DRAFT: Indian Health Board of Minneapolis
Section 1115 Waiver Request

Revised on April 17, 2017
Revisions found on page 5
Preliminary evaluation plan included at Attachment D

Jan 13, 2017

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Section I – Program Description

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

The 2016 Minnesota Legislature directed the Minnesota Department of Human Services (DHS) to seek federal authority to allow tribal organizations dually certified as Urban Indian Health Programs and Federally Qualified Health Centers to receive the Indian Health Services encounter rate used to reimburse eligible providers for Medicaid services provided to American Indian and Alaskan Native people. The legislature also directed DHS to seek federal authority to allow the state to be eligible for the 100 percent Federal Medical Assistance Percentage (FMAP) for such services. See Minn. Stat. § 256B.0625, specifically subdivisions 30 and 34. Currently, the Indian Health Board of Minneapolis (IHB) is the only entity that would qualify under this criteria.

This demonstration would increase financial resources to the IHB. We are proposing to test an option for increasing the number of American Indians who live in urban areas and enroll into Minnesota's Medicaid program, known as Medical Assistance (MA), and expand upon existing efforts by the IHB to improve access to care for its patients. This includes use of an abbreviated application process and targeted funding for increased application assistance and care coordination through existing innovative delivery models for this population.

The IHB is one of the 34 Urban Indian Health Programs in the country, operating under Title V of the Indian Health Care Improvement Act, PL 94-437. As an Urban Indian Health Program, the IHB contracts with the Indian Health Services to receive grant funding for serving the needs of American Indians who live in the Twin Cities, an urban area of Minnesota. The IHB provides medical and dental care and counseling services to approximately 5,000 people in the Twin Cities area, many of whom are uninsured and American Indian. The IHB also serves as one of the ten Federally Qualified Health Centers participating in the Federally Qualified Health Center Urban Health Network (FUHN), which operates as an accountable care organization (ACO) within Minnesota's Integrated Health Partnership (IHP) program.

Minnesota is one of a growing number of states to implement an ACO model in its Medicaid program with the goal of improving the health of the population and of individual members. In the first year of participation in the program, provider delivery systems share any financial savings with the state. After the first year, they also share the risk for any losses. The total costs for caring for MA enrollees are measured against targets of cost and quality for each delivery system. Providers participating in IHPs must: 1) provide the full scope of primary care services; 2) coordinate with specialty providers and hospitals to manage care; and 3) demonstrate how they will partner with community organizations and social service agencies and integrate their services into care delivery.

As of 2016, 19 provider organizations with approximately 225,000 attributed lives are covered through the IHP demonstration, including FUHN. Through the first two years of the IHP program, the savings in the total cost of care from the demonstration were estimated to be $75

million. The IHB's participation in this program provides a natural opportunity to evaluate the demonstration and its impact on improving health outcomes for American Indian people.

This demonstration will further the objectives of the Medicaid Program by increasing enrollment and improving access to and the quality of care for American Indians who are eligible for Medicaid. It will also test ways to stabilize and strengthen the ability of providers to serve this population through innovative delivery and care coordination models. Through these efforts, the state will be able to demonstrate ways to better connect American Indians to the Medicaid program and to models of care that improve health outcomes.

2) Include the rationale for the Demonstration.

American Indians living in Minnesota experience high rates of uninsurance and significant health disparities when compared to other populations. For example, according to a 2014 report on health disparities from the Minnesota Department of Health (MDH), American Indians in Minnesota experience substantially higher mortality rates at earlier ages than other populations.[1] Infant mortality rates for American Indians, along with African Americans, are nearly twice as high as other Minnesotans.[2] American Indians also have higher rates of uninsurance.[3] These high rates of uninsurance and health inequities are consistent with national rates.[4] The Indian Health Service provides that American Indians die from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault, homicide, intentional self-harm/suicide, and chronic lower respiratory diseases at higher rates than other Americans.[5]

When examining the experience of American Indians living in the Twin Cities, an urban area of Minnesota served by the IHB, data from birth and death records compiled by the Center for Health Statistics at MDH also show significant health disparities. For example:

- Among mothers living in Minneapolis and St. Paul, 8.2 percent of American Indian mothers gave birth to low-birthweight babies, compared to 4.4 percent of White mothers. (Time period: 2011 to 2015.)
- Among mothers living in Minneapolis and St. Paul, 22.8 percent of American Indian mothers received inadequate or no prenatal care, compared to 10.4 percent of Asian mothers (the next highest group) and 3.5 percent of White mothers. (Time period: 2011 to 2015.)
- The infant mortality rate for births to mothers from Minneapolis and St. Paul was 5.5 deaths per 1,000 for American Indian people and 4.4 deaths for Whites and 4.3 deaths for Asian people. (Time period: infants born from 2009 to 2013).
- American Indians also have the highest age-adjusted mortality rate of any race group residing in Hennepin and Ramsey Counties. The age-adjusted mortality rate was 922.5 deaths per 100,000 for American Indians, compared to 632.2 deaths per 100,000 for

[1] Minnesota Department of Health, 2014. Advancing Health Equity in Minnesota: Report to the Legislature. Available at: http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf
[2] *Id.*
[3] *Id.*
[4] Indian Health Service, 2016. Indian Health Disparities: Fact Sheet. Available at: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/Disparities.pdf
[5] *Id.*

Whites, and 532 deaths per 100,000 for Asian populations. Minneapolis and St. Paul are located in Hennepin and Ramsey Counties. (Time period: 2010 to 2014).

Furthermore, the Minnesota Student Survey reflects similar disparities for young people who are American Indian in Minnesota. This survey is conducted every three years among three populations of students served by Minnesota's public school system. The survey asks questions about student activities, experiences, and behaviors. Topics covered include tobacco, alcohol and drug use, school climate, physical activity, violence and safety, connections with school and family, health, and other topics. Questions about sexual activity are asked only of high school students. The survey is administered jointly by the Minnesota Departments of Education, Health, Human Services, and Public Safety.

Some of the results from the 2016 Minnesota Student Survey are compiled in the tables below. Table A includes selected health indicators comparing American Indian students with the total student population in Hennepin and Ramsey counties. The data show American Indian students had lower rates for seeing a dentist and higher rates for long-term physical and mental health problems, asthma, and obesity compared to the rates of other students in these two counties.

Table B includes selected health indicators for American Indian students across the state of Minnesota and compares American Indian students in Hennepin and Ramsey counties to the rest of the state. The data show that American Indian students living in Hennepin and Ramsey counties were more likely than American Indian students living elsewhere in the state to report having a disability/long-term physical health problem or having been told they have asthma.

Table A
Selected Health Indicators Comparing American Indian Students with the Total Student Population Hennepin and Ramsey Counties
Grades 5-8-9-11 Combined

	American Indian*	All Students
Percent who say a doctor or nurse for a check-up or physical exam in the last year	69.2%	70.9%
Percent who saw a dentist or dental hygienist for a regular check-up, teeth cleaning or other dental work in the last year	71.0%	80.4%
Percent who have physical disabilities or long-term health problems (that have lasted for six months or more)	24.5%	15.8%
Percent who have long-term mental health, behavioral or emotional problems (that have lasted for six months or more)**	27.4%	17.4%
Percent who have ever been told by a doctor or nurse that they have asthma	25.0%	17.2%
Percent obese, according to self-reported height and weight**	16.8%	8.8%
Percent overweight or obese, according to self-reported height and weight**	33.2%	21.9%

*Includes all students who checked "American Indian", including those who also checked one or more other races.
**Grades 8, 9 and 11 only.

Table B
Selected Health Indicators for American Indian Students
in Hennepin-Ramsey Counties and the Rest of the State
Grades 5-8-9-11 Combined

	American Indian*	
	Hennepin-Ramsey	**Rest of State**
Percent who say a doctor or nurse for a check-up or physical exam in the last year	69.2%	66.0%
Percent who saw a dentist or dental hygienist for a regular check-up, teeth cleaning or other dental work in the last year	71.0%	73.4%
Percent who have physical disabilities or long-term health problems (that have lasted for six months or more)	24.5%	20.6%
Percent who have long-term mental health, behavioral or emotional problems (that have lasted for six months or more)**	27.4%	30.1%
Percent who have ever been told by a doctor or nurse that they have asthma	25.0%	20.6%
Percent obese, according to self-reported height and weight**	16.8%	16.5%
Percent overweight or obese, according to self-reported height and weight**	33.2%	34.7%

*Includes all students who checked "American Indian", including those who also checked one or more other races.
**Grades 8, 9 and 11 only.

Under the federal trust responsibility doctrine, the federal government is responsible for the health care of American Indians and Alaskan Natives, regardless of whether they complete a Medicaid application. Therefore, providers serving this population face a unique challenge when trying to ensure their services do not go uncompensated.

Through this demonstration, the State seeks to test opportunities to address this issue as well as stabilize and support a vital provider that provides culturally appropriate care to the American Indian community in the Twin Cities.

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.

By providing an expedited application process for MA and targeting additional funding to the IHB to support care coordination and application assistance efforts, the health outcomes of the American Indian and Alaska Native (AI/AN) population served by the IHB will improve. Please refer to ***Attachment D*** for the preliminary evaluation plan that includes research hypothesis and evaluation parameters related to each of the demonstration's proposed goals.

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

This demonstration will operate in the Twin Cities metropolitan area with one health care provider participating—the IHB. Approximately 80 percent of people served at the IHB are residents of Minneapolis, with 12 percent living in St. Paul.

5) Include the proposed timeframe for the Demonstration.

Minnesota intends to implement this waiver under section 1115 of the Social Security Act for a five-year period.

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.

An expedited application process will be used in determining MA eligibility for uninsured American Indians and Alaskan Natives (hereinafter "AI/AN people") participating in the demonstration. Please see response to Section II, item 6 below.

Section II – Demonstration Eligibility

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

Eligibility Chart
Mandatory State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Standard
Children age 2-19; and infants under age two	1902(a)(10)(A)(i)(III), (IV), (VE and (VII) 42 CFR 435.118	at or below 275% FPL at or below 283% FPL
Pregnant Women	1902(a)(10)(A)(i)(III) & (IV) 42 CFR 435.116	at or below 278% FPL
Parents and Caretakers	1902(a)(10)(A)(i)(I) and 1931 42 CFR 435.110	at or below 133% FPL
Adults without Children	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	at or below 133% FPL

Eligibility Chart
Optional State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Standard
19-and 20-Year Olds	1902(a)(10)(A)(ii)	At or below 133% FPL

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.**

This population is a MA-eligible population and will experience no changes in eligibility. The State intends to use the converted standards and methodologies for Modified Adjusted Gross Income (MAGI) as established under the Affordable Care Act (ACA) to determine MA eligibility for demonstration participants.

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

N/A

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 MA.

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).

Expedited Application Process
Under the demonstration, AI/AN people who apply for MA at the IHB will have the option of using an expedited application process for obtaining a determination of MA eligibility. Under the expedited application process, the IHB will assist applicants in completing the application for MAGI-based eligibility, using information attested to by the person. The IHB will forward the screening recommendation to DHS, which will approve or deny eligibility. An applicant who meets the basic eligibility criteria will have his or her eligibility determined based on attestations and be enrolled in MA. Verification within six months of the initial eligibility determination is required in order to continue to receive coverage through the MA program.

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.

N/A

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

N/A

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)

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.

As previously described under Section I, the IHB's history with and participation in the State's delivery reform efforts through the IHP program allows for a unique opportunity to evaluate the impact of this demonstration on improving access to coverage and quality care for AI/AN people.

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

_X__ Managed care
__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)

People who are determined eligible through the expedited application process will be enrolled into the State's fee-for-service system for up to six months of coverage under this demonstration. Verification within six months of the initial eligibility determination is required in order to continue to receive coverage through MA. Once DHS completes the eligibility verification process, the person will be enrolled into managed care per the State's existing waiver authority under the Minnesota Senior Care Plus (MSC+) §1915(b) Waiver, control number MN-02.R041915(b), which allows the state to mandatorily enroll American Indians who do not live on a reservation into managed care. The MSC+ waiver has been approved for the period July 1, 2016 through June 30, 2021.

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.

See above. Under the authority of the Minnesota Senior Care Plus (MSC+) §1915(b) Waiver, AI/AN individuals who do not live on a reservation are mandatorily enrolled in managed care. The MSC+ waiver has been approved for the period July 1, 2016 through June 30, 2021.

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?

Mandatory enrollment for the AI/AN population. See above for the state's authority to mandatorily enroll this population.

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

Statewide under the state's existing MSC+ 1915(b) waiver authority.

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

N/A

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

All MA recipients who are potential enrollees in a managed care organization (MCO) are notified of the requirements and their options for enrolling in a MCO, including a deadline for enrollment. The deadline is no less than 30 days from the date the educational materials are mailed to the recipient. 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 provide information to MA recipients about their MCO. All recipients required to enroll in an MCO are encouraged to choose an MCO. If the recipient does not make a choice, the Department of Human Services assigns them to an MCO. When a recipient has either chosen or been assigned to an MCO, an enrollment notice is mailed to the recipient.

After enrollment, there are opportunities and options for changing enrollment between MCOs. Recipients may change health plans under the following circumstances:

- The enrollee may change MCOs because of problems with access, service delivery, or other good cause.

- The enrollee may change MCOs without cause within ninety (90) days following the initial enrollment. For counties in which the MCO is the only choice, the enrollee cannot disenroll but may change primary care providers.

- The enrollee elects to change MCOs once during the first year of initial enrollment in the MCO or during the first sixty (60) days after a change in enrollment from an MCO that no longer participates in MA.

- The enrollee elects to change MCOs due to substantial travel time or because their assignment to that MCO was erroneous.

- The enrollee elects to change MCOs during the Annual Health Plan Selection (AHPS) period.

- The enrollee elects to change MCOs within 120 days after receiving notice from the MCO of a material modification in the MCO's Provider Network.

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

The Department of Human Services periodically issues procurements that are fair and open competitive processes for managed care services. Minnesota law places a five-year limitation on the procurement of grant contracts, which includes 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.

This proposal will include all covered services in the MA program, to the extent they are provided by the IHB.

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.

This proposal will included all covered services in the MA program, to the extent they are provided by the IHB.

___ 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.

AI/AN individuals who are determined eligible through the expedited application process will be enrolled in the fee-for-service system for up to six months of coverage under this demonstration. For services provided to AI/AN individuals who are eligible for this demonstration, the State is deviating from the payment rates in the state plan. The IHB is a federally qualified health center, and will continue to receive the payment rate as a FQHC for people who are not eligible for the demonstration (i.e. non-AI/AN patients at the IHB). For people eligible for the demonstration (i.e. AI/AN individuals who are eligible for MA), the State proposes to reimburse the IHB at the rates listed in the state plan for the Indian Health Service and tribal facilities (i.e. 638 providers). The State also proposes that such payments made to the IHB under this demonstration be eligible for the 100 percent federal financial participation available under Section 1905(b) of the Social Security Act.

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.

After eligibility is verified, AI/AN individuals who are eligible for this demonstration will be enrolled in managed care per the State's current MSC+ §1915(b) waiver authority. Payments for services provided by the IHB to AI/AN enrollees will be paid at the IHS encounter rate. The State also proposes that such payments made to the IHB under this demonstration would be eligible for the 100 percent federal financial participation available under Section 1905(b) of the Social Security Act.

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.

N/A

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.

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

The expedited application process will include written notification of the denial or approval of temporary MA 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 under this demonstration in the same manner as it has for many years. 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. Procurement is conducted for each region of the state at least once every five years.

Section VI – Demonstration Financing and Budget Neutrality

1) <u>Budget Neutrality</u>

Federal Trust Responsibility
Under section 1905(b) of the Social Security Act (SSA), the federal government is required to match state expenditures at 100 percent for covered services received by American Indians and Alaskan Natives through an IHS facility whether operated by the IHS or by a Tribe or Tribal organization, as defined in section 4 of the Indian Health Care Improvement Act. These facilities are also eligible for the IHS encounter rate for payment of approved services.

Furthermore, under the federal trust responsibility doctrine, the federal government has a special obligation or duty when interacting with tribes and American Indians and Alaskan Natives. In the language of the law, where section 1905(b) of the SSA originated, Congress reaffirmed this duty by declaring that "it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and <u>*urban*</u> Indians and to provide <u>*all resources necessary*</u> to effect that policy." 25 U.S.C. Sec. 1602 (emphasis added).

The State applies both of these authorities in its rationale for the budget neutrality proposal of this demonstration. This means that the State assumes that the federal government's responsibility to finance the health care of American Indians and its Medicaid expenditures for the waiver population (i.e. AI/AN Medicaid-eligible individuals receiving covered services at the IHB) would be the same in both the with- and without-waiver scenarios.

For example, during the time period of this demonstration, the AI/AN individuals who make up the waiver population are not limited to receiving Medicaid-eligible services only from the IHB. They could also receive care and services, at any time, from the IHS or a Tribal provider. In such cases, the federal government would be responsible under the federal trust doctrine and requirements of section 1905(b) to pay all of the costs (i.e. 100% FMAP) for Medicaid-eligible services at the approved rates.

Therefore, under the proposed demonstration, the with-waiver and without-waiver cost projections for Medicaid-eligible AI/ANs, who receive services at the IHB, assume the same reimbursement and percentage rate that would be available to IHS facilities or tribal organizations for this population. Under this premise, the proposed demonstration will not cost the federal government more than what would have otherwise been spent absent the demonstration.

The State acknowledges that CMS has taken steps to support the health care system for American Indians through its recent guidance, released on February 26, 2016. (State Health Official letter #16-002.) In this guidance, CMS clearly uses its responsibility under the federal trust doctrine to expand its reading of section 1905(b) to include non-IHS providers serving AI/AN populations. While this new interpretation is more favorable for American Indian providers, like the IHB, it fails to recognize the unique role that many urban providers play in serving American Indians who do not receive care primarily through a Tribe or the IHS.

Unfortunately, to benefit under the new referral arrangement outlined in CMS' guidance, the IHB would have to remove itself from its role as the primary care provider for its AI/AN patients and allow the IHS or a Tribe to serve in that role and take on responsibility for the IHB's patients. Even if the IHB were to change its practice model, it would not benefit unless the IHS or the Tribe agrees to do the billing and subsequently pay the IHB the full IHS encounter rate it receives from the referral arrangement for covered services.

Through this waiver, the State is seeking to demonstrate a more feasible alternative in the spirit of the federal trust responsibility that recognizes the unique, and historically underfunded, role that providers like the IHB play in the health care system for American Indian people. Budget neutrality is accomplished in this demonstration because the State assumes that the expected expenditures by CMS for the waiver population in Minnesota reflect the financial responsibility that the federal government has to this population under the federal trust doctrine.

Expedited Application Process

Under the proposed demonstration, DHS will use an abbreviated application process for determining Medicaid eligibility for uninsured AI/ANs applicants. Through this process, AI/AN applicants would be enrolled in Medicaid on a temporary-basis (i.e. 6 months). Enrollees would

then need to complete a full application for Medicaid eligibility to maintain such coverage after the 6-month period.

It is expected that American Indians and Alaskan Natives affected under the demonstration would otherwise be eligible for Minnesota's Medicaid Program, Medical Assistance. Therefore, the demonstration will not cost the federal government more than what would have otherwise been spent absent the demonstration.

Please refer to the IHB Waiver Budget Neutrality Spreadsheet at ***Attachment A*** for additional information regarding the basis of the calculations and trend rates.

Section VII – List of Proposed Waivers and Expenditure Authorities

Statewideness & Uniformity **Section 1902(a)(1) of the Act as implemented by 42 CFR 431.50**

To the extent necessary to permit the State to operate the demonstration on a less than statewide-basis to the geographic area served by the IHB and to limit the participants eligible for the expedited application and payment methodology applied under this demonstration to American Indian and Alaska Native people served by a dually certified federally qualified health center and urban Indian health organization.

Eligibility Determinations **42 CFR §§435.911, 435.948, 435.949, 435.952**

To the extent necessary to permit the State to use an abbreviated or expedited application process for determining Medicaid eligibility that utilizes an initial self-attestation of eligibility factors for up to six months for people participating in the demonstration and to limit the use of this special application process to eligibility categories that use a MAGI income standard.

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Social Security 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 waiver.

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

Expenditures, which are not otherwise included as expenditures under Section 1903, for services to American Indian and Alaska Native people at dually-certified urban Indian organizations under Title V of the Indian Health Care Improvement Act at the same FMAP percentage and reimbursement rate available to Indian Health Service facilities or tribal organizations under section 1905(b) of the Social Security Act.

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 IHB waiver request was published in the Minnesota State Register on December 12, 2016. This notice announced a 30-day comment period from December 12, 2016 to January 10, 2016 on the IHB waiver request. The notice

informed the public on how to access an electronic copy or request a hard copy of the waiver. 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 IHB waiver web page for complete information on the waiver request including the public notice process, the public input process, planned hearings and a copy of waiver application. The IHB waiver request was posted on the DHS public web site on December 14, 2016. Therefore, a second notice was published in the Minnesota State Register on December 19, 2016, announcing that the comment period had been extended through January 13, 2016. The comment period was extended to ensure that a 30-day comment period was provided prior to the submission of the waiver request to CMS.

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 IHB Waiver Web Page provides the public with information about this waiver request. The web site is updated on a regular basis and includes information about the public notice process, opportunities for public input, planned hearings and a copy of the waiver application. After the comment period, this page will be updated to alert web visitors of the upcoming federal comment period on the IHB waiver 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 web page for this waiver.

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 primary DHS location at 450 Cedar Street in St. Paul on December 15, 2016. Public testimony was not given at this hearing. There were three members of the public in attendance. The second public hearing was held at a second DHS location at 444 Lafayette Road in St. Paul on December 19, 2016. 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 to notify the public. On December 14, 2016, an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the State's intent to submit this waiver request and directing them to the web page for this waiver. 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 request is expected soon.

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

DHS received two written comments from stakeholders regarding the proposed IHB waiver during the 30-day public comment period. Copies of the comments received and DHS' response are included at ***Attachment C***.

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

Please see ***Attachment C*** for DHS' response to the letter dated December 21, 2016.

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. 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.

On October 24, 2016, DHS held a conference call to update Tribal Health Directors on the proposed IHB waiver request and to provide an opportunity for comments and questions regarding the proposed demonstration.

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 officials of the tribal governments, tribal health directors, tribal social services directors, and the DHS tribal liaison. State agency staff attend as necessary depending on the topics covered at each meeting. The DHS tribal liaison attends all 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. DHS policy staff provided an overview of the IHB waiver at the Tribal Health Directors meeting on November 17, 2016. Opportunity for discussion and comments was provided.

On December 14, 2016, 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 the IHB waiver request. The letter also informed Tribes of the public input process and provided a link to the IHB waiver web page. Please refer to ***Attachment B*** for a copy of the December 14, 2016 letter.

The State's intent to submit this waiver request will also be included in a summary of federal waiver activity provided to Tribal Chairs and Tribal Health Directors at the November 17, 2016 Tribal Health Work Group meeting.

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

N/A

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

Stacie Weeks, Federal Relations
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

(651) 431-2151
Stacie.weeks@state.mn.us

Indian Health Board **Attachment A**

Cash-Basis Paid Claims

Actual Data

The definition of "claim month" is the same as "recipient month," that is, a service month for which a recipient has a paid claim.

Calendar Year	Half	Quarter	Amount Paid Total	Distinct Recipients	Claim Months	Distinct Claims	Payment Per Claim Month	Payment Per Claim
2011			$1,060,320.82	1,476	3,597	5,793.00	$294.78	$183.03
2012			$1,074,046.37	1,563	3,807	5,935.00	$282.12	$180.97
2013			$1,169,847.67	1,550	3,964	6,446.00	$295.12	$181.48
2014			$1,250,481.27	1,582	4,324	6,935.00	$289.20	$180.31
2015			$1,209,729.17	1,455	3,946	6,552.00	$306.57	$184.64
2016	1st		$621,272.59	957	1,901	3,238.00	$326.81	$191.87
2011-2014 Trend				2.34%	6.33%		-0.64%	
Trend applied in base projection				2.34%	6.33%		2.00%	

Base Projection Trending from 2014 Actual Distinct Recipients and Claim Months and Trending Payment per Claim Month by 2.0%

Distinct recipients are trended forward based on 2011 to 2014 trend, and starting from 2014, rather than 2015, because the reasons for the decreases in 2015 are not well understood. Because these projections are for a single clinic, and substantial year-to-year variance is possible, we rely on the consistent trends from 2011 to 2014.

The 2% trend in payment per claim months allows for routine increases in FQHC encounter rates. The actual average claim for the first half of 2016 is used for the 2016 projection. The 2% trend is applied beginning in 2017.

Calendar Year			Amount Paid Total	Distinct Recipients	Claim Months	Avg. Claim Months per Recipient	Payment Per Claim Month
2016			$1,597,653.49	1,657	4,889	2.95	$326.81
2017			$1,732,731.14	1,696	5,198	3.07	$333.35
2018			$1,879,229.27	1,735	5,527	3.19	$340.02
2019			$2,038,113.46	1,776	5,877	3.31	$346.82
2020			$2,210,430.90	1,817	6,249	3.44	$353.75
2021			$2,397,317.37	1,860	6,644	3.57	$360.83

Assume Higher IHS Encounter Rate Beginning in 2017, Trending Payment per Claim Month by 4.6%

The IHS encounter rate for 2016 is $368, 84% higher than Minnesota's FQHC encounter rate, so the $333.35 average payment for 2017 from above is increased by 84% (to $613.36) in the table which follows. For 2018 and later a 4.6% average trend is applied, based on the trend in IHS rates from 2011 to 2016 ($294 to $368).

Calendar Year			Amount Paid Total	Distinct Recipients	Claim Months	Avg. Claim Months per Recipient	Payment Per Claim Month
2016			$1,597,653.49	1,657	4,889	2.95	$326.81
2017			$3,188,225.30	1,696	5,198	3.07	$613.36
2018			$3,545,921.40	1,735	5,527	3.19	$641.58
2019			$3,943,748.44	1,776	5,877	3.31	$671.09
2020			$4,386,208.83	1,817	6,249	3.44	$701.96
2021			$4,878,310.12	1,860	6,644	3.57	$734.25

Represent Coverage of Uninsured by Adding 700 Distinct Recipients, Otherwise Uninsured

Based on the number of uninsured American Indians served by the clinic, we assume that outreach efforts with add 700 distinct recipients in 2017, and that this number will grow at the same rate as the Base Projection of distinct recipients. This added previously uninsured group is assume to have twice as many claim months per distinct recipient as in the Base Projection.

Calendar Year			Amount Paid Total	Distinct Recipients	Claim Months	Avg. Claim Months per Recipient	Payment Per Claim Month
2016							
2017			$2,632,391.25	700	4,292	6.13	$613.36
2018			$2,927,726.74	716	4,563	6.37	$641.58
2019			$3,256,196.76	733	4,852	6.62	$671.09
2020			$3,621,518.77	750	5,159	6.88	$701.96
2021			$4,027,827.29	768	5,486	7.14	$734.25

Base Projection Plus IHS Encounter Rate, Plus Addition for Uninsured

This sums the Base Projection with the higher IHS encounter rate and the added uninsured group, calculating composite average claim months.

Calendar Year			Amount Paid Total	Distinct Recipients	Claim Months	Avg. Claim Months per Recipient	Payment Per Claim Month
2016			$1,597,653.49	1,657	4,889	2.95	$326.81
2017			$5,820,616.55	2,396	9,490	3.96	$613.36
2018			$6,473,648.14	2,452	10,090	4.12	$641.58
2019			$7,199,945.20	2,509	10,729	4.28	$671.09
2020			$8,007,727.60	2,568	11,408	4.44	$701.96
2021			$8,906,137.41	2,628	12,130	4.62	$734.25

Minnesota Department of **Human Services**

December 14, 2016

Re: Indian Health Board of Minneapolis Section 1115 Waiver Request

Dear Tribal Leader:

The Minnesota Department of Human Services (DHS) is announcing a 30-day comment period on the Indian Health Board of Minneapolis, section 1115 Medicaid waiver request.

The 2016 Minnesota State Legislature directed DHS to seek federal waiver authority to allow tribal organizations dually certified as Urban Indian Health Programs and Federally Qualified Health organizations to receive the Indian Health Services encounter rate for Medicaid services provided to American Indian and Alaskan Native populations, and for the state to be eligible for 100 percent federal financial participation for such services. See Minn. Stat. § 256B.0625, specifically subdivisions 30 and 34.

DHS plans to submit this waiver request in January of 2017. Currently, the Indian Health Board of Minneapolis (IHB) would be the only entity eligible under this waiver authority, if approved by the Centers for Medicare and Medicaid Services (CMS). As a demonstration project under section 1115 of the Social Security Act, DHS plans to test an alternative approach to accessing coverage and quality care for urban American Indians served by the IHB. This approach includes the use of an abbreviated application process for American Indians eligible for Medicaid and targeting additional funding for the IHB into enhanced care coordination and application assistance for this population.

A copy of the IHB waiver request and information on the public input process is available at IHB Waiver Web Page.

Questions or comments regarding this notification or the waiver renewal are welcome at any time within the next 30 days and should be submitted to Stacie Weeks, DHS Health Care Federal Relations. I can be reached by telephone at (651) 431-2151, in writing at PO Box 64983, St Paul, MN 55164-0967 or via email at Stacie.Weeks@state.mn.us. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529.

Sincerely,

[redacted]

Stacie Weeks
Federal Relations
Minnesota Department of Human Services

Fond du Lac Band of Lake Superior Chippewa

Reservation Business Committee

1720 Big Lake Rd.
Cloquet, MN 55720
Phone (218) 879-4593
Fax (218) 879-4146

December 21, 2016

Stacie Weeks
Federal Relations
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Ms. Weeks:

Thank you for your letter of December 14, 2016, requesting comment on the 1115 Medicaid waiver request regarding the Indian Health Board of Minneapolis. I also appreciate your invitation to participate in earlier telephone conversations about this topic and the presentation you made to the tribal health directors at their November 17th, meeting. Elected tribal officials are gratified to be included in important policy discussions as issues emerge so that they have time to shape their thoughts and concerns.

As you know, Fond du Lac has been supportive of bringing more health and social services to urban American Indians and has provided direct services to AI residents in Duluth, MN, since 1984 and Minneapolis, since 2007. We applaud your effort to assist the Indian Health Board of Minneapolis to increase access to quality care for their American Indian patients through the use of an abbreviated application process for American Indians eligible for Medicaid.

The conditions for the 100% FMAP in the MOA between IHS and CMS were originally based on the designation of a particular facility as federal. There are important reasons why the facilities of Indian organizations have never been placed on the "A2" list provided to states. Although we do not believe that the IHB meets the standards of being called a "tribal organization", we believe that it will be in the best interest of American Indian residents of Minneapolis for the IHB to be paid at the encounter rate and that the State of Minnesota become eligible for 100% FMAP for the services provided to American Indians. We could support this more vigorously if there were some assurance that the financial benefits that come from this rate fall to American Indian patients of the IHB and not to the non-Indian patients. In the past, the IHS has insisted on the strict

segregation of resources when beneficiaries of care are not all eligible according to IHS regulations. Tribal pharmacies that serve non-Indians, for example, must keep separate formularies, inventories, and budgets so resources intended for American Indians are actually received by American Indians. Perhaps this could be one of the issues this demonstration project might work out.

The MOA calls for CMS and the states to provide technical assistance to tribes and tribal organizations so that "IHS-owned or leased or tribally owned facilities" can receive the encounter rate and the state can receive 100% FMAP. Minnesota DHS decision-makers may wish to explore how they may more aggressively assist with the development of tribally operated facilities within the metro areas in cooperation with American Indian organizations and non-profits that serve mostly American Indian patients. We believe there are enormous opportunities with this approach to service delivery.

Thank you for this opportunity to respond to this exciting new policy initiative. We appreciate the State's willingness to identify and explore ways to improve access to health care for American Indian residents.

Sincerely,

[redacted]

Kevin R. Dupuis Sr., Chairman
Fond du Lac Band of Lake Superior Chippewa

DEPARTMENT OF HUMAN SERVICES

January 11, 2017

Kevin R. Dupuis Sr. Chairman
Fond du Lac Band of Lake Superior Chippewa
1720 Big Lake Rd.
Cloquet, MN 55720

Dear Chairman Dupuis,

Thank you for your correspondence dated December 21, 2016 in response to the state's request for comments on the section 1115 waiver request for the Indian Health Board of Minneapolis.

If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver will allow the state to test innovative ways for increasing enrollment of American Indian people into Medical Assistance and for improving health outcomes for this population through the use of innovative models of care at the Indian Health Board of Minneapolis.

Thank you for your expressed support for the goals of this demonstration. We also appreciate your feedback about the need to assure additional resources are segregated because all of the patients served by the Indian Health Board are not American Indians. In accordance with Minnesota Statutes, section 256B.0625, subdivision 34, the application provides that the additional increase in payment rate made available under this waiver will be applied to services received by American Indians at the Indian Health Board of Minneapolis. All other patients served will receive the current payment rate that the Indian Health Board receives as a federally qualified health center.

I hope this information addresses any concerns regarding how the increased funds will be applied under this waiver. If you have further questions regarding this or any other component of this waiver, please feel free to contact me at (651) 431-2151.

We look forward to working with the Fond du Lac Tribe and other tribes and tribal organizations in developing and implementing policies that will improve the health care of American Indian people in Minnesota.

Sincerely,

[redacted]

Stacie Weeks

Minnesota Association of
COMMUNITY HEALTH CENTERS
www.mnachc.org
1113 E. Franklin Avenue, Suite 202 | Minneapolis, MN 55404 | 612.253.4715 | Fax 612.872.7849

January 9, 2017

Marie Zimmerman
Medicaid Director
MN Department of Human Services
P.O. Box 64983
Saint Paul, MN 55164-0983

Submitted via dhs.waiver.comments@state.mn.us

Dear Ms. Zimmerman:

The purpose of this correspondence is to convey the Minnesota Association of Community Health Centers' (MNACHC) support for the proposed Indian Health Board of Minneapolis Section 1115 Waiver.

MNACHC is the state-based membership organization for Federally Qualified Health Centers (FQHCs). Minnesota's 17 FQHCs play a vital role in Minnesota's health care system, serving as a health care home for nearly 175,000 low-income Minnesotans at over 70 delivery sites. In 2015, FQHCs served over 83,000 Medical Assistance (MA) and MinnesotaCare enrollees – roughly 48% of FQHC total patients.

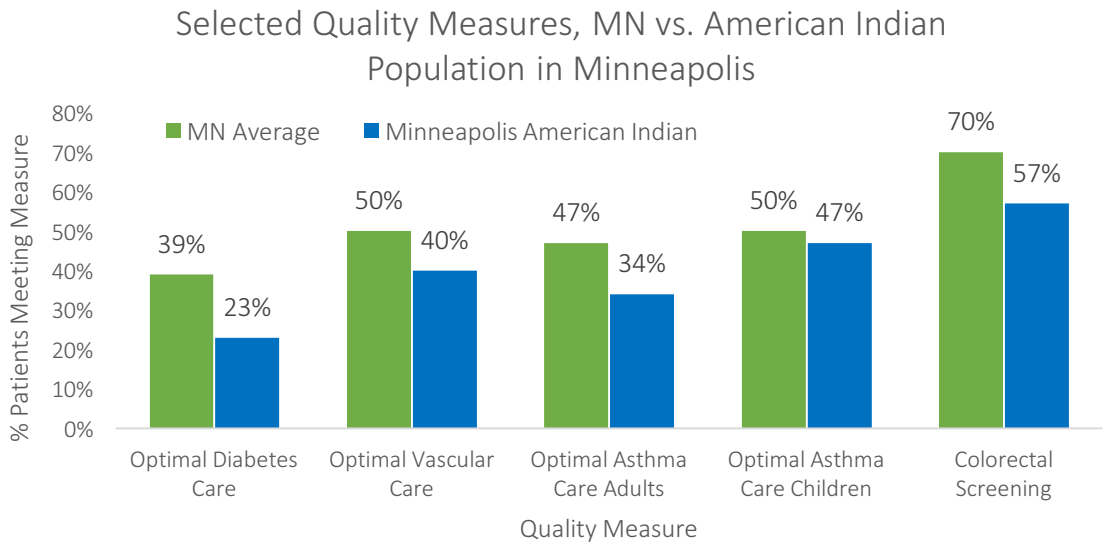
The Indian Health Board (IHB) of Minneapolis is a member of MNACHC. In 2015, IHB served roughly 5,000 individuals – 46% of which are American Indian. Moreover, 29% of IHB's patients were uninsured in 2015 – over six times the statewide uninsured rate of 4.3%.

MNACHC's support of your Department's 1115 waiver request is founded on two principles: 1] promoting health equity for American Indian populations; and 2] continuing the innovative Minnesota-specific MA reforms that improve quality of care to underserved populations.

Promoting Health Equity for American Indian Populations

Minnesota's 1115 waiver request provides extensive documentation of the health disparities American Indians in Minneapolis experience. When compared to Minnesota's general population, American Indians in Minnesota experience higher mortality rates, higher infant mortality rates, higher low-birthweight births and lower rates of prenatal care.

Additional Minnesota-specific data related to disparities experienced by American Indian populations in Minnesota supports the data in the waiver request:



Source: "2014 Health Equity of Care Report," MN Community Measurement

These disparities are a result of a myriad of factors ranging from the social determinants of health (e.g. poverty) along with the environmental factors that impact population heath. However, one large contributor to these disparities is the rate of uninsurance in the American Indian population. A recent report[1] from the Minnesota Department of Health cites the uninsurance rate of Minnesota's American Indian population at 8.7% - roughly double the state's overall 4.3% uninsurance rate in 2015.

Minnesota's 1115 waiver request will improve access to MA services for American Indian populations through an expedited application process and coverage. MNACHC strongly supports this request as it will support IHB's and the State of Minnesota's efforts to promote health equity.

Improve the Quality of Care for American Indian Populations

Starting in 2013, Minnesota began testing alternative health care delivery systems as part of the MA program. Through the use of accountable care organizations, 19 provider organizations are serving 225,000 MA enrollees through the Integrated Health Partnership (IHP) program. The program both saves taxpayer funds (approximately $75

[1] "Health Insurance Coverage in Minnesota: Results from the 2015 Minnesota Health Access Survey," February 29, 2016, Minnesota Department of Health, Health Economics Program
http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015brief.pdf

million to date) and improves the quality of care for enrollees by holding organizations accountable for certain quality measures.

The Indian Health Board of Minneapolis is part of one of the 19 organizations participating in Minnesota's IHP program. Along with nine other FQHCs in the Twin Cities, IHB is part of the FQHC Urban Health Care Network (FUHN). FUHN is one of the first six "charter" IHPs in Minnesota that began in 2013. Moreover, FUHN is the first "FQHC-only" Medical Assistance ACO in the United States and is currently one of two "FQHC-only" MA ACOs in existence. Now in its fourth year, FUHN has reduced state spending by nearly $17 million and reduced emergency department care for its attributed population by nearly 20%.

Part of FUHN's success is built upon robust care coordination informed by analysis of patient utilization data in the health care system. Minnesota's 1115 waiver request will provide resources to IHB to further invest in care coordination for newly insured American Indians. Given the track record of FUHN, MNACHC strongly supports supporting IHB's care coordination efforts to ensure American Indians receive services to improve their overall health.

Conclusion

MNACHC supports the Department of Human Services' Indian Health Board of Minneapolis Section 1115 Waiver Request as it will reduce the unfortunate disparities that American Indians in the Twin Cities experience. By coupling Medical Assistance coverage along with resources for robust care coordination, MNACHC believes that the 1115 waiver will improve the health of the American Indian population. Moreover, the waiver builds on the Indian Health Board's 45-year history in the Phillips neighborhood along with its recent innovation as part of the Department's IHP delivery system reform.

Lastly, thank you for you and your staff's efforts over the course of the recent months to submit this waiver request. We are grateful for your support of FQHCs and ultimately the 175,000 low-income patients that rely on them for their primary care needs. Please feel free to contact me a 612-253-4715, ext. 11, or at jonathan.watson@mnachc.org if you have any questions regarding the content of these comments or other inquiries related to FQHCs in Minnesota.

Respectfully submitted,

Jonathan Watson

Jonathan Watson
Associate Director | Director of Public Policy

Evaluation Plan

The table below presents an overview of a preliminary plan to evaluate the Indian Health Board of Minneapolis waiver. This evaluation plan is subject to change and will be further defined as the program is implemented. The measures identified in the table below will be tracked and compared across demonstration years to test each hypothesis.

Goal: Improve access to quality health care for individuals served by the Indian Health Board of Minneapolis, the majority of whom are American Indian people.

Hypothesis	Example measures (measure type)	Data sources
Application assistance and an abbreviated application process under the demonstration will maintain or increase the percent of American Indian people served by the Indian Health Board who enroll in Minnesota's Medical Assistance (MA) program.	Principal Third Party Medical Insurance Source Patients by race.	Bureau of Primary Health Care Uniform Data Systems Report
The demonstration will maintain or decrease uninsurance rates for American Indian people served by the Indian Health Board of Minneapolis.	Principal Third Party Medical Insurance Source Patients by race.	Bureau of Primary Health Care Uniform Data Systems Report

Goal: Improve health outcomes for American Indian people served by the Indian Health Board of Minneapolis

Hypothesis	Example measures (measure type)	Data sources
The demonstration will maintain or increase the use of preventive services.	Immunization Group ((IHS/GPRA)* • Influenza Immunization (6 mo -17 years) • Adult Immunizations (18+) • Childhood Immunizations • Pneumococcal Immunization (65+) Cancer Screening Group (IHS/GPRA): • Cancer Screening: Pap Smear Rates • Cancer Screening: Mammogram Rates • Colorectal Cancer Screening • Tobacco Cessation	For Immunization Group and Cancer Screening Group and Breastfeeding Rates - Clinical Reporting System (CRS) tool used by the Indian Health Service (IHS) to collect and report clinical performance to HHS.

Hypothesis	Example measures (measure type)	Data sources
	Other Clinical Group (IHS/GPRA): • Breastfeeding Rates MN Statewide Quality Reporting and Measurement System (SQRMS): • Adolescent Overweight Counseling	For SQRMS - Direct Data Submission to the Minnesota Community Measurement (MNCM)for the Statewide Quality Reporting and Measurement System (SQRMS)
The demonstration will maintain or improve health outcomes and optimal chronic disease management for at risk populations.	Diabetes Group (IHS/GPRA): • Diabetes Prevalence • Diabetes Glycemic Control • Diabetes: Blood Pressure • Statin therapy to Reduce Cardiovascular Disease Risk in Patient with Diabetes • Diabetes: Nephropathy Assessment Cardiovascular Disease Related Group (IHS/GPRA): • Childhood Wight Control MN Statewide Quality Reporting and Measurement System (SQRMS): • Optimal Diabetes Care composite (SQRMS) • Optimal Vascular Care composite (SQRMS) • Optimal Asthma Control Composite Child and Adult (SQRMS)	For Diabetes Group and Cardiovascular Disease Related Group measures - Clinical Reporting System (CRS) tool used by the Indian Health Service (IHS) to collect and report clinical performance to HHS. For SQRMS - Direct Data Submission to the Minnesota Community Measurement (MNCM)for the Statewide Quality Reporting and Measurement System (SQRMS)
The demonstration will maintain or increase access to behavioral health services.	Behavioral Health Group (IHS/GPRA): • Alcohol Screening • Intimate Partner (Domestic) Violence Screening • Depression Screening MN Statewide Quality Reporting and Measurement System (SQRMS): • Depression Remission at 6 Months • Adolescent Mental Health and Depression Screening	For Behavioral Health Group measures - Clinical Reporting System (CRS) tool used by the Indian Health Service (IHS) to collect and report clinical performance to HHS. Direct Data Submission to the Minnesota Community Measurement (MNCM)for the Statewide Quality Reporting and Measurement System (SQRMS)

Hypothesis	Example measures (measure type)	Data sources
The demonstration will maintain or improve patient satisfaction with care	MN Statewide Quality Reporting and Measurement System • CG-CAHPS**: Timely Appointments, Care and Information • CG-CAHPS: How Well Providers Communicate with Patients • CG-CAHPS: Helpful Respectful and Courteous Office Staff CG-CAHPS: Patient Rating or Provider as 9 or 10	Direct Data Submission to the Minnesota Community Measurement (MNCM)for the Statewide Quality Reporting and Measurement System (SQRMS)
* IHS and GPRA – Indian Health Service (IHS) and Government Performance and Results Act (GPRA) **CG-CAHPS – Clinician and Group Consumer Assessment of Healthcare Providers and Systems survey		