 10 percentage points within both MinnesotaCare and F&C MA programs.

Figure 11a



Measure 12:

Cervical Cancer Screening: 21-64 Yrs.

HEDIS 2013 Technical Specifications: the percentage of managed care women 21-64 years old who received one or more Pap tests to screen for cervical cancer during measurement year. (see Table 12 in the Appendix for more detailed results).

Table 12a

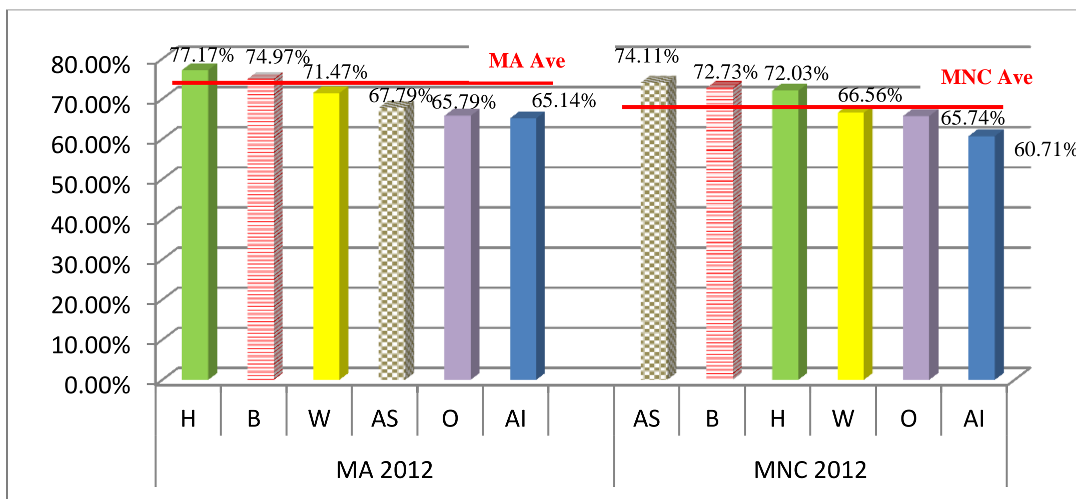
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	71.93%	74.32%	78.11%	76.39%
MinnesotaCare (MNC)	67.47%	67.99%	67.79%	70.17%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 12 in the Appendix A for more detailed results):

1. F&C MA rates over the four year period are higher than in MinnesotaCare by 4 to 10 percentage points. However the averages reflect the significantly larger White population that were significantly higher (10 to 12 percentage points) than F&C MA rates over the 4 year period, both appear to be trending downward over the past 3 years. MinnesotaCare and F&C MA were above the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 64.51%, and within the 50th (66.42) to 90th percentile (76.64).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity demonstrate the lack of any patterns over the 4 year period or between the race/ethnic subgroups. The range between the highest and lowest subgroups is relatively small (10 percentage points) and consistent over the 4 year period. As seen in other measures there are differences between subgroup utilization, and no one race/ethnic subgroup has the highest or lowest performance over time.

Figure 12a



Measure 13:

Comprehensive Diabetes Care: Hemoglobin A1c Testing

HEDIS 2013 Technical Specifications: the percentage of managed care enrollees, 18-64 years old with diabetes who had a Hemoglobin A1c (A1c) test during measurement year. (see Table 13 in the Appendix for more detailed results).

Table 13a

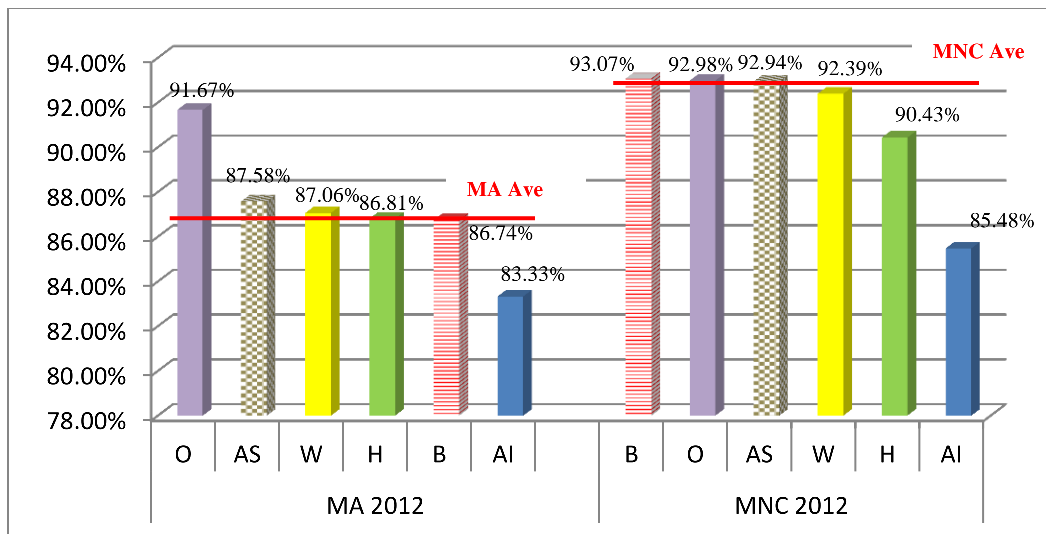
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	86.77%	86.11%	79.55%	79.74%
MinnesotaCare (MNC)	92.22%	92.21%	90.28%	89.16%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 13 in the Appendix A for more detailed results):

1. MinnesotaCare rates over the four year period where slightly higher than F&C MA and there was an upward trend from CY 2009 to CY 2012. MinnesotaCare and F&C MA were also above the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 82.98%, and MinnesotaCare was within the 90th percentile (91.11).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity results exhibit a very small difference in A1c testing between subgroups over the 4 year period. As seen in other measures, there no one race/ethnic subgroup that has the highest or lowest performance. CYs 2009-2011 results for the F&C MA Other (O) subgroup should be disregarded due to very small number of eligible enrollees.

Figure 13a



Measure 14:

Comprehensive Diabetes Care: LDL-C Screening

HEDIS 2013 Technical Specifications: the percentage of managed care enrollees, 18-64 years old with diabetes who had a LDL-C screening test during measurement year. (see Table 14 in the Appendix for more detailed results).

Table 14a

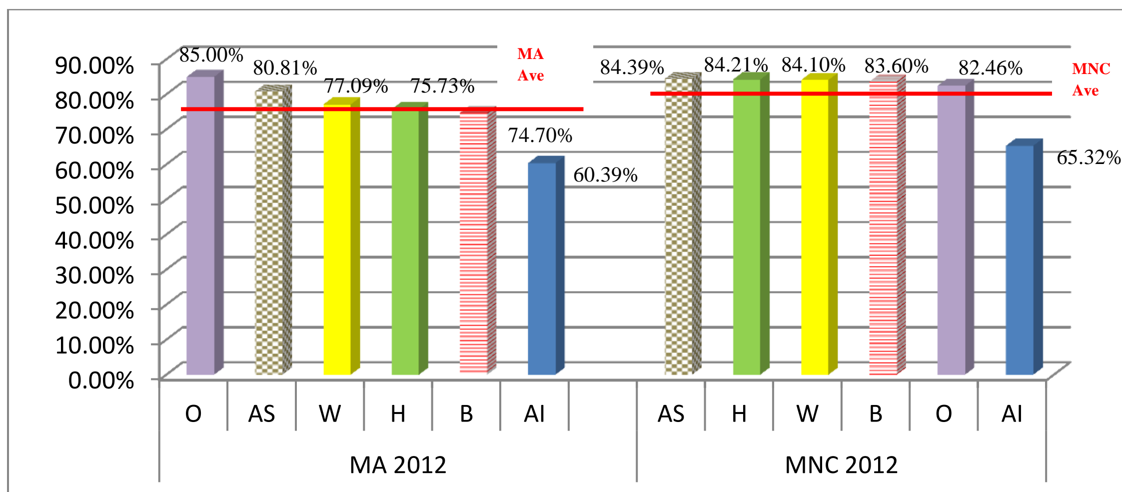
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	75.52%	73.69%	66.63%	67.85%
MinnesotaCare (MNC)	83.50%	83.48%	81.55%	81.73%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 14 in the Appendix A for more detailed results):

1. The MinnesotaCare rates have remained consistent; however the F&C MA rates over the 4 year period have trended upwards so the gap between the two programs has narrow. MinnesotaCare and F&C MA CY 2012 rates are at or above the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 75.56%, and within the 50th (76.28) to 90th percentiles (83.52).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity reveal a slightly different picture because program average rates primarily reflect the White subgroup performance. In CY 2012, the race/ethnicity rates are very similar between the programs. CYs 2009-2011 results for the F&C MA Other (O) subgroup should be disregarded due to very small number of eligible enrollees.

Figure 14a



Measure 15:

Chlamydia Screening in Women

HEDIS 2013 Technical Specifications: the percentage of managed care women, 16-24 years old, who were identified as sexually active and who had at least one test for chlamydia during the measurement year (see Table 15 in the Appendix A for more detailed results).

Table 15a

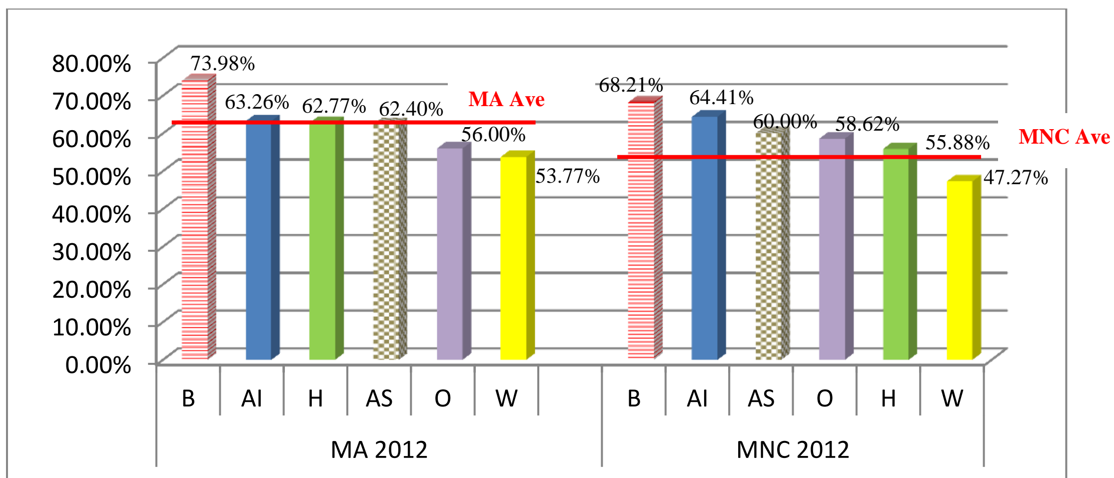
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	61.09%	60.39%	60.27%	57.65%
MinnesotaCare (MNC)	50.17%	50.91%	51.70%	49.84%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 15 in the Appendix A for more detailed results):

1. F&C MA and MinnesotaCare rates have remained approximately the same over the 4 year period; although the F&C MA rates were 8 to 10 percentage points high than MinnesotaCare rates. F&C MA 2012 rates are above, while the MinnesotaCare rates are significantly below the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 57.1%, and both program rates are below the 75th and 90th percentiles (63.72/68.81).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity reveal a unique pattern between the subgroups where the Black subgroups are consistently the highest, and the White subgroups the lowest. The range between the Black and White subgroups is large and the large difference in the number of eligible enrollees' bias the program rates, reflecting the lower White screening rate (see Table 15).

Figure 15a



Measure 16:

Childhood Immunization Status: Combo 2

HEDIS 2013 Technical Specifications: the percentage of managed care children, two year of age during the measurement year, who had four DTaP, three IPV, one MMR, three Hib, three HepB and one VZV vaccinations by their second birthday (see Table 16 in the Appendix A for more detailed results).

Table 16a

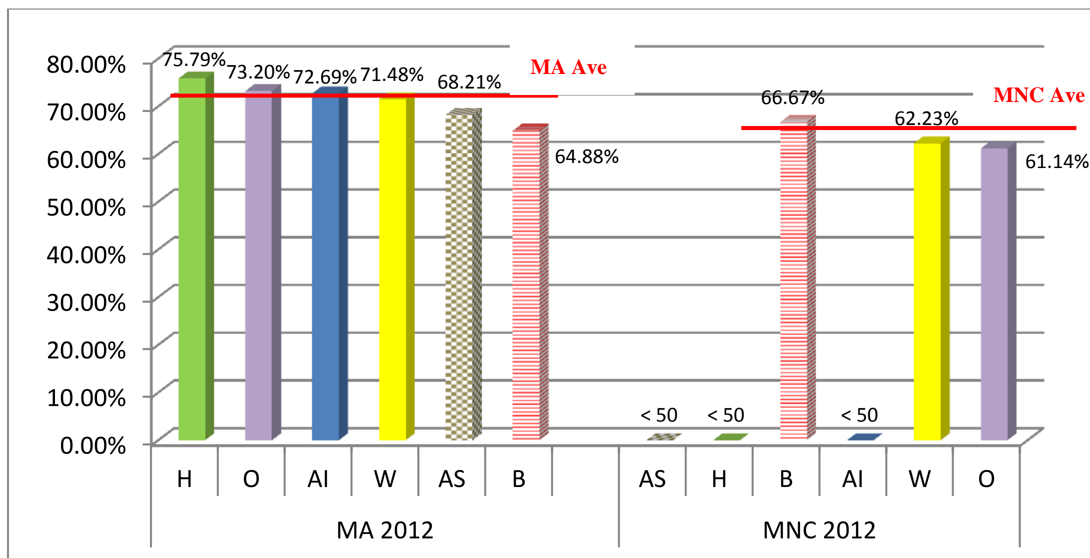
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	70.30%	72.11%	64.28%	36.48%
MinnesotaCare (MNC)	63.74%	62.42%	63.03%	34.78%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 16 in the Appendix A for more detailed results):

1. In comparison to MinnesotaCare rates, the F&C MA rates over the 4 year period have significantly trended upwards. MinnesotaCare rates also show real improvement over the 4 year period but tail behind F&C MA averages. MinnesotaCare and F&C MA CY 2012 rates are below the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 75.74%, and below the 50th (76.89) to 90th percentiles (85.4).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity reveal a 5 to 10 percentage point range between subgroup where the White subgroup performance lagging behind the other subgroups. In CY 2012, the race/ethnicity rates are very similar between the programs. There are no consistent race/ethnicity patterns between the programs or within the programs as can be seen in Graph 16.

Figure 16a



2012 MinnesotaCare Asian, American Indian and Hispanic eligible populations were less than 50 enrollees and removed from the analysis

Measure 17:

Well-Child Visits in the First 15 Months of Life

HEDIS 2013 Technical Specifications: the percentage of managed care children, who turned 15 months old during the measurement year and had six or more well-child visits with a primary care provider during their first 15 months (see Table 17 in the Appendix A for more detailed results).

Table 17a

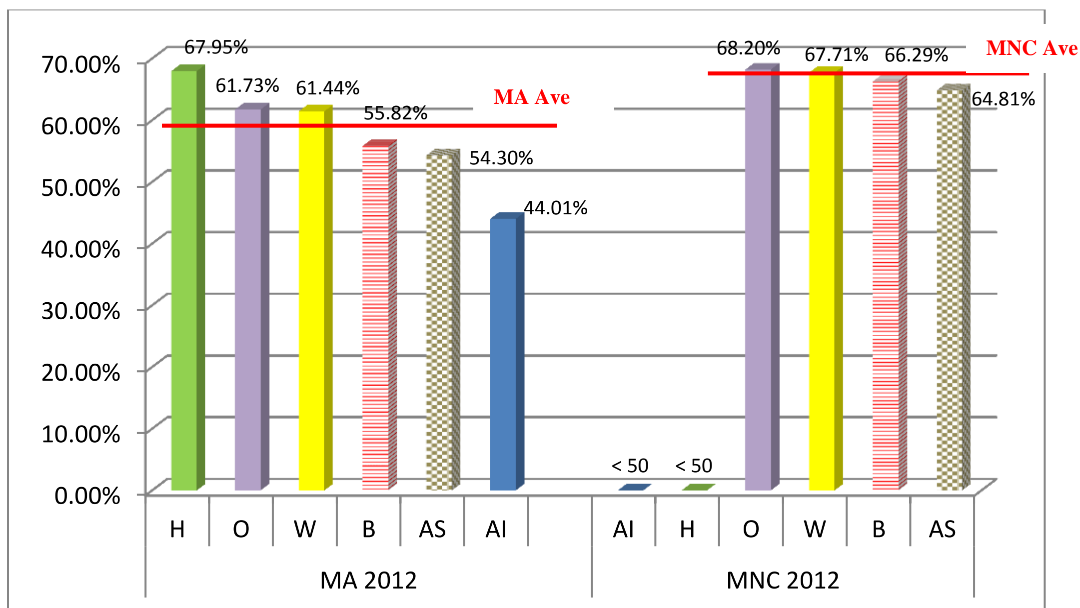
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	59.76%	63.25%	59.33%	56.89%
MinnesotaCare (MNC)	67.91%	69.24%	64.23%	60.00%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 17 in the Appendix A for more detailed results):

1. The MinnesotaCare and F&C MA rates have remained unchanged over the 4 year period. MinnesotaCare and F&C MA CY 2012 rates are slightly above or below the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 63.65%, and within the 50th (63.65) to 90th percentiles (77.44).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity reveal little change between the subgroups the American Indian subgroup in F&C MA is consistently 10 to 20 percentage points below the other subgroup rates.

Figure 17a



2012 MinnesotaCare American Indian and Hispanic eligible populations were less than 50 enrollees and removed from the analysis

Measure 18:

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

HEDIS 2013 Technical Specifications: the percentage of managed care children, 3-6 years of age who had one or more well-child visits with a primary care provider during the measurement year (see Table 18 in the Appendix A for more detailed results).

Table 18a

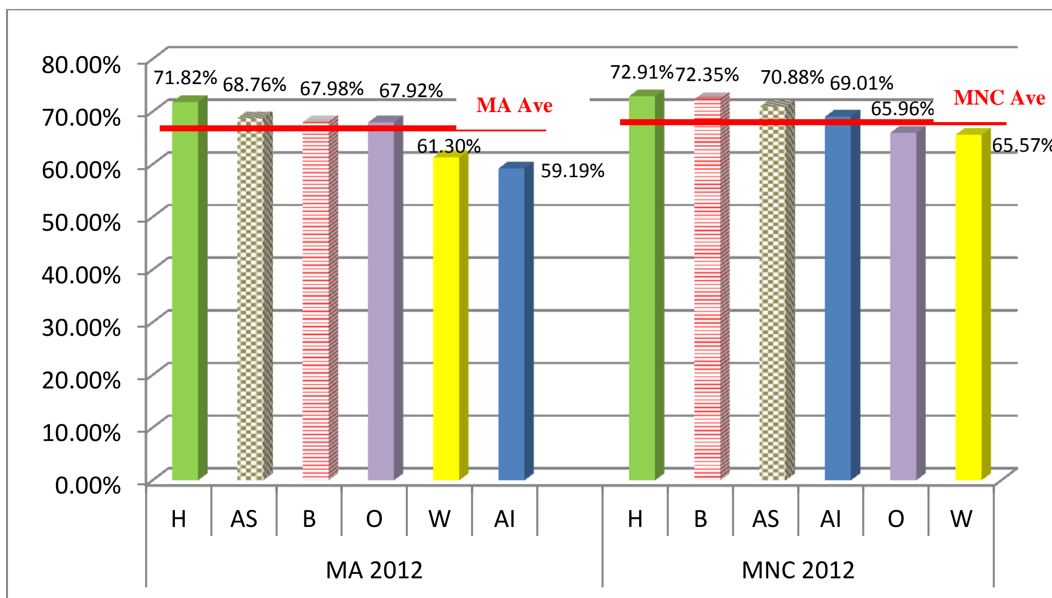
	2012 Rate	2011 Rate	2010 Rate	2009 Rate
F&C MA (MA)	65.60%	65.16%	66.05%	64.69%
MinnesotaCare (MNC)	67.14%	66.59%	66.03%	63.65%

Analysis

Over the 4 year period of calendar years 2009 through 2012 calculated rates indicate (see Figure 18 in the Appendix for more detailed results):

1. The MinnesotaCare rates have remained consistent; however the F&C MA rates over the 4 year period have trended upwards so the gap between the two programs has narrow, but in the last two years MinnesotaCare rates have been higher. MinnesotaCare and F&C MA CY 2012 rates are below the national Medicaid HMO HEDIS (Quality Compass) benchmark average rate of 72%, and just within the 50th (65.16) percentile and well below the 75th or 90th percentiles (78.51/82.08).
2. Stratification of the F&C MA and MinnesotaCare rates by race/ethnicity reveal MinnesotaCare minority subgroups rates that are slightly higher than F&C MA over all 4 years. The White subgroup rates are 5 to 10 percentage points below the Hispanic subgroup over the study period.

Figure 18a



Appendix C: Overview of the Race/Ethnicity Disparity Trends

The following table is presented as a simple aid in understanding and communicating the relative relationship between subgroups in Minnesota's publicly funded managed care programs (F&C MA and MinnesotaCare). The symbols (↑, ↓, ≅) are intended as a gross indicator of each racial/ethnic subpopulation rates for 2012 as: roughly Higher, Lower or Approximately the same as the White subpopulation during calendar year 2012.

Measures/Programs	Black	AS	AI	Other	Hispanic
1. Adult Access to Ambulatory or Preventive Visit: 20-44 years					
F&C MA	↓	↓	↑	↓	≅
MinnesotaCare	↑	↓	≅	↓	↑
3. Antidepressant Medication Management: Effective Continuation Phase Tx.					
F&C MA	↑	↑	↑	< 50	↓
MinnesotaCare	↓	< 50	< 50	< 50	< 50
5. Use of Appropriate Medication for People with Asthma: Total 5-64 Years					
F&C MA	↑	↑	↓	< 50	↑
MinnesotaCare	↑	< 50	< 50	↑	< 50
6. Adolescent Well−Care 12-21 years					
F&C MA	↑	↑	↑	≅	↑
MinnesotaCare	↑	↑	↑	↑	↑
7. Breast Cancer Screening 40-64 years					
F&C MA	↓	↓	↓	↑	↑
MinnesotaCare	↓	↓	↓	↑	↑
10. Children and Adolescents' Access to Primary Care Practitioners: 7-11 years					
F&C MA	≅	↓	↓	≅	↑
MinnesotaCare	↑	↓	↑	≅	↑
12. Cervical Cancer Screening: 24-64 years					
F&C MA	↑	↓	↓	↓	↑
MinnesotaCare	↑	↑	↓	↓	↑
13. Comprehensive Diabetes Care Screening A1C Testing					
F&C MA	↓	≅	↓	↑	↓
MinnesotaCare	↑	≅	↓	≅	↓
15. Chlamydia Screening in Women					
F&C MA	↑	↑	↑	↑	↑
MinnesotaCare	↑	↑	↑	↑	↑
16. Childhood Immunizations Combo 2					
F&C MA	↓	↓	↑	↑	↑
MinnesotaCare	↑	< 50	< 50	↓	< 50
17. Well−Child Visits in the First 15 Months of Life					
F&C MA	↓	↓	↓	≅	↑
MinnesotaCare	↓	↓	< 50	↑	< 50
18.Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
F&C MA	↑	↑	↓	↑	↑
MinnesotaCare	↑	↑	↑	≅	≅

↑ = Historical movement is roughly Higher ↓ = Historical Trend is Lower ≅ = Historical movement is approximately the same as White subpopulation; < 50 = less than 50 eligible enrollees rate not utilized.

Attachment G

Proposed Evaluation for PMAP+ Section 1115 Demonstration Waiver

This proposed evaluation plan relates to the demonstration periods July 1, 2011 through December 31, 2013 and 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.

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.

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.

2. 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.

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.

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.

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 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 five 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 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

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 (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

4.2 Evaluation Populations for the 2011-2013 Waiver

Evaluation populations will 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.

4.3 2011-2013 Waiver Evaluation Metrics

Goals one through four:

The HEDIS 2014 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.[1] Performance measure data for the period calendar years 2009 through 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 2014 performance measures that will be analyzed in the evaluation.[2] 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 measures are not available for pregnant women. Each of the HEDIS measures will be stratified by race and ethnicity.

Children (0- 20 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 (5-11, 12-20 yrs)
Follow-up After Hospitalization for Mental Illness (6-20 yrs)
Adults (21-64 yrs.)
Diabetes A1c screening (21-64 yrs)
Diabetes LDL screening (21-64 yrs)
Adult access preventive/ambulatory health services (21-44, 45-64 yrs)
Annual Dental Visit (21-64 yrs)
Cervical CA screening (21-64 yrs)
Medication Management for People with Asthma (21-50, 51-64 yrs)
Follow-up After Hospitalization for Mental Illness within 7 and 30 Days (21-64 yrs)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (21-64 yrs)
Pregnant Women
Postpartum Care

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-

[1] A statewide immunization registry for the Childhood immunization performance measure will be used to augment DHS managed care encounters.
[2] Cervical CA Screening measure will utilize HEDIS 2013 Technical Specifications to ensure measurement comparability over the entire measurement period of 2009 through 2014.

submitted encounter data are accurate and DHS-produced performance measures follow HEDIS specifications.[3]

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, dental visits, 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.

- **Enrollee satisfaction.** DHS will conduct an analysis and comparison of satisfaction survey results reflecting the enrollee's perspective on the delivery and quality of health care services. The annual CAHPS satisfaction survey of adults composite measures 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 the cells defined by DHS.

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

4.4 Plan for Analysis of 2011-2013 Waiver

The selected HEDIS 2014 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 calendar years 2009 through 2013 will be calculated for the targeted populations and compared. 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 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 15months 5. Well-child visits 3 to 6 yrs. 6. Adolescent will-care visits (12-19 yrs) 7. Medication Management for People with Asthma (5-11, 12-20 yrs) 8. Follow-up After Hospitalization for Mental Illness (6-20 yrs)	CYs 2009 through 2013
2.MinnesotaCare Pregnant Women (DHS program/eligibility codes: LL/P1, P2)	3. MA Pregnant Women (DHS program/eligibility codes: MA/PX)	1. Postpartum Care	CYs 2009 through 2013
3. MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)	2. MA Adults (DHS program/eligibility codes: MA/AA)	1. Diabetes A1c screening (21-64 yrs) 2. Diabetes LDL screening (21-64 yrs) 3. Adult access preventive/ambulatory health services (21-50, 12-18 yrs) 4. Annual Dental Visit (21-64 yrs) 5. Cervical CA screening (21-64 yrs) 6. Medication Management for People with Asthma (21-50, 51-64 yrs) 7. Follow-up After Hospitalization for Mental Illness within 7 & 30 Days (21-64 yrs) 8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatement (21-64 yrs)	CYs 2009 through 2013
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 (21-64 yrs) 2. Diabetes LDL screening (21-64 yrs) 3. Adult access preventive/ambulatory health services (21-50, 12-18 yrs) 4. Annual Dental Visit (21-64 yrs) 5. Cervical CA screening (21-64 yrs) 6. Medication Management for People with Asthma (21-50, 51-64 yrs)	CYs 2009 through 2013

		7. Follow-up After Hospitalization for Mental Illness within 7 & 30 Days (21-64 yrs) 8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (21-64 yrs)	
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. Childhood immunizations (2 yrs) 2. Child access to PCP (age groups 12-24 mos;) 2. Well –child visits first 15months	CYs 2009 through 2013

5. Evaluation Strategy for the 2014 Waiver

5.1 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:

5.11 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.

5.12 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.

5.13 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 (CAHPS satisfaction survey composite 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.

5.2 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 designated state health program (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.

5.3 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 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 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 15months 5. Well-child visits 3 to 6 yrs. 6. Adolescent will-care visits (12-19 yrs) 7. Medication Management for People with Asthma (5-11, 12-20 yrs) 8. Follow-up After Hospitalization for Mental Illness (6-20 yrs)	CYs 2009 through 2014
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 (21-64 yrs) 2. Diabetes LDL screening (21-64 yrs) 3. Adult access preventive/ambulatory health services (21-50, 12-18 yrs) 4. Annual Dental Visit (21-64 yrs) 5. Cervical CA screening (21-64 yrs) 6. Medication Management for People with Asthma (21-50, 51-64 yrs) 7. Follow-up After Hospitalization for Mental Illness within 7 & 30 Days (21-64 yrs) 8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (21-64 yrs)	CYs 2009 through 2014
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 (21-64 yrs) 2. Diabetes LDL screening (21-64 yrs) 3. Adult access preventive/ambulatory health services (21-50, 12-18 yrs) 4. Annual Dental Visit (21-64 yrs) 5. Cervical CA screening (21-64 yrs) 6. Medication Management for People with Asthma (21-50, 51-64 yrs)	CYs 2009 through 2014

		7. Follow-up After Hospitalization for Mental Illness within 7 & 30 Days (21-64 yrs) 8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (21-64 yrs)	
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. Childhood immunizations (2 yrs) 2. Child access to PCP (age groups 12-24 mos;) 2. Well –child visits first 15months	CYs 2009 through 2014

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.

5.4 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. [4]

Children (0-20 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)
Medication Management for People with Asthma (5-11, 12-20 yrs)
Follow-up After Hospitalization for Mental Illness (6-20 yrs)

[4] Cervical CA Screening measure will utilize HEDIS 2013 Technical Specifications to ensure measurement comparability over the entire measurement period of 2009 through 2014.

Adults (21-64 yrs)
Diabetes A1c screening (21-64 yrs)
Adult access preventive/ambulatory health services (21-44, 45-65 yrs)
Annual Dental Visit (21-64 yrs)
Medication Management for People with Asthma (21-50, 51-64 yrs)
Follow-up After Hospitalization for Mental Illness within 7 and 30 Days (21-64 yrs)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (21-64 yrs)
Cervical CA screening (21-64 yrs)

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 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 measurement periods performance of the adult caretaker waiver population and non-waiver adult caretaker population by the diabetes screening, adult preventive visits, dental 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 2009-2013 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 adult AHRQ ambulatory care sensitive conditions (ACSC) program (all adults in MA and MinnesotaCare) level measures will be calculated to provide additional insight into the quality of care provided over the calendar years 2009 through 2014.

6. Evaluation Implementation Strategy and Timeline

6.1 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 2011 – 2013 Waiver report is submitted to CMS.

A subset of HEDIS 2014 performance measures and stratification by race/ethnicity are expected to demonstrate the continuation of the ongoing quality of care and services provided by the contracted managed care organizations.

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									X	X		

Measure Analysis												
Draft Report-March 2015												
Final Report & Approval – May 2015												

6.2 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 2014 Waiver 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												

6.3 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.

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.

6.4 Limitations and Opportunities

The following limitations may impact the results of this evaluation:

- Unexpected consequences due to changes in state law regarding public programs.
- Future changes to HEDIS technical specifications influence future coding or data reporting that would bias this type of longitudinal analysis. If these types of changes occur the biases and potential consequences will be reported in the final report limitation section.
- Measures with high rates 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.

6.5 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. 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 H

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 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved a temporary extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the PMAP+ waiver will no longer be needed for MinnesotaCare once the state receives federal approval for a Basic Health Plan. However, some provisions in the existing waiver will remain necessary. For example, the PMAP+ waiver will still be necessary to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for groups that would otherwise be excluded and payment of medical education and research.

DHS invites public comment on the PMAP+ waiver. 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 18, 2014.

James I. Golden, PhD
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:	Wednesday, May 21, 2014
Time:	1:30 p.m.
Location:	Department of Human Services, Elmer L. Andersen Human Services Building, 540 Cedar St., St. Paul, MN 55101. Room 2390

(This hearing will be held in conjunction with the previously scheduled post-award public forum on the PMAP waiver)

Public Hearing #2

Date: Wednesday, May 28, 2014
Time: 1:00 p.m.
Location: Department of Human Services, 444 Lafayette Rd., St. Paul, MN 55155. Room 3146

Attachment I
PMAP+ Waiver Extension
Stakeholder Email List
Last Updated: 5/30/14

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cgrass@mnscha.org
jkidder@mnscha.org
jwhitington@mnscha.org
aeckard@mnscha.org
mward@mnscha.org
cmahagnoul@mnscha.org
abaumann@mnscha.org
mmurray@mnscha.org
jkidder@mnscha.org
ASmith@mnscha.org
garnold@mnscha.org
agrimmius@mnscha.org
garnold@mnscha.org
rseefeld@mnscha.org
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Medicaid Citizens Advisory Committee
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dawn.petroskas@cctwincities.org
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Minnesota Disability Law Center
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SeeSharePoint

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smmoore@mylegalaid.org
denaus@mylegalaid.org
dremes@mylegalaid.org

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kathleen.vanderwall@state.mn.us
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ruth.klein@state.mn.us
larry.grewach@state.mn.us
Emily.Waymire@state.mn.us

Attachment J

Public Comment

Minnesota Hospital Association

2550 University Ave. W., Suite 350-S
St. Paul, MN 55114-1900

phone: (651) 641-1121; fax: (651) 659-1477
toll-free: (800) 462-5393; www.mnhospitals.org

June 17, 2014

James I. Golden, PhD
Medicaid Director
Minnesota Department of Human Services
PO Box 64983
St. Paul, MN 55164-0983

Submitted electronically to Section1115WaiverComments@state.mn.us

Dear Dr. Golden:

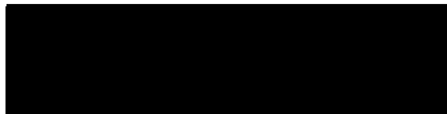
On behalf of our 143 member hospitals and related health systems, the Minnesota Hospital Association (MHA) appreciates the opportunity to comment on the proposed PMAP+ Section 1115 Waiver extension request.

MHA strongly supports extending the waiver. Extending the waiver will provide continuity of care and stability for patients between Medicaid and MinnesotaCare.

In addition, the waiver extension will continue Minnesota's practice of supporting graduate medical education through the Medical Education and Research Costs (MERC) program. Continuing these payments is crucial to ensuring Minnesota's future health care workforce. Minnesota already faces health care workforce shortages across the state, from primary care physicians to child and adult psychiatrists. The MERC program requires predictable and sustained funding to keep our state from falling further behind and threatening our status as one of the healthiest states in the country.

Thank you again for the opportunity to comment. Please do not hesitate to contact me directly at (651) 659-1405 or jmcnertney@mnhospitals.org with any questions.

Sincerely,



Jennifer McNertney, MPP
Policy Analyst

June 18, 2014

Mr. James Golden, PhD
Medicaid Director
Minnesota Department of Human Services
P. O. Box 64983
St. Paul, MN 55164-0983

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

Dear Mr. Golden:

Key to UCare's mission is improving the health of our members through innovative services, and we focus on what best supports individuals who need health care and other home and community-based services. As a managed organization with a proven track record of ensuring Minnesotans receive necessary Medicaid (Medical Assistance) services, UCare supports an extension of the Department's PMAP+ Section 1115 waiver renewal request from January 1, 2015-December 31, 2017.

The waiver renewal will ensure that:

- otherwise excluded Medical Assistance eligible individuals continue to receive quality health care via managed care
- federal funding for medical education and research continues
- the Department can require 12-month reviews for medically needy Medical Assistance individuals with unvarying, unearned income
- one-year olds (defined as 12-23 months) and parents or caregiver relatives of children age 18 who are not full-time students will also be able to receive quality health care services

A three year renewal of the PMAP+ waiver will ensure children, adults, and families have comprehensive coverage and the benefits of coordinated care now and into the future.

Thank you for this opportunity to comment on the waiver renewal. We look forward to continuing to serve Minnesota's Medical Assistance citizens.

Sincerely,

Ghita Worcester
Senior VP, Public Affairs and Marketing

500 Stinson Blvd. NE Minneapolis MN 55413-2615 • P.O. Box 52 Minneapolis MN 55440-0052
612-676-6500 • 1-866-457-7144 • TTY: 1-800-688-2534 • Fax: 612-676-6501 • www.ucare.org

Attachment K

Medicaid Tribal Consultation Process

January 2014

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.

Attachment L

Tribal Letter
May 18, 2014

Minnesota Department of **Human Services**

May 19, 2014

Dr. Pat Rock, M.D. Executive Director
Minneapolis Indian Health Board, Inc.
1315 East 24TH Street
Minneapolis, MN 55404

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

Dear Dr. Rock:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Jenny Jenkins, Executive Director
Bemidji Area Indian Health Service
522 Minnesota Ave. NW, Room 119
Bemidji, MN 56601

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

Dear Ms. Jenkins:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chairwoman Erma Vizenor
White Earth Band of Ojibwe
P. O. Box 418
White Earth, MN 56591

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

Dear Chairwoman Vizenor:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chairman Kevin Jensvold
Upper Sioux Community
P. O. Box 147
Granite Falls, MN 56241

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

Dear Chairman Jensvold:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chairman Charlie Vig
Shakopee Mdewakanton Dakota Community
2330 Sioux Trail, NW
Prior Lake, MN 55372

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

Dear Chairman Vig:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chairman Floyd Jourdain
Red Lake Chippewa
P. O. Box 550
Red Lake, MN 56671

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

Dear Chairman Jourdain:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

President Johnny Johnson
Prairie Island Community of Mdewakanton Dakota
5636 Sturgeon Lake Rd.
Welch, MN 55089

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

Dear President Johnson:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chief Executive Melanie Benjamin
Mille Lacs Band of Ojibwe
43408 Oodena Drive
Onamia, MN 56359

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

Dear Chief Executive Benjamin:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chairman Kevin Leecy
Bois Forte Band - MN Chippewa Tribe
P. O. Box 16
Nett Lake, MN 55772

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

Dear Chairman Leecy:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

President Denny Prescott
Lower Sioux Community
RR #1, Box 308
Morton, MN 56270

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

Dear President Prescott:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

PO Box 64983 • St. Paul, MN • 55164-0983 • An equal opportunity and veteran-friendly employer

Minnesota Department of **Human Services**

May 19, 2014

Chairman Carri Jones
Leech Lake Band of Ojibwe
115- 6th Street NW
Cass Lake, MN 56633

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

Dear Chairman Jones:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chairman Norman Deschampe
Chippewa Tribe of Grand Portage, MN
P. O. Box 428
Grand Portage, MN 55605

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

Dear Chairman Deschampe:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Minnesota Department of **Human Services**

May 19, 2014

Chairwoman Karen Diver
Fond du Lac Reservation
1720 Big Lake Road
Cloquet, MN 55720

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

Dear Chairwoman Diver:

This letter is to inform you that DHS is announcing a 30-day comment period on the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver renewal request.

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved an extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. This waiver extension has allowed Minnesota to continue to operate the MinnesotaCare Program while preparing to transition to a Basic Health Plan in calendar year 2015. The current waiver ends December 31, 2014.

DHS expects that the MinnesotaCare program will be funded as a Basic Health Plan in 2015. DHS is requesting a renewal of the PMAP+ waiver to continue operating the Medical Assistance Program as it stands today, including mandatory managed care for Indians and other groups that would otherwise be excluded from managed care and payment of medical education and research.

We invite you to comment on the proposed waiver renewal. 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) 431-2192 or Gretchen.Ulbee@state.mn.us or Kathleen Vanderwall at (651) 431-2186 or Kathleen.Vanderwall@state.mn.us. Thank you.

Sincerely,

Gretchen Ulbee

Department of Human Services

Health Care Administration

Post-Award Public Forum on the Prepaid Medical Assistance Project Plus Section 1115 Medicaid Waiver

On December 20, 2013 the Centers for Medicare & Medicaid Services (CMS) approved a one-year temporary extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. The waiver extension includes changes to MinnesotaCare to align the program with the requirements for a Basic Health Plan (BHP) under the Affordable Care Act. The extension ensures the continued provision of services to Minnesotan's with incomes at or below 200 percent of the federal poverty line, in order to not disrupt coverage as the State prepares a request for a Basic Health Plan. Minnesota will continue to receive federal financial participation for MinnesotaCare at the state's regular federal medical assistance percentage (FMAP) during the extension period which is set to expire on December 31, 2014.

A copy of the waiver approval 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 first of these public forums is scheduled as follows:

PMAP Waiver Public Forum

Date: Wednesday, May 21, 2014
Time: 1:30 p.m.
Location: Department of Human Services, Elmer L. Andersen Human Services Building, 540 Cedar St., St. Paul, MN 55164. Room 2390

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 N

Stakeholder Email Notice – Post-Award Public Forum

Kooistra, Jan M (DHS)

From: *DHS_Section1115WaiverComments
Sent: Wednesday, May 07, 2014 12:24 PM
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Subject: PMAP+ Waiver - Post-Award Public Forum

The Centers for Medicare & Medicaid Services (CMS) approved a one-year temporary extension of Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver in December 2013. This waiver extension has allowed Minnesota to continue to provide MinnesotaCare, while preparing to transition to a Basic Health Plan in 2015. The waiver is currently approved through December 31, 2014.

Under the terms of the PMAP+ 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 first of these public forums is scheduled as follows:

PMAP Waiver Public Forum

Date: Wednesday, May 21, 2014
Time: 1:30 p.m.
Location: Department of Human Services, Elmer L. Andersen Human Services Building, 540 Cedar St., St. Paul, MN 55101. Room 2390

Map of DHS Central Office buildings and visitor parking (PDF) (DHS-4023a). Please be aware that Cedar Street is closed due to construction related to the light-rail line. Metered parking adjacent to the building is very limited, and visitors may have to park at meters one or two blocks away. Limited parking is available in the ramp adjacent to the building; see page 2 of the map of DHS Central Office buildings for details on visitor parking in the Cedar Street ramp

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.

Public Input on Proposed Renewal of PMAP+ Waiver beyond December 2014

DHS will seek federal approval for a Basic Health Plan to run the MinnesotaCare program in 2015 instead of using the PMAP+ waiver. The PMAP+ waiver will still be necessary to continue operating some aspect of the current Medical Assistance program, including mandatory managed care for groups that would otherwise be excluded and payment of medical education and research. The PMAP+ waiver is currently authorized through December 31, 2014. The Department of Human Services plans to submit a request to renew the PMAP+ waiver in July 2014. Details on the public comment period and two public hearings on the proposed renewal of the PMAP+ waiver will be forthcoming.

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