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

Demonstration Year 21
First Quarter Report
July 1, 2015 through September 30, 2015

Submitted to:

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

Submitted by:

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State of Minnesota
Department of Human Services

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Appendices

FORWARD

As required by the terms and conditions approving §1115(a) waiver No. 11 -W-00039/5, entitled "Minnesota Prepaid Medical Assistance Project Plus (PMAP+)," this document is submitted to the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services as the first quarter report for the period of July 1, 2015 through September 30, 2015. This document provides an update on the status of the implementation of the PMAP + Project.

1. Overview

The PMAP+ Section 1115 Waiver has been in place for the last 20 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care through Medicaid funding for people with income in excess of the standards in the Medical Assistance Program. On January 1, 2015, the MinnesotaCare Program converted to a Basic Health Plan (BHP), which is funded through payments related to the federal tax credit subsidies, and therefore the program no longer receives Medicaid funding.

However, the waiver continues to be necessary in order to continue certain elements of the Medical Assistance Program. On December 30, 2014 CMS granted a one-year extension of Minnesota's PMAP+ waiver for the period January 1, 2015 through December 31, 2015. The current waiver provides federal authority for the following:

- Medical Assistance for groups not included in Minnesota's Medicaid state plan; specifically, children ages 12 through 23 months with incomes above 275 percent and at or below 283 percent of the FPL, and parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18 year old who is not a full time secondary school student;
- Full Medical Assistance benefits for pregnant women during the period of presumptive eligibility;
- Mandatory enrollment into prepaid managed care of certain groups that are excluded from such under section 1932 of the Act; and
- Payments for graduate medical education through the MERC fund.

On June 30, 2015 DHS submitted a request to renew the PMAP+ waiver for the period January 1, 2016 through December 31, 2018.

2 PMAP+ Enrollment

Please refer to the table below for PMAP+ §1115 enrollment activity by demonstration eligibility group for the period July 2015 through September 2015.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter (September 30, 2015)	Current Enrollees	Disenrolled in Current Quarter (July 1, 2015 through September 30, 2015)
Population 1: MA One Year Olds with incomes above 275% FPL and at or below 283% FPL	48	58	20
Population 2: Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18 who is not a full time secondary school student	N/A	N/A	N/A

3 Purchasing and Service Delivery

3.1 PMAP Purchasing

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

- PMAP+ §1115 Waiver
- State Plan managed care under §1932(a)
- Mandatory managed care under a §1915(b) waiver for most people over age 65.
- Comprehensive, risk-based managed care, authorized under §1915(a) of the Social Security Act, for dually eligible Medicare and Medicaid recipients who voluntarily enroll with a managed care organization (MCO) for Medicare and Medicaid coverage. This purchasing model includes both acute and certain long term care services.
- Consolidated Chemical Dependency Treatment Fund §1915(b) waiver.
- §1915(c) waivers for people at risk of requiring institutional care.

The remaining MA recipients receive services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities; the rest are

excluded from managed care for other reasons. MCO contracts are in place covering all 87 Minnesota counties.

3.1.1 Mandatory Enrollment of Exempt Groups

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

In December of 2014, CMS notified DHS that it would need to transition its PMAP+ waiver authority, allowing the mandatory enrollment of certain groups in managed care, to a section 1915(b) waiver. Over the past 30 years, DHS has taken many steps to create a more coordinated and simplified eligibility and enrollment system for beneficiaries of Medical Assistance, the Children's Health Insurance Program (CHIP), and MNsure. DHS has determined that waiver authority is unnecessary for some of the groups listed under the current PMAP+ waiver. These groups are enrolled in managed care on a voluntary or an optional basis through the modernized eligibility and enrollment process for Medical Assistance. Therefore, in October of 2015, DHS plans to submit an amendment to the MSC+ 1915(b) waiver requesting continued waiver authority to require the following groups to enroll in managed care:

- American Indians, as defined in 25 U.S.C. 1603(c), who would not otherwise be mandatorily enrolled in managed care;

- Children under age 21 who are in state-subsidized foster care or other out-of-home placement; and

- Children under age 21 who are receiving foster care under Title IV-E.

3.1.2 Purchasing for American Indian Recipients

Tribal Health Work Group. The quarterly Tribal Health Work Group was formed to address the need for a regular forum for formal consultation between tribes and state employees. The work group meets on a quarterly basis and is regularly attended by Tribal Health Directors, Tribal Human Services Directors, and representatives from the Indian Health Service, the Minnesota Department of Health and the Minnesota Department of Human Services. The work group met in Prior Lake, Minnesota on August 27, 2015. A copy of the agenda is at Appendix A.

PMAP+ Out-of-Network Model. The Minnesota Legislature enacted a number of provisions, subsequently authorized by CMS, to address issues related to tribal sovereignty, that prevent Indian Health Service (IHS) facilities from entering into contracts with MCOs, and other provisions that have posed obstacles to enrolling American Indian MA recipients living on

reservations into PMAP. The legislation permits MA and MinnesotaCare to cover services provided to American Indian MCO enrollees by IHS and certain tribal providers (commonly referred to as "638s") whether or not those providers are in the MCO's network.

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

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

Summary Data. Following is summary information showing the number of people identified as American Indians who were enrolled in Medical Assistance during calendar year 2014.

Medical Assistance Enrollees who are American Indian Calendar Year 2014	
Families and Children	36,723
Disabled	5,247
Elderly	1,204
Adults with no Children	9,887
Total	53,061

3.2 Managed Care Contract Development and Management

The managed care contracts are structured into three model contracts: Families and Children, Minnesota Senior Health Options/ Minnesota Senior Care Plus (MSHO/MSC+), and Special Needs Basic Care (SNBC). The Families and Children contract covers persons eligible for MA under the age of 65 and all eligible persons in Minnesota Care (Minnesota's Basic Health Plan, approved December 15, 2014).

3.2.1 2015 Contracts

Negotiations for a 12-month contract (January 1, 2015 – December 31, 2015) for Families and Children began in September 2014 and resulted in agreements with eight MCOs: Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan d/b/a Hennepin Health, PrimeWest Health, South Country Health Alliance and UCare Minnesota. Final contracts, rate setting methodologies and actuarial certifications were submitted to the CMS Regional Office as required for CMS approval.

3.2.2 MCO Service Areas

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

3.2.3 Contract Management

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

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

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

3.2.4 MCO Meetings

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

3.2.5 Managed Care Contract Managers Meeting

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

3.3 Service Implementation

3.3.1 Development and Maintenance

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

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

3.3.2 PMAP Education and MCO Enrollment Activities

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

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

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

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

3.4 Application for Health Care Coverage

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

3.5 Advocacy and Ombudsman Activities

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

3.5.1 MCO Grievance and Appeal Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If the enrollee disagrees with the determination of the State resulting from the State fair hearing, the enrollee may seek judicial review in district court. Please refer to Appendix D for a summary of state fair hearings closed in the third quarter of calendar year 2015.

3.5.2 Notifications and Continuation of Services

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

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

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

An MCO DTR must include the following:

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

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

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

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

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

Timing of the DTR Notice:

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

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

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

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

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

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

Continuation of Benefits Pending Decision:

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

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

3.5.3 County Advocates

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

3.6 Managed Care Quality Improvement

3.6.1 Quality Improvement

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

3.6.2 Quality Strategy

The DHS Quality Strategy 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)
- Minnesota Care (Minnesota's Basic Health Plan)
- MSHO (Minnesota Senior Health Options)
- 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, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 CFR 438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) is the core of DHS' responsibility to ensure the delivery of quality care and services in publicly funded managed health care programs. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the Annual Technical Report (ATR).

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

3.6.3 MCO Internal Quality Improvement System

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

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

3.6.4 External Review Process

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

1) Determination of compliance with federal and state requirements,

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

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

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

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The annual survey results report is published annually and is available on DHS' public web page at Managed Care Reporting.

3.6.5 Consumer Satisfaction

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

3.7 PMAP+ Evaluation Activities

3.6.1 PMAP+ Evaluation Report 2011 through 2013

The PMAP+ evaluation for waiver period July 1, 2011 through December 31, 2013 utilizes a subset of HEDIS performance measures to compare, contrast and draw out differences between PMAP and MinnesotaCare populations compared to the national Medicaid rates. A final report of evaluation activities and findings for the PMAP+ waiver period July 1, 2011 through December 31, 2013 was submitted to CMS in December of 2014. A copy of the report is included at Appendix E.

3.6.2 PMAP+ Evaluation Plan 2014

The evaluation plan for the PMAP+ waiver period January 1, 2014 through December 31, 2014 was submitted to CMS in August of 2014. A copy of the evaluation plan is included at Appendix F. One goal of the waiver was to reduce the proportion of uninsured and provide high quality coverage for those who are participating in the MinnesotaCare Program. The evaluation will compare coverage levels under MinnesotaCare and coverage available under a qualified health plan purchased through MNsure.

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

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

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

3.6.3 PMAP+ Evaluation Plan 2015 to 2018

The evaluation plan for the PMAP+ waiver period January 1, 2015 through December 31, 2018 was submitted with Minnesota's PMAP+ waiver extension request in December of 2014. A copy of the evaluation plan is included at Appendix G.

Appendix A

Tribal Health Director's Meeting
SMSC – The Link Conference Center
2200 Trail of Dreams
Prior Lake, MN 55372

Thursday, August 27, 2015
10:00 AM to 3:00 PM

10:00 – 10:15 am
Welcome/Opening Prayer and Introductions

MDH Agenda Items:

10:15 – 10:45 am Opiates Update and Youth Suicide (MIAC Resolution)	Jon Roesler and Intern Nate
10:45 – 11:00 am Office of Emergency Preparedness Grants	Cindy Borgen
11:00-11:30 am Community Healing Models from Trauma and Adversity	Lonna Hunter
11:30 – Noon Moving Home MN – Tribal Initiative	Jeanne Nelson & John Anderson
Noon **Lunch Break**	

DHS Agenda Items:

12:30 – 1:00 p.m. Updated from MDH Executive Office	Dan Pollock, Deputy Commissioner
1:00 – 1:30 p.m. MN SEI-IDTA Pregnant A.I. Women Addicted to Opiates	Jackie Dionne and Don Moore
1:30 – 2:00 p.m. Mini-MN Indian Health Symposium II	Jackie Dionne & Planning Committee members
2:00 – 2:30 p.m. Medicaid Waiver Update State Plan Amendment Update	Jan Kooistra (DHS) Jan Kooistra (DHS)

Adjourn

Agenda items for next meeting

Remaining meeting dates 2015
November 19th

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 (Greater Than 133% FPG)

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%

Current Waiver MEGs

MA One-Year-Olds (Greater Than 275% FPG)

SFY	Member Mo	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
2010	263		255.05		62,004	5,073	67,077		
2011	513		356.76		177,735	5,284	183,020		39.88%
2012	378		239.48		80,702	9,822	90,524		-32.87%
2013	376		164.71		51,085	10,846	61,931		-31.22%
2014	700	182.64	182.64		122,132	5,715	127,847		10.88%
2015	889	182.64	168.03	162,388	142,141	7,259	149,401	12,988	-8.00%
2016	920	182.64	193.97	168,024	166,899	11,550	178,449	-10,425	15.44%
2017	926	182.64	195.86	169,123	167,943	13,422	181,365	-12,242	0.97%
2018	935	182.64	204.59	170,853	176,832	14,558	191,390	-20,537	4.46%
2019	472	182.64	228.09	86,273	92,756	14,989	107,745	-21,472	11.49%

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		4,051,963	255,203	4,307,107		-0.20%	Appendix B
2011	9,375		483.36		4,225,464	306,022	4,531,486		-3.73%	
2012	9,061	476.54	476.54		3,957,623	360,261	4,317,884		-1.41%	
2013	8,945	476.54	447.89		3,650,671	355,691	4,006,362		-6.01%	
2014	13,309	476.54	429.45		5,384,791	330,723	5,715,514		-4.12%	
2015	16,249	476.54	394.92	7,743,084	6,023,794	393,181	6,416,975	1,326,109	-8.04%	
2016	16,813	476.54	450.33	8,011,818	7,072,973	498,190	7,571,163	440,655	14.03%	
2017	16,923	476.54	454.19	8,064,224	7,117,248	568,812	7,686,060	378,164	0.86%	
2018	17,096	476.54	474.44	8,146,708	7,493,935	616,966	8,110,902	35,806	4.46%	
2019	8,633	476.54	528.94	4,113,697	3,930,898	635,202	4,566,100	-452,403	11.49%	

Annual ceiling less expenditures, all waiver groups

	MinnesotaCare Pregnant Women	MinnesotaCare Children	MinnesotaCare Caretaker Adults	MinnesotaCare Adults w/o Kids	MA 1-Year-Olds	MA Parents with Youngest Child 18-Years-Old	Total	Cumulative
1996	2,692,881	9,250,752			2,158,358		14,101,991	14,101,991
1997	2,832,636	10,201,710			2,050,449		15,084,795	29,186,786
1998	4,910,528	19,557,636			1,522,966		25,991,130	55,177,916
1999	755,546	10,011,142	-3,716,799		74,263		7,124,152	62,302,068
2000	738,261	3,933,620	-12,354,648		557,348		-7,125,419	55,176,649
2001	4,199,164	2,672,021	-18,714,932		843,571		-11,000,176	44,176,473
2002	8,144,885	-15,745,463	-28,010,530		595,744		-35,015,364	9,161,109
2003	-39	-1,758	-1,985		12		-3,770	9,157,339
2004	-90,686	2,155,155	-1,052,319		839,648		1,851,798	11,009,137
2005	-383,770	3,065,710	283,130		1,112,658		4,077,729	15,086,865
2006	-191,627	6,972,198	3,681,467		5,080		10,467,118	25,553,984
2007	480,707	8,158,083	7,503,999		-125,473		16,017,316	41,571,300
2008	824,967	-202,428	4,541,853		-486,802		4,677,590	46,248,890
2009	696,873	-18,114,128	3,216,530		-88,152		-14,288,879	31,960,012
2010	856,988	-17,905,857	9,207,123		919,073		-6,922,673	25,037,339
2011	3,178,437	6,777,516	42,634,429		2,916,096		55,506,477	80,543,816
2012	4,814,281	14,879,506	59,873,229	27,513,718	2,671,712		109,752,447	190,296,264
2013	2,547,552	7,885,440	31,455,297	3,539,904	5,991,058		51,419,252	241,715,515
2014	3,173,276	33,068,357	40,147,843	-23,782,395	6,583,868		59,190,950	300,906,465
2015	-576,070	-7,775,955	85,693,920	67,942,465	12,988	1,326,109	146,623,457	447,529,922
2016	0	-562,051	-15,703,841	-24,117,771	-10,425	440,655	-39,953,432	407,576,490
2017					-12,242	378,164	365,922	407,942,411
2018					-20,537	35,806	15,269	407,957,680
2019					-21,472	-452,403	-473,875	**407,483,805**
Sum	39,604,788	78,281,206	208,683,767	51,095,922	28,089,791	1,728,331	407,483,805	

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%

<= Bottom line cost neutrality

Total waiver expenditures, all waiver groups

	MinnesotaCare Pregnant Women	MinnesotaCare Children	MinnesotaCare Caretaker Adults	MinnesotaCare Adults w/o Kids	MA 1-Year-Olds	MA Parents with Youngest Child 18-Years-Old	Total	Federal Share
1996	2,255,164	36,975,285			1,304,893		40,535,342	21,897,192
1997	4,434,527	42,935,448			1,631,891		49,001,866	26,304,201
1998	6,382,066	40,923,510			1,632,486		48,938,062	25,697,376
1999	9,493,489	55,397,445	25,620,274		1,212,991		91,724,200	47,384,722
2000	11,932,002	68,468,394	58,670,873		1,330,612		140,401,882	72,292,929
2001	10,419,027	81,779,245	80,807,937		1,593,395		174,599,604	89,394,997
2002	8,873,703	115,443,524	63,562,150		1,898,065		189,777,441	95,420,098
2003	9,803,946	129,399,234	69,540,849		1,777,805		210,521,835	105,260,917
2004	11,953,746	140,988,649	79,342,154		4,450,252		236,734,800	118,367,400
2005	10,640,957	120,391,330	69,775,385		6,641,804		207,449,475	103,724,738
2006	10,946,574	125,561,626	71,777,975		9,166,974		217,453,150	108,726,575
2007	10,124,013	113,366,163	75,759,847		10,438,608		209,688,632	104,844,316
2008	8,387,671	112,878,122	58,177,047		12,007,220		191,450,061	95,725,030
2009	8,250,505	131,655,885	91,186,386		13,774,134		244,866,910	122,433,455
2010	8,467,437	136,782,241	164,031,834		14,992,188		324,273,701	162,136,850
2011	8,867,981	141,670,380	185,877,671		14,566,789		350,982,821	175,491,411
2012	8,448,671	146,477,270	188,416,966	221,541,108	16,056,815		580,940,830	290,470,415
2013	9,423,468	149,525,768	198,267,122	218,046,217	12,697,852		587,960,428	293,980,214
2014	6,308,967	106,294,757	208,878,607	291,462,488	127,847	5,715,514	618,788,180	309,394,090
2015	576,070	15,152,933	132,068,566	192,689,731	149,401	6,416,975	347,053,675	173,526,838
2016	0	562,051	15,703,841	24,117,771	178,449	7,571,163	48,133,275	24,066,637
2017					181,365	7,686,060	7,867,425	3,933,712
2018					191,390	8,110,902	8,302,292	4,151,146
2019					107,745	4,566,100	4,673,845	2,336,922
Sum	165,989,985	2,012,629,261	1,837,465,484	947,857,315	128,110,971	40,066,713	5,132,119,730	2,576,962,182

NOTES

1. Payments through December 2014 are actual data.
2. MA one-year olds--enrollment is actual through December 2014.
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. FY2019 reflects a six month waiver period: July-December 2018.
10. FY2019 expenditures reflect the State's obligation to pay back the HMO withhold collected during CY2018.

May 19, 2015

DHS-6696-ENG, Application for Health Coverage and Help Paying Costs (PDF)

State Fair Hearings Closed in Quarter 3 of 2015 by Metro and Non-Metro Areas

	Number of SFHs
Area	
Eleven County Metro Area	187
Non-Metro Area	64
Total	**251**

State Fair Hearings Closed in Quarter 3 of 2015 by Type, Service Category and Outcome

Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	State affirmed	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category						
Health Plan Change	2	1	.	5	1	**9**
Restricted Recipient	6	4	6	2	.	**18**
Total	**8**	**5**	**6**	**7**	**1**	**27**

Billing Type by Service Category and Outcome

Outcome	Dismissed	Health Plan prevailed	Resolved before hearing	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category				
Chemical Dependency	2	.	2	**4**
Chiropractic	.	.	1	**1**
DME-Medical Supplies	.	1	2	**3**
Dental	1	2	.	**3**
Hearing Services	.	.	1	**1**
Hospital	.	.	4	**4**
Pharmacy	2	.	.	**2**
Professional Medical Services	5	.	6	**11**
Therapies/Rehabilitation	.	.	1	**1**
Transportation	.	.	1	**1**
Total	**10**	**3**	**18**	**31**

Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved after hearing	Resolved before hearing	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category							
Chiropractic	1	.	.	.	.	1	**2**
DME-Medical Supplies	2	2	.	1	.	.	**5**
Dental	2	1	.	4	.	2	**9**
EW Services	1	1	.	5	2	3	**12**
Home Care	21	15	4	30	4	26	**100**

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

Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved after hearing	Resolved before hearing	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category							
Mental Health	.	.	.	3	.	.	**3**
Pharmacy	2	.	.	7	1	13	**23**
Professional Medical Services	5	1	.	10	.	7	**23**
Therapies/Rehabilitation	.	1	.	5	.	1	**7**
Transportation	2	.	.	1	.	1	**4**
Vision Services	1	.	.	1	.	1	**3**
Total	**37**	**21**	**4**	**67**	**7**	**55**	**191**

Access Type by Service Category and Outcome

Outcome	Health Plan prevailed	Resolved after hearing	Total
	Number of SFHs	Number of SFHs	Number of SFHs
Service Category			
Dental	.	1	**1**
Professional Medical Services	1	.	**1**
Total	**1**	**1**	**2**

Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved after hearing	Resolved before hearing	State affirmed	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category								
Chemical Dependency	2	.	.	.	.	2	.	**4**
Chiropractic	1	.	.	.	.	2	.	**3**
DME-Medical Supplies	2	2	.	2	.	2	.	**8**
Dental	3	1	.	6	1	2	.	**13**
EW Services	1	1	.	5	2	3	.	**12**
Health Plan Change	2	1	.	.	.	5	1	**9**
Hearing Services	.	.	.	.	.	1	.	**1**
Home Care	21	15	4	30	4	26	.	**100**
Hospital	.	.	.	.	.	4	.	**4**
Mental Health	.	.	.	3	.	.	.	**3**
Pharmacy	4	.	.	7	1	13	.	**25**
Professional Medical Services	10	1	.	11	.	13	.	**35**
Restricted Recipient	6	4	.	6	.	2	.	**18**
Therapies/Rehabilitation	.	1	.	5	.	2	.	**8**
Transportation	2	.	.	1	.	2	.	**5**
Vision Services	1	.	.	1	.	1	.	**3**
Total	**55**	**26**	**4**	**77**	**8**	**80**	**1**	**251**

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

Summary of SFHs Closed in Quarter 3 of 2015 by Outcome

	Number of SFHs
Outcome	
Dismissed	55
Enrollee prevailed	26
HP Partially Upheld/Member Partially Denied	4
Health Plan prevailed	77
Resolved after hearing	8
Resolved before hearing	80
State affirmed	1
Total	**251**

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

Attachment E

Minnesota Department of Human Services

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

Evaluation Report

Waiver Period July 1, 2011 through December 31, 2013

March 2015

Table of Contents

1. Evaluation Goals

This evaluation report relates to the demonstration period July 1, 2011 through December 31, 2013 for the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 waiver. The goal of the waiver is to provide comparable access and quality of health care to waiver populations as compared to Minnesota's other public health care program enrollees in managed care. Both preventive care and treatment of chronic conditions will be assessed. The objective of the evaluation is to demonstrate that access, quality of care and enrollee satisfaction is maintained and is comparable to care provided to Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.

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

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

- Objective: Provide coverage for expansion groups provided under this waiver so that access and quality of care for child and adult waiver populations are comparable to national Medicaid averages.
- Measurement: Access and quality will be evaluated using HEDIS adult, postpartum and child preventive care measures for PMAP+ waiver populations and for a national Medicaid sample.
- Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access and quality of care for child and adult waiver populations that is comparable to national Medicaid averages.
- Data Sources: MMIS claims data and national Medicaid NCQA Quality Compass data.

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

- Objective: Provide coverage for expansion groups provided under this waiver so that access and quality of care for child and adult waiver populations are comparable to access and quality for Minnesota Health Care Program recipients who are not enrolled under the demonstration.
- Measurement: Access and quality will be evaluated using HEDIS adult, postpartum and child measures for PMAP+ waiver populations and for Minnesota Medicaid enrollees.
- Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access and quality of care for child and adult waiver populations that is comparable to access and quality of care for Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.
- Data Sources: MMIS claims data

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

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

- Measurement: Compare Annual DHS CAHPS results for all MinnesotaCare and MA adults.
- Hypothesis: Satisfaction rates for Medicaid expansion groups under the PMAP+ waiver will be comparable to satisfaction rates for Minnesota Medicaid enrollees who are not enrolled under the PMAP+ waiver.
- Data Sources: Annual DHS CAHPS composite results for all MinnesotaCare and MA adults

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

- Objective: Provide coverage for expansion groups under this waiver so that access, quality of care and enrollee satisfaction is maintained over time and is comparable to access, quality of care, and enrollee satisfaction for non-waiver Medicaid enrollees.
- Measurement: Satisfaction, access and quality will be evaluated using CAHPS data (adults only) and HEDIS measures for adult, postpartum and child care measures for PMAP+ waiver populations and for Minnesota Medicaid enrollees.
- Hypothesis: Providing health care coverage to Medicaid expansion groups under the PMAP+ waiver will result in access, quality of care and enrollee satisfaction for waiver populations that is maintained over time and is comparable to access, quality of care and enrollee satisfaction for Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver.
- Data Sources: Annual DHS CAHPS results for all MinnesotaCare and MA adults and MMIS claims data

2. Evaluation Populations: Waiver (W) Compared to Medical Assistance (MA)

Evaluation populations consist of the following groups:

Waiver population subgroups:

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

Medical Assistance (MA) Comparison Groups:

- MA Children. Children under age 21 in MA with family incomes at or below 275 percent of the FPG.

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

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

3. Evaluation Overview

The selected HEDIS 2013 performance measures are compared between the waiver populations and other public program managed care enrollees. Performance measurement rates for the baseline period (CYs 2009 through 2010) have been calculated for the targeted populations and compared to the first three calendar years (CYs 2011, 2012 and 2013) of the waiver period. Performance measurement rates used for this comparative analysis are presented in a series of 26 tables at Appendix A: Waiver and MA Measurement Rate Tables. In addition, national benchmarks have been obtained from NCQA's Medicaid Quality Compass data to compare performance of Minnesota's waiver and other public program managed care population's performance measurement rates. Please refer to the table at Appendix B for an overview of the HEDIS National Medicaid Quality Compass 2014 benchmark rates used for this analysis.

Waiver Populations	MA Comparison Populations	Measures	Measurement Years
1. MinnesotaCare Children	MA Children	1. Childhood immunizations (2 yrs) 2a. Child access to PCP (12-24 mos) 2b. Child access to PCP (25 mos-6 yrs) 2c. Child access to PCP (7-11 yrs) 2d. Child access to PCP (12-19 yrs) 3a. Annual Dental Visit (2-3 yrs) 3b. Annual Dental Visit (4-6 yrs;) 3c. Annual Dental Visit (7-10 yrs) 3d. Annual Dental Visit (11-14 yrs) 3e. Annual Dental Visit 15-18 yrs) 4. Well-child visits: first 15 mos. 6+ visits 5. Well-child visits: 3-6 yrs 6. Adolescent Well-child visits (12-19 yrs) 7a. Asthma Medication Management (5-11 yrs) 7b. Asthma Medication Management (12-20 yrs) 8.a F/U After Hospitalization 7 days (6-20 yrs) 8.b F/U After Hospitalization 30 days (6-20 yrs)	CYs 2009 through 2013
2.MinnesotaCare Pregnant Women	MA Pregnant Women	9. Postpartum Care	CYs 2009 through 2013
3. MinnesotaCare Caretaker Adults	MA Adults	10a. Diabetes A1c Screening (21-64 yrs) 10b. Diabetes LDL Screening (21-64 yrs) 11a. Adult Access Preventive (21-44 yrs) 11b. Adult Access Preventive (45-64 yrs) 12. Annual Dental Visit (21-64 yrs) 13. Cervical Cancer Screening (21-64 yrs)	CYs 2009 through 2013

		14a. Asthma Medication Management (21-50 yrs) 14b. Asthma Medication Management (51-64 yrs) 15a. F/U Hospitalization 7 Days (21-64 yrs) 15b. F/U Hospitalization 30 Days (21-64 yrs) 16a. Initiation Alcohol Tx (21-64 yrs) 16b. Engagement Alcohol Tx (21-64 yrs)	
4. MinnesotaCare Adults w/o Children	MA Adults w/o Children	17a. Diabetes A1c Screening (21-64 yrs) 17b. Diabetes LDL Screening (21-64 yrs) 18a. Adult Access Preventive (21-44 yrs) 18b. Adult Access Preventive (45-64 yrs) 19. Annual Dental Visit (21-64 yrs) 20. Cervical Cancer Screening (21-64 yrs) 21a. Asthma Medication Management (21-50 yrs) 21b. Asthma Medication Management (51-64 yrs) 22a. F/U Hospitalization 7 Days (21-64 yrs) 22b. F/U Hospitalization 30 Days (21-64 yrs) 23a. Initiation Alcohol Tx (21-64 yrs) 23b. Engagement Alcohol Tx (21-64 yrs)	CYs 2009 through 2013
5. MA Children 12-24 Mos. 133 to 275 % FPG	MA Children 12-24 Mos. less than 133 %	24. Childhood immunizations (2 yrs) 25. Child access to PCP (12-24 mos) 26. Well-child visits: first 15 mos.	CYs 2009 through 2013

4. Waiver Compared to MA Analysis

4.1 MinnesotaCare Children (W) Compared to MA Children (MA)

HEDIS rates were calculated for each Waiver and MA population based on DHS encounter and enrollment data. Rates were compared for a difference of 5 percentage points to evaluate differences between Waiver and MA population performance, identify rate trends over a five year period, and compare to the HEDIS National Medicaid Quality Compass benchmark rates.

Summary Chart I: Waiver compared to MA Childhood Measurement Rates 1-8.

Measure	**W-MA Comparison** (<, >, ≈) [1]	**W Rate Trend** (≈,↑, ↓) [2]	**MA Rate Trend** (≈,↑, ↓) [2]	**CY 2013 W/QC Ave. Comparison** (≈,↑, ↓) [3]
1. Childhood immunizations (2 yrs)	W ≈ MA	≈	≈	↓
2a. Child access to PCP (12-24 mos)	W ≈ MA	≈	≈	≈
2b. Child access to PCP (25 mos-6 yrs)	W ≈ MA	≈	≈	≈
2c. Child access to PCP (7-11 yrs)	W ≈ MA	≈	≈	≈
2d. Child access to PCP (12-19 yrs)	W ≈ MA	≈	≈	≈
3a. Annual Dental Visit (2-3 yrs)	W ≈ MA	↑	≈	≈
3b. Annual Dental Visit (4-6 yrs;)	W > MA	↓	≈	↑
3c. Annual Dental Visit (7-10 yrs)	W > MA	↓	≈	↑
3d. Annual Dental Visit (11-14 yrs)	W > MA	↓	≈	↑
3e. Annual Dental Visit 15-18 yrs)	W > MA	↓	≈	↑

4. Well-child visits: first 15 mos. 6+ visits	W > MA	↑	≈	↑
5. Well-child visits: 3-6 yrs	W ≈ MA	≈	≈	↓
6. Adolescent Well-child visits (12-19 yrs)	W ≈ MA	≈	≈	NA[4]
7a. Asthma Medication Management (5-11 yrs)	W ≈ MA	≈	≈	↑
7b. Asthma Medication Management (12-20 yrs)	W ≈ MA	≈	≈	≈
8a. F/U After Hospitalization 7 Days (6-20 yrs)	W > MA	≈	≈	NA[4]
8b. F/U After Hospitalization 30 Days (6-20 yrs)	W > MA	≈	≈	NA[4]

1. < - W is less than MA by 5 percentage points; > - W is greater than MA by 5 percentage points; ≈ - W is approximately the same as MA rates.
2. ≈ - Rates have remained approximately the same over the measurement periods; ↑ - Rates have increased by at least 5 percentage points over the measurement periods; ↓ - Rates have decreased by at least 5 percentage points over the measurement periods.
3. ≈ - CY 2013 W rates are approximately the same as National Quality Compass average rate; ↑ - CY 2013 W rates are greater by at least 5 percentage points then National Quality Compass average rate; ↓ - CY 2013 W rates are at least 5 percentage points below National Quality Compass average rate. See Appendix C for the Medicaid National Quality Compass benchmark rates.
4. NA - For these two measures the Waiver and MA age groups are not consistent with national Medicaid benchmark age groupings.

Highlights of Summary Charts I: Waiver Compared to MA Childhood Measurement Rates 1-8.

- MinnesotaCare Children's waiver populations were within five percentage points of the MA population for ten out of the seventeen measures reviewed. The other seven measures show the Waiver population's rates were greater than the MA rates by 5 or more percentage points.
- Waiver population trends over the annual measurements for calendar years 2009 through 2013 remained stable for eleven of the seventeen measures. Of the remaining six measures, four measurement trends were downward by at least five percentage points while the remaining two measurements increased by more than five percentage points. All of the MA population measures remained relatively stable over the entire five year period.
- When calendar year 2013 measurement rates were compared to HEDIS National Medicaid Quality Compass benchmark rates; six measures were above the QC rates, and only two measures were below the national benchmark average rates.

4.2 MinnesotaCare Pregnant Women (W) Compared to MA Pregnant Women (MA)

Summary Chart II: Postpartum Care

Measure	**W-MA Comparison** (<, >, ≈)	**W Rate Trend** (≈,↑, ↓)	**MA Rate Trend** (≈,↑, ↓)	**CY 2013 W/QC Ave. Comparison** (≈,↑, ↓)
9. Postpartum Care	W > MA	↓	↓	↓

Highlights of Summary Chart II.

- The Waiver population postpartum care rates are higher than the comparison MA population (CY 2013- 43.9% vs 38.4%).
- Waiver and MA rates have trended downward over the past several years, and both population rates were below the National 2013 QC average rate of 61.29%.

4.3 MinnesotaCare Caretaker Adults (W) Compared to MA Adults (MA)

Summary Chart III: Adult Measures 10-16

Measure	W-MA Comparison (<, >, ≈)	W Rate Trend (≈,↑, ↓)	MA Rate Trend (≈,↑, ↓)	CY 2013 W/QC Ave. Comparison (≈,↑, ↓)
10a. Diabetes A1c Screening (21-64 yrs)	W > MA	≈	≈	NA[5]
10b. Diabetes LDL Screening (21-64 yrs)	W > MA	≈	↑	NA[5]
11a. Adult Access Preventive (21-44 yrs)	W ≈ MA	≈	≈	NA[5]
11b. Adult Access Preventive (45-64 yrs)	W ≈ MA	≈	≈	≈
12. Annual Dental Visit (21-64 yrs)	W > MA	↓	↓	NA[5]
13. Cervical Cancer Screening (21-64 yrs)	W ≈ MA	↓	≈	NA[5]
14a. Asthma Medication Management (21-50 yrs)	W > MA	≈	≈	NA[5]
14b. Asthma Medication Management (51-64 yrs)	W ≈ MA	↓	↑	↑
15a. F/U Hospitalization 7 Days (21-64 yrs)	W > MA	↓	≈	NA[5]
15b. F/U Hospitalization 30 Days (21-64 yrs)	W > MA	≈	≈	NA[5]
16a. **Initiation** /Engagement Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[5]
16.b Initiation /**Engagement** Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[5]

5. NA – QC Benchmark rates are for different age groups for these measures and are not appropriate comparisons.

Highlights of Summary Chart III.

- All eleven of the MinnesotaCare Caretaker Adults measures are similar or above the MA Adult rates.
- Most (7) of the eleven MinnesotaCare Caretaker Adult measures have remained stable over the past five years. While, almost all (10) of the MA trends have remained stable or increased over the measurement periods.
- Five of the MinnesotaCare Caretaker Adult measures are at least similar to, or greater than, the 2013 HEDIS National Medicaid Quality Compass average rates.

4.4 MinnesotaCare Adults without Children (W) Compared to MA Adults without Children (MA)

In contrast to the other waiver population comparisons only three years of data (CYs 2011 – 2013) is available due to DHS program changes.

Summary Chart IV: Adults w/o children Measures 17-20

Measure	W-MA Comparison (<, >, ≈)	W Rate Trend (≈,↑, ↓)	MA Rate Trend (≈,↑, ↓)	CY 2013 W/QC Ave. Comparison (≈,↑, ↓)
17a. Diabetes A1c Screening (21-64 yrs)	W ≈ MA	≈	≈	NA[6]
17b. Diabetes LDL Screening (21-64 yrs)	W ≈ MA	↑	≈	NA[6]
18a. Adult Access Preventive (21-44 yrs)	W ≈ MA	≈	≈	NA[6]
18b. Adult Access Preventive (45-64 yrs)	W ≈ MA	≈	≈	↑
19. Annual Dental Visit (21-64 yrs)	W ≈ MA	↓	↓	NA[6]
20. Cervical Cancer Screening (21-64 yrs)	W ≈ MA	≈	≈	↓
21a. Asthma Medication Management (21-50 yrs)	W > MA	≈		NA[6]
21b. Asthma Medication Management (51-64 yrs)	W ≈ MA	≈	≈	↑
22a. F/U Hospitalization 7 Days (21-64 yrs)	W > MA	≈	≈	NA[6]
22b. F/U Hospitalization 30 Days (21-64 yrs)	W > MA	≈	≈	NA[6]
23a. **Initiation**/Engagement Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[6]
23b. Initiation/**Engagement** Alcohol Tx (21-64 yrs)	W ≈ MA	≈	≈	NA[6]

6. NA – QC Benchmark rates are for different age groups for these measures and are not appropriate comparisons.

Highlights of Summary Chart IV.

- All of the MinnesotaCare Adults without children comparisons are similar to or greater then MA.
- The majority of measures for both the Waiver and MA populations are stable over the past three years.
- Four out of five Waiver population rates when compared to the QC rates were greater than the QC averages.

4.5 MA Children 12-24 Months with Income 133 to 275% FPG (W) Compared to MA Children 12-24 Months with Income and Less Than 133% FPG

Summary Chart V: 12-24 Month Old Measures 24-26

Measure	W-MA Comparison (<, >, ≈)	W Rate Trend (≈,↑, ↓)	MA Rate Trend (≈,↑, ↓)	CY 2013 W/QC Ave. Comparison (≈,↑, ↓)
24. Childhood immunizations (2 yrs) Combo 3	W > MA	↑	↑	NA[7]

25. Child access to PCP (12-24 mos)	W ≈ MA	≈	≈	≈
26. Well-child visits: first 15 mos. 6+ visits	W ≈ MA	↑	↑	↓

7. NA – QC Benchmark rate is for a different age group and is not an appropriate comparison.

Highlights of Summary Chart V.

- For all three 12-24 month measures, the waiver population is similar or greater than the comparison MA population.
- Trending patterns for the Waiver and MA populations are same over the past five years.
- Children's access measures are similar to the national Medicaid average rate while the first 15 months well-child measure is below.

5. Waiver and MA Stratification Analysis

Each of the 26 tables presented in Appendix C have been stratified by race and ethnicity for calendar years 2009 through 2013. A number of comparisons have not been done due to the small number of enrollees in MinnesotaCare Waiver or MA populations.

Waiver and MA populations were stratified by the following race and ethnicity subgroups. Race/ethnicity is a characteristic combined from two fields (Race and Ethnicity) and has the following six subgroups:

1. White
2. African American (Black)
3. American Indian, Alaskan Native, Native American (NA)
4. Asian or Pacific Islander (AS/PI)
5. Unknown
6. Hispanic (Hisp)

Assigning recipients to one of the six race/ethnicity subgroups:

- If a recipient identified him/herself by a single race, and did not identify as Hispanic, s/he was assigned to the appropriate one of the first 4 subgroups above.
- If a recipient identified him/herself as having more than one race, such as being White and Black, or Black and White, or Black and NA, and so on, and did not identify as Hispanic, s/he was assigned to Unknown.
- If the Recipient did not identify any race, and did not identify as being of Hispanic ethnicity, s/he was also assigned to Unknown.
- If the recipient identified him or herself as of Hispanic Ethnicity, s/he was assigned to the category Hispanic, no matter what race or combination of races, if any, s/he may also have identified.

Several stratification tables were not analyzed since there were dominators smaller than 30 eligible enrollees (indicated in the charts by "SD"). The following Charts have been removed from the text due to the small dominators across all subgroups:

Summary Chart 7a-S: Asthma Medication Management (5-11 yrs.)

Summary Chart 7b-S: Asthma Medication Management (12-20 yrs.)
Summary Chart 8a-S: F/U After Hospitalization 7 Days (6-20 yrs.).
Summary Chart 8b-S: F/U After Hospitalization 30 Days (6-20 yrs.).
Summary Chart 14a-S: Asthma Medication Management (21-50 yrs.).
Summary Chart 14b-S: Asthma Medication Management (51-64 yrs.)
Summary Chart 15a-S: F/U Hospitalization 7 Days (21-64 yrs.).
Summary Chart 15b-S: F/U Hospitalization 30 Days (21-64 yrs.).
Summary Chart 16-S: **Initiation** /Engagement Alcohol Tx (21-64 yrs.).
Summary Chart 21a-S: Asthma Medication Management (21-50 yrs.).
Summary Chart 21b-S: Asthma Medication Management (51-64 yrs.).
Summary Chart 22a-S: F/U Hospitalization 7 Days (21-64 yrs.).
Summary Chart 22b-S: F/U Hospitalization 30 Days (21-64 yrs.)
Summary Chart 23-S: Initiation/**Engagement** Alcohol Tx (21-64 yrs.).

5.1 MinnesotaCare Children (W) compared to MA Children (MA)

As seen in the following summary charts almost all of the Waiver subgroups rates were similar or greater than the MA Children's populations. Stratification of these measures did not show consistent trends or a pattern indicating the Waiver race/ethnic subgroup's utilization was different than the MA population.

Summary Charts 1-8-S:

Summary Chart 1-S: Childhood immunizations (2 yrs.) Combo 3. For the Waiver and MA children that had their second birthday during the measurement year receiving; four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV and 4 PCV vaccinations (Combo 3)

	CY 2013 Rates W-MA Comparison (<, >, ≈)[8]	**CY 2012 Rates W-MA Comparison** (<, >, ≈)	**CY 2011 Rates W-MA Comparison** (<, >, ≈)	**CY 2010 Rates W-MA Comparison** (<, >, ≈)	**CY 2009 Rates W-MA Comparison** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W < MA
Black	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA
NA	SD[9]	SD	SD	SD	SD
White	W ≈ MA	W ≈ MA	W < MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W < MA	W < MA	W ≈ MA	W ≈ MA

8. < - W rate is less than MA by 5 percentage points; > - W rate is greater than MA by 5 percentage points; ≈ - W rate is approximately the same as MA rates.
9. SD = Small dominators, less than 30 enrollees.

Summary Chart 2a –S: Child access to PCP (12-24 mos.). Children age twelve to twenty-four months who had a primary care visit during the year was similar to the comparison MA subgroup over the five year period.

	CY 2013 Rates	**CY 2012 Rates**	**CY 2011 Rates**	**CY 2010 Rates**	**CY 2009 Rates**

	(<, >, ≈)	(<, >, ≈)	(<, >, ≈)	(<, >, ≈)	(<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	SD	SD	SD	SD	SD
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 2b –S: Child access to PCP (25 mos-6 yrs.). Children age twenty-five months to six years of age who had a primary care visit during the year was similar to the comparison MA subgroup over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W ≈ MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W > MA	W ≈ MA	W ≈ MA =
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA =
NA	W ≈ MA	W > MA	W > MA	W ≈ MA	W ≈ MA =
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA =
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA =

Summary Chart 2c –S: Child access to PCP (7-11 yrs.). Children age seven to eleven years of age who had a primary care visit during the year or the year prior was similar to the comparison MA subgroup over the five year period with the exception of the Waiver AS/PI subgroup that was consistently seen more frequently than the MA comparison subgroup.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W ≈ MA	W ≈ MA	W > MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W > MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA

Summary Chart 2d –S: Child access to PCP (12-19 yrs.). Children age twelve to nineteen years of age who had a primary care visit during the year or the year prior was similar to the comparison MA subgroup over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W > MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA

Summary Chart 3a-S: Annual Dental Visit (2-3 yrs.). Waiver children age two to three years for all race/ethnic subgroups had similar annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W < MA	W > MA	W > MA	W ≈ MA
Black	W ≈ MA	W > MA	W > MA	W > MA	W ≈ MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	SD	SD	SD	SD
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W > MA	W ≈ MA	W ≈ MA	W ≈ MA	W < MA

Summary Chart 3b-S: Annual Dental Visit (4-6 yrs.). Waiver children age four to six years for most of the race/ethnic subgroups had similar annual dental visit rates when compared to MA population over the five year period. However, the Hispanic, White and Unknown subgroups had consistently higher rates over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W ≈ MA	W ≈ MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3c-S: Annual Dental Visit (7-10 yrs.). Waiver children age seven to ten years, for all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3d-S: Annual Dental Visit (11-14 yrs.) Waiver children age eleven to fourteen years, for all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)

AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3e-S: Annual Dental Visit (15-18 yrs.). Waiver children age fifteen to eighteen years, for all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 3e-S: Annual Dental Visit (19-20 yrs.). Asian, Native American, White and Unknown subgroups of nineteen to 20 year old children had consistently higher annual dental visits than the MA comparison population.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Hisp	W ≈ MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	SD	SD
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 4-S: Well-child visits: first 15 mos. 6+ visits. The percentage of Asian children that turned fifteen months during the measurement year who had six or more well-child visits had a higher rate consistently than the Asian MA comparison group over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W > MA	W > MA	W > MA
Hisp	SD	SD	SD	SD	SD
NA	SD	SD	SD	SD	SD
White	W ≈ MA	W > MA	W > MA	W > MA	W > MA
Unknown	W ≈ MA	W > MA	W ≈ MA	W > MA	W ≈ MA

Summary Chart 5-S: Well-child visits: (3-6 yrs.). Asian, Black, and Native American children in the third, fourth, fifth and sixth years of life compared to the same race MA subgroups had consistently higher rates of one or more well-child visits during the year over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W ≈ MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 6-S: Adolescent Well-child visits (12-19 yrs.). The percentage of children age twelve to nineteen who had at least one comprehensive well-child visit during the measurement year for both the Waiver and MA subgroups were similar over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W > MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W > MA	W > MA	W > MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Charts 7a-S: Asthma Medication Management (5-11 yrs.), 7b-S: Asthma Medication Management (12-20 yrs.) 8a-S: F/U After Hospitalization 7 Days (6-20 yrs.) and 8b-S: F/U After Hospitalization 30 Days (6-20 yrs.) charts demonstrate that almost all of the subgroups had small denominators except the White Waiver subgroup which had rates approximately (within 5 percentage points) the same as the MA subgroups.

5.2 MinnesotaCare Pregnant Women (W) Compared to MA Pregnant Women (MA)

Summary Chart 9-S:

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	SD	SD	SD	SD	SD
Black	W ≈ MA	W ≈ MA	SD	SD	SD
Hisp	SD	SD	SD	SD	SD
NA	SD	SD	SD	SD	SD
White	W > MA	W > MA	W ≈ MA	W > MA	W > MA
Unknown	SD	SD	SD	SD	SD

Other than the Waiver White subgroup, there were too few enrollees to compare to the MA subgroups. The Waiver White subgroup had similar or higher rates than the MA population of pregnant women.

5.3 MinnesotaCare Caretaker Adults (W) Compared to MA Adults (MA).

The comparison between the Waiver and MA race/ethnic subgroups demonstrate that most often the Waiver subgroups rates are greater than the comparable MA race/ethnic subgroup rates and consistent over the five year period.

Summary Charts 10-16S:

Summary Chart 10a-S: Diabetes A1c Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an HbA1c test performed during the measurement year. For most of the race/ethnic subgroups the Waiver population rates were greater than the comparison MA subgroups.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W > MA	W ≈ MA	W > MA	W > MA
Black	W ≈ MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	SD
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	SD	SD	SD	SD	SD

Summary Chart 10b-S: Diabetes LDL Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an LDL-C test performed during the measurement year. All of the Waiver race/ethnic subgroups rates were greater than the comparison MA subgroups over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	SD	W > MA	SD	SD
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	SD	SD	SD	SD	SD

Summary Chart 11a-S: Adult Access Preventive (21-44 yrs.). Waiver and MA comparison population adults, age twenty-one to forty-four years old that had an ambulatory or preventive care visit during the measurement year. All of the Waiver race/ethnic subgroups rates were similar to the MA comparison populations.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 11b-S: Adult Access Preventive (45-64 yrs.). Waiver and MA comparison population adults, age forty-five to sixty-four years old that had an ambulatory or preventive care visit during the measurement year. Almost all of the Waiver race/ethnic subgroups rates were similar to the MA comparison populations.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W > MA	W < MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 12-S: Annual Dental Visit (21-64 yrs.). Waiver adult's age twenty-one to sixty-four years, almost all of the race/ethnic subgroups, had consistently higher annual dental visit rates when compared to MA population over the five year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA	W > MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W > MA	W > MA	W > MA	W > MA	W > MA
Unknown	W > MA	W > MA	W > MA	W > MA	W > MA

Summary Chart 13-S: Cervical Cancer Screening (21-64 yrs.). Percentage of women age twenty-one to sixty-four years old that were screened for cervical cancer (cervical cytology every 3 years or cytology/human papillomavirus co-testing every five years). Waiver and MA race/ethnic subgroups were similar or greater over the five year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA	W > MA	W > MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W > MA
NA	W > MA	W > MA	W > MA	W > MA	W > MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 14a-S: Asthma Medication Management (21-50 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 14b-S: Asthma Medication Management (51-64 yrs.). All Waiver and MA race/ethnicity subgroups had dominators of less than 30 enrollees.

Summary Chart 15a-S: F/U Hospitalization 7 Days (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 15b-S: F/U Hospitalization 30 Days (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 16-S: Initiation /Engagement Alcohol Tx (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same than the MA subgroups.

5.4 MinnesotaCare Adults without Children (W) Compared to MA Adults without Children (MA)

Since there was a recent change in eligibility for this Wavier and MA comparison only three years of data is available to compare. The Adults without Children population rate comparisons between the Waiver and MA race/ethnic subgroups showed over the three period that Waiver and MA race/ethnic subgroups rates were comparable to MA race/ethnic subgroup rates.

Summary of Charts 17-23S :

Summary Chart 17a-S: Diabetes A1c Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an HbA1c test performed during the measurement year. For most of the race/ethnic subgroups the Waiver population rates were similar to the comparison MA subgroups over the three year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W > MA

Summary Chart 17b-S: Diabetes LDL Screening (21-64 yrs.). Waiver and MA comparison population adults, age twenty-one to sixty-four years old with type 1 or 2 diabetes that had an LDL-C test performed during the measurement year. Waiver race/ethnic subgroups rates were similar or greater than the comparison MA subgroups.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W ≈ MA
Black	W > MA	W > MA	W > MA
Hisp	W ≈ MA	W > MA	W ≈ MA
NA	W > MA	W ≈ MA	W > MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 18a-S: Adult Access Preventive (21-44 yrs.). Waiver and MA comparison population adults, age twenty-one to forty-four years old that had an ambulatory or preventive care visit during the measurement year. All of the Waiver race/ethnic subgroups rates were similar or greater than the MA comparison populations with the exception of the Hispanic subgroup that was consistently higher than the MA comparison group over the three years.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W > MA	W ≈ MA	W > MA
Black	W ≈ MA	W > MA	W > MA
Hisp	W > MA	W > MA	W > MA
NA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W > MA	W ≈ MA

Summary Chart 18b-S: Adult Access Preventive (45-64 yrs.). Waiver and MA comparison population adults, age forty-five to sixty-four years old that had an ambulatory or preventive care visit during the measurement year. All of the Waiver race/ethnic subgroups rates were similar or greater than the MA comparison populations with the exception of the Black subgroup that was consistently higher than the MA comparison group over the three years.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA
Black	W > MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA
NA	W > MA	W ≈ MA	W ≈ MA
White	W > MA	W > MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 19-S: Annual Dental Visit (21-64 yrs.) Waiver adult's age twenty-one to sixty-four years, almost all of the race/ethnic subgroups, had similar annual dental visit rates when compared to MA population over the three year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 20-S: Cervical Cancer Screening (21-64 yrs.). Percentage of women age twenty-one to sixty-four years old that were screened for cervical cancer (cervical cytology every 3 years or cytology/human papillomavirus co-testing every five years). Waiver and MA race/ethnic subgroups were similar with the exception of the Hispanic and Native American subgroups which were lower than the MA comparisons during the measurement periods.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)
AS/PI	W > MA	W > MA	W > MA
Black	W > MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W < MA	W < MA
NA	W ≈ MA	W ≈ MA	W < MA
White	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W > MA	W ≈ MA	W ≈ MA

Summary Chart 21a-S: Asthma Medication Management (21-50 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same or higher than the MA subgroups.

Summary Chart 21b-S: Asthma Medication Management (51-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same as the MA subgroups.

Summary Chart 22a-S: F/U Hospitalization 7 Days (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates higher (5 percentage points or more) than the MA subgroups.

Summary Chart 22b-S: F/U Hospitalization 30 Days (21-64 yrs.) All of the subgroups had small denominators except the White Waiver subgroup that had rates higher (5 percentage points or more) than the MA subgroups.

Summary Chart 23-S: Initiation/Engagement Alcohol Tx (21-64 yrs.). All of the subgroups had small denominators except the White Waiver subgroup that had rates approximately (within 5 percentage points) the same as the MA subgroups.

5.5 MA Children 12-24 Months with Income 133 to 275% FPG (W) Compared to MA Children 12-24 Months with Income Less Than 133% FPG.

The comparison between the Waiver and MA populations show the Waiver subgroups rates are generally similar or higher than the MA rates for all three measures. The race/ethnicity stratification indicates there are no apparent consistent trends or patterns to indicate a race/ethnic disparity either between or within the subgroups.

Summary Charts 24-26S

Summary Chart 24-S: Childhood immunizations (2 yrs.) Combo 3. Inferences drawn from this measure should be carefully considered since the measure is only of those children that had by their second birthday (within the measurement period) received; four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV and 4 PCV vaccinations, and were within Waiver 133 to 275 percent FPG, or the MA population less than the 133 percent of the FPG. The measure is not designed to evaluate the immunization status for all children age 12 to 23 months during the measurement year, only those children that were 24 months old in the calendar year.

Waiver children age two years old immunization rates were similar or greater than MA comparison population rates

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W > MA	W > MA	SD	SD	SD
Black	W > MA	W > MA	W > MA	W > MA	W > MA
Hisp	W ≈ MA	W ≈ MA	W > MA	W > MA	W ≈ MA
NA	SD	SD	SD	SD	SD
White	W ≈ MA	W > MA	W ≈ MA	W ≈ MA	W > MA
Unknown	SD	SD	SD	SD	SD

Summary Chart 25-S: Child access to PCP (12-24 mos.). Children age twelve to twenty-four months that had a primary care visit during the year are comparable to the MA subgroup over the five year period.

	CY 2013 Rates (<, >, ≈)	**CY 2012 Rates** (<, >, ≈)	**CY 2011 Rates** (<, >, ≈)	**CY 2010 Rates** (<, >, ≈)	**CY 2009 Rates** (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W < MA	W ≈ MA	W < MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W < MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
White	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA

Summary Chart 26-S: Well-child visits: first 15 mos. 6+ visits. The percentage of Waiver children that turned fifteen months during the measurement year who had six or more well-child visit rates was consistently similar with the MA comparison group over the five year period.

	CY 2013 Rates (<, >, ≈)	CY 2012 Rates (<, >, ≈)	CY 2011 Rates (<, >, ≈)	CY 2010 Rates (<, >, ≈)	CY 2009 Rates (<, >, ≈)
AS/PI	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Black	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
Hisp	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA	W ≈ MA
NA	SD	W > MA	W ≈ MA	SD	W > MA
White	W ≈ MA	W < MA	W ≈ MA	W ≈ MA	W ≈ MA
Unknown	W ≈ MA	W < MA	W > MA	W < MA	W < MA

6. Evaluation of CAHPS Consumer Satisfaction Results

The 2014 Minnesota Managed Care Public Programs Consumer Satisfaction Survey was conducted by DataStat, Inc., an NCQA-certified CAHPS® vendor, under contract with the Minnesota Department of Human Services (DHS).

The survey is designed to assess and compare the satisfaction of enrollees in managed care Minnesota health care programs (MC MHCP) administered by DHS on an annual basis utilizing the standardized survey instrument from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Medicaid core survey.

The core instrument is 58 questions. The instrument assessed such topics as: *how well doctors communicate; getting care without long waits; getting care that is needed; health plan customer services; shared decision making; and overall satisfaction with health plans and health care.* DHS added questions to assess topics such as immunization, behavioral health and care coordination.

The survey was administered from January 2014 through April 2014. Each respondent received up to four waves of mail with telephone interview call attempts made to non-responders. Participation in the survey was entirely voluntary and all data collected is kept confidential. The mailing materials were sent in English and contained instructions in Spanish that told respondents they could complete the questionnaire in Spanish by calling an 800 number. In addition, a language block on the backside of the letters in Hmong, Russian, Somali, and Vietnamese let respondents with these native languages know the survey was only being administered in English and Spanish, and that they could call DataStat to have their names removed from the sample list if they did not wish to participate.

The study had a goal of receiving at least 300 returned questionnaires for each health plan or group in each of the six program populations; 32 sample groups in all. To achieve this goal, the sample was designed to select an appropriate number of enrollees from each of the 32 sample groups. An oversample design was used for the Families and Children (F&C)-MA and Hennepin Health programs to address a multi-year pattern where the target number of completes was not reached. In addition, the sample design took into account a multi-year pattern of better than average response rates for the MSHO population. All seven of the MSHO groups used a smaller than typical sample size allowing for the F&C-MA / Hennepin Health groups to use a larger than typical sample size. When individual health plans did not have an adequate number of enrollees to warrant an individual sample, health plans were combined and treated as a single reporting unit. For single plans with insufficient enrollees to achieve the respective target sample, all

eligible enrollees were selected. A total of 28,230 enrollees across all programs were selected to participate in the survey.

Questionnaires were mailed to all selected enrollees. Enrollees who did not return a mail questionnaire received telephone calls and were offered the opportunity to complete the questionnaire over the telephone. During the course of the survey, some sampled enrollees were determined to be ineligible. Some were no longer enrolled; some were deceased; others had language problems or incapacities that prevented them from completing the interview.
The study response rate is the percentage of those who completed an interview among all those who were eligible to participate. Completed interviews were obtained from 9,793 enrollees. The study response rate was 37.0%.

Population	Quantity mailed	Eligible for	Response rate	Cases for analysis
F&C MA	9,230	7,382	27.5%	2,030
MinnesotaCare	5,400	5,165	37.8%	1,925

Respondent Characteristics		F&C-MA	MinnesotaCare
Gender	*Male*	38%	37%
	Female	62%	63%
Age	*18 to 24*	14%	10%
	25 to 34	26%	19%
	35 to 44	22%	16%
	45 to 54	22%	23%
	55 to 64	16%	31%
	65 to 74	1%	1%
	75 or older	0%	0%
Education Level	*HS or less*	49%	44%
	Some college	41%	42%
	College graduate	10%	14%
Self-Reported Health Status	*Excellent/Very Good*	41%	47%
	Good	36%	38%
	Fair/Poor	23%	15%
Hispanic or Latino	*Yes*	5%	4%
	No	95%	96%
Race	*White*	71%	80%
	Black/African American	9%	6%
	Asian	5%	5%
	Pacific Islander	1%	0%
	American Indian	7%	3%
	Other	4%	3%

6.1 Comparison of F&C MA and MinnesotaCare 2014 CAHPS Satisfaction Results

Composite Scores (Always)

Program	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*	*Shared Decision Making*
F&C-MA	50%	55%	77%	65%	52%
MinnesotaCare	56%	61%	80%	63%	50%
QC Benchmarks	54%	59%	72%	65%	51%

Rating Scores (9 & 10)

Program	*Rating of all health care*	*Rating of personal doctor*	*Rating of specialist seen most often*	*Rating of health plan*
F&C-MA	48%	67%	61%	56%
MinnesotaCare	51%	70%	63%	58%
QC Benchmarks	51%	63%	65%	57%

Comparison between results for the two DHS public managed care programs show satisfaction of public program managed care enrollees are very similar without regard to which program they may be enrolled. The greatest differences between the programs are seen in the Composite scores of "Getting needed care" and "Getting Care Quickly". MinnesotaCare enrollees report a six percentage point higher satisfaction.

6.2 Stratification of CAHPS Results by Race/Ethnicity.

The following tables demonstrate there is very little difference in satisfaction between MA and MinnesotaCare when rates are stratified by race/ethnicity. The shaded cells below indicate where MinnesotaCare Composites or Ratings are five percentage points lower than the MA composite/rates. Overall, MinnesotaCare composites/ratings are similar or higher than the comparable MA results.

Composites (Always)					
Race/Ethnicity	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
White-F&C MA	50.7%	56.0%	77.0%	66.9%	51.7%
White-MinnesotaCare	57.8%	63.2%	81.4%	65.4%	49.0%
Black-F&C MA	49.2%	61.4%	80.7%	64.2%	55.4%
Black-MinnesotaCare	56.3%	51.5%	80.7%	60.7%	52.8%
Asian-F&C MA	32.3%	33.1%	60.3%	41.2%	54.7%
Asian-MinnesotaCare	45.4%	43.8%	69.7%	35.2%	57.6%
Pacific Islander-F&C MA	42.3%	58.9%	78.8%	50.0%	47.6%

Pacific Islander-MinnesotaCare	46.4%	41.7%	43.8%	75.0%	88.9%
American Indian-F&C MA	45.3%	62.5%	76.1%	58.1%	45.1%
American Indian-MinnesotaCare	61.3%	63.0%	82.7%	57.1%	63.0%
Other-F&C MA	55.5%	54.4%	83.1%	73.6%	59.8%
Other-MinnesotaCare	52.1%	56.6%	77.5%	49.2%	43.1%
Hispanic-F&C MA	61.8%	53.1%	82.6%	79.0%	55.8%
Hispanic-MinnesotaCare	60.7%	52.5%	85.2%	51.9%	52.3%

Ratings (9 & 10)				
Race/Ethnicity	Health Care	Personal Doctor	Specialist	Health Plan
White-F&C MA	49.5%	68.0%	61.4%	55.4%
White-Minnesota Care	51.5%	69.5%	64.0%	58.6%
Black-F&C MA	52.9%	75.7%	62.3%	61.5%
Black-Minnesota Care	51.3%	78.1%	63.6%	60.9%
Asian-F&CMA	42.9%	48.0%	46.2%	47.5%
Asian-Minnesota Care	35.2%	54.4%	50.0%	46.9%
Pacific Islander-F&CMA	29.4%	75.0%	12.5%	52.0%
Pacific Islander-Minnesota Care	28.6%	66.7%	50.0%	50.0%
American Indian-F&CMA	41.7%	63.5%	55.0%	50.4%
American Indian Minnesota Care	49.0%	66.7%	62.1%	48.4%
Other-F&CMA	49.1%	69.2%	60.9%	53.2%
Other-Minnesota Care	51.4%	64.9%	87.5%	66.0%
Hispanic-F&CMA	51.7%	72.5%	68.2%	64.2%
Hispanic-Minnesota Care	60.4%	79.1%	65.2%	66.7%

7. Summary of Findings – Waiver Period 2011-2013 Update

The analysis of the 26 performance measures and satisfaction results demonstrate the goals of the waiver to provide comparable access and quality of health care to waiver populations as compared to Minnesota's other public health care program enrollees in managed care has been achieved. Both preventive care and treatment of chronic conditions were assessed and found to be similar or greater than the MA comparison populations. The evaluation objectives to demonstrate that access, quality of care and enrollee satisfaction is maintained and is comparable

to care provided to Minnesota Health Care Program recipients who are not enrolled under the PMAP+ waiver have been met.

When waiver population performance measure rates are also compared to HEDIS National Medicaid Quality Compass benchmark rates, nine out of nineteen measures are higher than the National Medicaid averages. Six of the nineteen comparable measures are at or above HEDIS National Medicaid Quality Compass 75th percentile rates and two are in the 95th percentile.

Overall the race/ethnicity stratification did not indicate consistent trends or patterns to indicate a race/ethnic disparity either between or within the subgroups. The stratification of the performance measures or satisfaction results provided very little new or additional information.

Enrollees in MinnesotaCare reported two ratings and three composite satisfaction scores that were above the National Medicaid averages.

Appendix F

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

Evaluation Plan 2014

1. Introduction

This proposed evaluation plan relates to the demonstration period January 1, 2014 through December 31, 2014 for the Prepaid Medicaid Assistance Project Plus (PMAP+) Section 1115 waiver. The State of Minnesota has provided care to eligible individuals under a Section 1115 demonstration waiver for many years. One of the primary components of the waiver has been the MinnesotaCare program, which was created in 1992 to help people who struggled with the high cost of private insurance but earned too much to qualify for Medicaid. This program, which requires payment of a monthly premium and higher cost sharing than Medicaid, has been credited with keeping Minnesota's uninsured rate lower than the national average. During the 2011-2013 demonstration period, the primary purpose of the demonstration was to provide cost-effective and comprehensive health insurance coverage to people with family incomes above Medicaid state plan income levels. In July of 2012, midway through the 2011-2013 demonstration period, there were over 120,000 people covered under the demonstration. On August 1st, 2011, Minnesota received authority to add coverage for a category of adults without children to the MinnesotaCare program. Over 30,000 adults received coverage under the waiver every month. This group was previously covered under state-funded programs. Coverage became available under Minnesota's health insurance exchange, MNsure, in January of 2014. The PMAP+ waiver was amended to reflect the expansion of eligibility in Minnesota's Medicaid program, and to modify the MinnesotaCare program to ease the planned transition to Basic Health Plan authority in 2015.

2. Background on the PMAP+ Section 1115 Waiver

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

Enrollees began receiving services from health plans on a prepaid capitated basis under the first Prepaid Medical Assistance Project (PMAP) Section 1115 waiver in July of 1985, almost thirty years ago. The project required that Medical Assistance or MA recipients (other than persons with disabilities) be enrolled with a health plan for a 12-month period. PMAP was initially limited to a few Minnesota counties.

In April 1995, CMS approved a statewide health care reform amendment to the PMAP waiver. This allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the federal poverty guidelines (FPG) into the Medicaid program. An amendment approved in 1999 expanded the program to include parents enrolled in

MinnesotaCare. A subsequent amendment in 2000 allowed for administrative simplification and mandatory enrollment of certain MA populations in managed care.

With promulgation of managed care regulations in 2002, states were able to implement mandatory enrollment in managed care through their Medicaid state plans. Minnesota now provides prepaid managed care coverage to infants, children, pregnant women, parents and adults without children via the state plan. Nevertheless, the PMAP+ waiver remains necessary to implement several important components of Minnesota's publicly funded health care programs, including providing Medicaid services with federal financial participation to expansion population under the MinnesotaCare program and mandatory managed care for certain MA populations, such as American Indians and children with special needs.

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

As the scope of the demonstration authority has evolved over time, so has the evaluation design. Similarly, as mandatory managed care has been implemented statewide for almost all of Minnesota's recipients without disabilities, Minnesota does not have fee-for-service data for comparison.

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

3. The PMAP+ § 1115 Waiver January 1, 2014 through December 31, 2014

With the implementation of many aspects of the ACA in 2014, Minnesota expanded eligibility for its Medicaid program, which necessitated some corresponding changes in MinnesotaCare. Minnesota also sought to amend MinnesotaCare at the beginning of the operation of Minnesota's MNsure health care exchange to smooth the transition to Basic Health Plan authority in 2015.

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

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

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

- Pregnant women and children under age 19 with family incomes at or below 275% of the FPL were enrolled in MinnesotaCare in 2013, but were transitioned to MA in 2014.

- In 2014, MinnesotaCare covers parents, adults and 19-20 year-olds with family incomes up to 200% FPL instead of 250% or 275% FPL to align eligibility standards with requirements for the Basic Health Plan.

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

- Benefits: For adults without children, the $10,000 cap on inpatient hospital services is eliminated.
- Cost-sharing: For adults without children, the 10% co-pay on inpatient hospital services is eliminated.
- Reduced premiums. Premiums are reduced for adult in MinnesotaCare. Enrollees under age 21 pay no premium.

The benefit set offered to MinnesotaCare Children and MA One-Year-Olds under the 2014 waiver is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid state plan, including all services that meet the definition of early and periodic screening, diagnostic, and treatment (EPSDT). The benefit offered to MinnesotaCare Caretaker Adults and MinnesotaCare Adults without Children is identical to the benefits offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (a) through (h) below are excluded.

1. Services included in an individual's education plan;
2. Private duty nursing;
3. Orthodontic services;
4. Non- emergency medical transportation services;
5. Personal Care Services;
6. Targeted case management services (except mental health targeted case management);
7. Nursing facility services; and
8. ICF/MR services.

In 2014, MinnesotaCare eligibility rules were changed to align with requirements in the Affordable Care Act. MinnesotaCare no longer has an asset test. The 4-month and 18-month eligibility waiting periods were eliminated. MinnesotaCare coverage may begin while an

individual is hospitalized. Eligibility for certain special populations (volunteer firefighters, former foster care children) is eliminated. (Former foster care children are covered under MA).

In 2014, MinnesotaCare eligibility was expanded to include groups that are expected to be covered by the Basic Health Plan in 2015 so that these groups would experience fewer coverage transitions.

- MinnesotaCare provides coverage for children under age 19 who are not eligible for MA under MA household composition rules but who have family incomes at or below 200% FPL using different household composition rules.
- MinnesotaCare provides coverage for adults who would not have family incomes at or below 200% FPL using Medicaid income calculation rules, but would have incomes at or below 200% FPL using income calculation rules that will apply under the Basic Health Plan.

Following these changes, the 2014 waiver makes coverage available to 19- and 20-year olds and adults with incomes between 133% and 200% of the federal poverty level, providing a more generous benefit set and lower cost sharing than people at these income levels are likely to be able to purchase with federal tax credits through MNsure.

In addition, the demonstration allows Minnesota to provide coverage to additional groups under a "designated state health program" during the interim year prior to the BHP: children who are barred from Medicaid due to Medicaid income methodologies; and adults and children who would not otherwise qualify for MinnesotaCare using Medicaid income methodologies but would be eligible under Marketplace income methodologies.

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

4. Evaluation Strategy for the 2014 Waiver

4.1 Demonstration Goals, Hypotheses and Objectives for 2014

The goal of the waiver is to reduce the proportion of uninsured and provide better coverage and better value for those who are participating in the program as compared to people who are not covered under Medicaid expansion. The evaluation will compare coverage levels under MinnesotaCare and coverage available under a qualified health plan purchased through MNsure. The demonstration also seeks to provide comparable access and quality of care to the waiver populations as compared to Medicaid managed care enrollees not eligible under the waiver. The objective is to demonstrate that access, quality of care and enrollee satisfaction is maintained

under the demonstration and is comparable to care provided to Medicaid managed care enrollees not eligible under the waiver.

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

4.11 Goal 1: Provide better coverage for insured.

Provide better health insurance coverage to Minnesotans at MinnesotaCare income levels than they might otherwise select through MNsure.

Objective: Increase the proportion of Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance as compared with the Minnesotans at 200-250% FPL with coverage purchased on MNsure.

Measurement:

- Categorize MinnesotaCare waiver benefits, cost-sharing and premiums, and that of plans available through MNsure, to determine comparative levels of coverage comprehensiveness.
- Determine the proportions of people receiving coverage through MNsure with incomes 200-250% FPL who are enrolled in bronze, silver, gold and platinum level plans.
- Determine the proportion of people at incomes of 200-250% FPL enrolled through MNsure who have benefit sets just as or more comprehensive than the benefit set of the waiver group.

Hypothesis: Minnesotans in the waiver group will have more comprehensive coverage and lower cost-sharing than they would likely have otherwise chosen through MNsure assuming their choices would be similar to those Minnesotans purchasing coverage through MNsure with incomes between 200 and 250% FPL.

Data Source: MNsure eligibility data, MNsure coverage data.

4.12 Goal 2: Provide value.

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

Objective: Provide Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance in a cost effective manner.

Measurement:

- Compare MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

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

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

Data Source: MNsure eligibility data; state expenditure data on waiver group; CMS data on cost-sharing settle-ups.

4.13 Goal 3: Improve the quality of care.

The goal of the waiver is to provide comparable access and quality of health care to waiver populations as compared to Minnesota's other public health care program enrollees in managed care.

Objectives: Improve:

- Utilization of services for children (childhood immunizations, child access to PCP, annual dental visits, well-child visits, medication management for people with asthma and follow-up after hospitalization for mental illness.)
- Utilization of services for adults (diabetes care, depression management, adult preventive visits, cervical cancer screening, dental visits, medication management for people with asthma, initiation and engagement of alcohol and other drug dependence treatment, and follow-up after hospitalization for mental illness.)
- Enrollee satisfaction with the delivery and quality of services (satisfaction survey results)

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

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

Data Source: Encounter data.

5. Evaluation Populations for 2014 Waiver

Waiver evaluation populations will consist of the following subgroups:

Waiver population subgroups:

- MinnesotaCare Children. Children ages 19 and 20 years old with family incomes 133-200% of the FPG and DSHP Children ages 0-18 with family incomes at or below 200% of the FPG.
- MinnesotaCare Caretaker Adults. Parents and adults caring for children with family incomes 133-200% of the FPG.
- MinnesotaCare Adults without Children. Adults age 21 or older without dependent children, and incomes 133-200% of the FPL.
- Medical Assistance One-Year-Olds. Children enrolled in MA ages 12-23 months and family incomes 133-275 percent of the FPG.

Medical Assistance (MA) Comparison Groups:

- MA Children. Children in MA ages 0-20.
- MA Caretaker Adults. Parents or adults caring for children with family incomes at or below 100 percent of the FPG, enrolled in managed care.
- MA Caretaker Adults. Adults caring for children with family incomes at or below 133 percent of the FPG, enrolled in managed care.
- MA Adults without Children. Adults age 21 or older without dependent children, and incomes at or below 133 percent of the FPG.

5.1 Evaluation Plan for the 2014 Waiver

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

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

Overview of Populations, Measures and Years

Waiver Populations	Comparison Populations	Measures	Measurement/Reference Years
2. MinnesotaCare Children 0-20 to 200% FPG (DHS program/eligibility codes: LL/C1, C2, I1, I2.)	2. MA Children0-20	1. Childhood immunizations (2 yrs) 2. Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs) 3. Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs) 4. Well –child visits first 5. 15months 5. Well-child visits 3 to 6 yrs.	MY = CY 2014 RYs = 2011 through 2013

		6. Adolescent well-care visits (12-19 yrs) 7. Medication Management for People with Asthma 8. Follow-up After Hospitalization for Mental Illness	
3. MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)	3. MA Caretaker Adults (DHS program/eligibility codes: MA/AA)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness	MYs = CY 2014 RYs = 2011 through 2013
4. MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)	4. MA Adults w/o Children (DHS program/eligibility codes: AX)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness 7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	MYs = CY 2014 RYs = 2011 through 2013
1. MA Children 12-24 Mos. 133 to 275 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	1. MA Children 12-24 Mos. less than 133 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	1. Child access to PCP (age groups 12-24 mos) 2. Well–child visits first 15months	MY = CY 2014 RYs = 2011 through 2013

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

5.2 Evaluation Metrics for the 2014 Waiver

1. Measures:

Rates and program attributes will be displayed to assist in making comparisons between MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

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

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

Children (0-19 yrs.)
Childhood immunizations (2 yrs)
Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs)
Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs)
Well –child visits first 15 months
Well-child visits 3 to 6 yrs.
Adolescent well-care visits (12-19 yrs)
Adults
Adult access preventive/ambulatory health services
Annual Dental Visit
Medication Management for People with Asthma
Follow-up After Hospitalization for Mental Illness
Comprehensive Diabetes Care
Cervical CA screening

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

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

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

2. Comparison Metrics between CYs 2011-2013 and CY 2014. The key factor that would limit the comparison metric is subpopulation size. Modification of the planned metrics may be

needed based upon the initial data analytical step to determine subpopulation enrollment characteristics. Public program eligibility changes will also influence metric comparisons and would need to be assessed during the initial data analytical step.

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

6. Evaluation Implementation Strategy and Timeline

6.1 Management and Coordination of the 2014 Waiver Evaluation

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

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

2014 Waiver Evaluation Process Steps Timeline
CY 2015

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

Draft Report – March 2016												
Final Report & Approval- May 2016												

6.2 Integration of the Quality Improvement Strategy

Compliance, oversight and improvement activities for all Minnesota managed health care programs are conducted in a comprehensive manner across all managed care programs. These activities are not segregated according to the waiver. Annually, DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCOs' compliance with state and federal Medicaid and Medicare managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcome of DHS' quality improvement activities is included in the Annual Technical Report (ATR). Since 2004, the ATR is the most comprehensive evaluation of quality, access and timeliness of Minnesota's health care programs.

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

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

6.3 Limitations and Opportunities

The following limitations may impact the results of this evaluation:

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

6.4 Conclusion, Best Practices, and Recommendations

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

Appendix G

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

Evaluation Plan 2015 to 2018

1. Introduction

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

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

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

3. PMAP+ Section 1115 Waiver Renewal January 1, 2016 through December 31, 2018

On June 30, 2015 DHS submitted a request to renew the PMAP+ waiver for the time period beginning January 1, 2016, and ending December 31, 2018. The proposed waiver extension seeks to continue federal authority for the following:

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

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

4. Waiver Populations and Expenditure Authorities for PMAP+ 2015-2018 Evaluation

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

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

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

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

Pregnant Women
The Patient Protection and Affordable Care Act (ACA) established the hospital presumptive eligibility (PE) program effective January 2014 allowing qualified hospitals to make Medical Assistance eligibility determinations for people who meet basic criteria. Under hospital PE, covered benefits for pregnant women during a presumptive eligibility period are limited to

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

5. Research Questions and Evaluation Metrics

5.1 MA One-Year-Olds

To evaluate the impact of the provision allowing Medical Assistance coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medical Assistance with incomes above 275% and at or below 283% of the FP, the following questions will be addressed.

- How many individuals qualify for Medical Assistance each year due to the MA One-Year-Old provision?
- Of those, how many would not have qualified for Medical Assistance under the approved state plan or under CHIP?
- What coverage would these children qualify for if not covered under this category?

Research Question	Metrics	Data Source
How many individuals qualify for Medical Assistance each year due to the MA One-Year-Old provision?	Number of children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medicaid program in calendar year 2015 through 2018.	MNsure, MMIS and MAXIS via DHS Data Warehouse
Of those, how many would not have qualified for Medicaid under the approved state plan or under CHIP?	Number of children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medicaid program in calendar year 2015 through 2018	MNsure, MMIS and MAXIS via DHS Data Warehouse
What coverage would these children qualify for if not covered under this category?	Children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medical Assistance program in calendar year 2015 through 2018.	MNsure, MMIS and MAXIS via DHS Data Warehouse

5.2 Medicaid Caretaker Adults with 18 –Year- Old

To evaluate the impact of the provision allowing Minnesota to waive the requirement to track the full-time student status of children age 18 living with a caretaker, the following questions will be addressed:

- What is the estimated number of individuals who qualify for medical assistance each year due to the provision covering caretaker adults with an 18 year old?
- What is the nature of the administrative savings resulting from this provision?

Research Question	Metrics	Data Source
What is the estimated number of individuals who qualify for Medical Assistance each year due to the provision covering caretaker adults with an 18 year old?	Number of caregiver adults enrolled in Minnesota's Medicaid program in calendar year 2105 through 2018. Estimate percentage of caregiver adults enrolled in Minnesota's Medicaid program with a youngest or only child age18 in calendar year 2015 through 2018.	MMIS claims and enrollment data
What is the nature of the administrative savings resulting from this provision?	Case worker average hourly compensation in calendar year 2015 through 2018. Case worker average time saved per case as a result of simplified procedures in calendar year 2015 through 2018.	MMIS claims and enrollment data Minnesota Social Services Information System (SSIS)

5.3 Medical Education and Research Costs (MERC) Trust Fund

To evaluate the impact of the provision allowing alternative funding and payment approaches to support graduate medical education through the MERC fund, the following questions will be addressed:

- How do the recipients of payments issued through the MERC fund use those monies?
- How many graduate medical training slots are supported through MERC?
- What is the impact of MERC on the number of providers available to serve the needs of the Medicaid eligible population?

- Did the number of primary providers increase in rural Minnesota as compared to provides in urban counties?
- What is the advantage of distributing payments from a medical education trust fund, compared to making GME subsidy payments directly to providers?

Research Question	Metrics	Data Source
How do the recipients of payments issued through the MERC fund use those monies?	Aggregate level data on the use of MERC funds by recipients in calendar year 2015 through 2018.	MERC Expenditure reporting data
How many graduate medical training slots are supported through MERC?	Aggregate level data on the number of training slots in each eligible profession in calendar year 2015 through 2018.	MERC program data
What is the impact of MERC on the number of providers available to serve the needs of the Medicaid eligible population?	Providers in MERC- eligible professions enrolled in Medicaid Percent of medical residents whose training occurs in MERC-supported facilities Comparing of physician and primary care provider supply with other states. Change in Number of MERC supported trainees over time Percent of MERC trainees who remain in Minnesota to practice upon completing training (where available)	MERC and Medicaid data MERC and Association of American Medical Colleges Annual report on resident numbers and location. Minnesota Department of Health and HRSA Bureau of Health Professions MERC annual and historical program data MERC program data; sponsoring institution data on alumnae
Did the number of primary providers increase in rural Minnesota as compared to provides in urban counties?	Number and location of primary care providers.	Minnesota Department of Health Health Professional Shortage Area data - Minnesota Department of Health and HRSA

The evaluation will include a discussion of the advantages of distributing payments from a medical education trust fund compared to making graduate medical education subsidy payments directly to providers.

5.4 Pregnant Women in a Presumptive Eligibility Period

To evaluate the impact of the provision allowing pregnant women to receive the full MA benefit during their presumptive eligibility period, the following questions will be addressed:

- What covered services do pregnant women receive during a hospital presumptive eligibility period with the full Medicaid benefit?
- What services would not be covered during a hospital presumptive eligibility period if the benefit was limited to ambulatory prenatal care?
- What is the cost of any additional services?
- What is the impact of providing full Medicaid benefits on access to care and quality of care?

Research Question	Metrics	Data Source
What services did pregnant women receive during an HPE period with the full MA benefit?	Number of services received by pregnant women during an HPE eligibility span in calendar year 2015 through 2018. Cost of services received by pregnant women during an HPE eligibility span in calendar year 2015 through 2018.	MMIS claims and enrollment data MMIS claims and enrollment data
Of the services received by pregnant women during an HPE period, what services would have been covered if the benefit was limited to ambulatory prenatal care?	Number of services received by pregnant women during an HPE eligibility span, that were not ambulatory prenatal care in calendar year 2015 through 2018. Cost of services received by pregnant women during an HPE eligibility span, that were not ambulatory prenatal care in calendar year 2015 through 2018.	MMIS claims and enrollment data MMIS claims and enrollment data

The evaluation will include a discussion of the impact of providing full Medicaid benefits on access to care and quality of care for PE pregnant women. MMIS data will be accessed via the DHS Data Warehouse to assess demographic characteristics of enrollees, as well as to measure utilization and changes in enrollment status, for this evaluation.

Evaluation data will be drawn from the following sources:
Medicaid Management Information System (MMIS) is the electronic claims processing and information retrieval system used by DHS. MMIS contains recipient, eligibility, and claims payment data. MAXIS is the legacy eligibility system for Medical Assistance and other public assistance. SSIS is Minnesota's case management and data collection system for all county social services programs. The DHS Data Warehouse allows DHS employees to access data sets from MAXIS, MMIS and other systems in order to customize reports and answer specific questions rather than relying on the routine reports generated from the larger statewide systems.

6. Evaluation Implementation Strategy and Timeline

DHS will conduct the waiver evaluation and review results over the first half of calendar years 2016, 2017, 2018 and 2019 with an interim report submitted to CMS at the end of 2016, 2017 and 2018 and a final report submitted to CMS by the end of 2019.

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

Demonstration Year 21
Second Quarter Report
October 1, 2015 through December 31, 2015

Submitted to:

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

Submitted by:

Minnesota Department of Human Services
540 Cedar Street
St. Paul, Minnesota 55164-0983

State of Minnesota
Department of Human Services

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ATTACHMENTS

FORWARD

As required by the terms and conditions approving §1115(a) waiver No. 11 -W-00039/5, entitled "Minnesota Prepaid Medical Assistance Project Plus (PMAP+)," this document is submitted to the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services as the second quarter report for the period of October 1, 2015 through December 31, 2015. This document provides an update on the status of the implementation of the PMAP + Program.

Introduction

Background

The PMAP+ Section 1115 Waiver has been in place for 30 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care coverage through Medicaid funding for people with incomes in excess of the standards in the Medical Assistance program. On January 1, 2015, MinnesotaCare was converted to a basic health plan, under section 1331 of the Affordable Care Act. As a basic health plan, MinnesotaCare is no longer funded through Medicaid. Instead, the state receives federal payments related to the premium tax credits and cost-sharing subsidies available through the health insurance exchange.

The PMAP+ waiver also provided the State with longstanding federal authority to enroll certain populations eligible for Medical Assistance into managed care who otherwise would have been exempt from managed care under the Social Security Act. In December of 2014, CMS notified the Department of Human Services (DHS) that it would need to transition this portion of its PMAP+ waiver authority to a section 1915(b) waiver. Therefore, on October 30, 2015, DHS submitted a request to transfer this authority to its Minnesota Senior Care Plus section 1915(b) waiver.

During this process, DHS determined that continued waiver authority was unnecessary for all of the groups historically included under the PMAP+ waiver. Because of the state's updated eligibility and enrollment processes for Medical Assistance, some of these populations are no longer mandatorily enrolled into managed care. Instead, they can enroll in managed care on a voluntary or an optional basis.

Therefore, the amendment to the MSC+ 1915(b) waiver only sought to continue federal waiver authority to require the following groups to enroll in managed care:

- American Indians, as defined in 25 U.S.C. 1603(c), who otherwise would not be mandatorily enrolled in managed care;
- Children under age 21 who are in state-subsidized foster care or other out-of-home placement; and
- Children under age 21 who are receiving foster care under Title IV-E.

CMS approved the amendment to the MSC+ waiver on December 22, 2015 with an effective date of January 1, 2016.

PMAP+ Waiver Renewal

The PMAP+ waiver continues to be necessary to continue certain elements of Minnesota's Medical Assistance program. On February 11, 2016, CMS approved DHS's request to renew the PMAP+ waiver for the period of January 1, 2016 through December 31, 2020.

The current waiver provides continued federal authority to:

- Cover children as "infants" under Medical Assistance who are 12 to 23 months old with income eligibility above 275 percent and at or below 283 percent of the federal poverty level (FPL) (referred to herein as "MA One Year Olds");
- Waive the federal requirement to redetermine the basis of Medical Assistance eligibility for caretaker adults with incomes at or below 133 percent of the FPL who live with children age 18 who are not full-time secondary school students;
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility; and
- Fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

Enrollment Information

Please refer to the table below for PMAP+ enrollment activity for the period October 2015 through December 2015.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter December 31, 2015	Current Enrollees (as of data pull on January 4, 2016)	Disenrolled in Current Quarter (October 1, 2015 through December 31, 2015)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	45	60	32
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	2,143	2,178	797

Pregnant Women in a Hospital Presumptive Eligibility Period		
Eligibility Month	**Eligibility Year**	**Unique Enrollees**
October	2015	34
November	2015	41
December	2015	40

Outreach and Marketing

Education and Enrollment

On October 1, 2013, DHS converted to a common streamlined application for Medical Assistance, MinnesotaCare and MNsure coverage. Medical Assistance and MinnesotaCare

applicants have the option of applying online through the MNsure website or by mail with a paper application.

The MNsure website provides information on Minnesota's health care programs. The site is designed to assist individuals with determining their eligibility status for insurance affordability programs in Minnesota. The site provides a description of coverage options through qualified health plans, Medical Assistance and MinnesotaCare. It also provides information about the application, enrollment and appeal processes for these coverage options.

In-person assisters and navigators are also available to assist individuals with the eligibility and enrollment process through the MNsure website. MNsure has a navigator grantee outreach program that does statewide activities to help individuals with enrollment.

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

PMAP Purchasing

Coverage for a large portion of enrollees in Medical Assistance is purchased on a prepaid capitated basis. The remaining recipients receive services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities. DHS contracts with MCOs in each of Minnesota's 87 counties.

PMAP Purchasing for American Indian Recipients

The Minnesota Legislature enacted a number of provisions, subsequently authorized by CMS, to address issues related to tribal sovereignty that prevent Indian Health Service (IHS) facilities from entering into contracts with MCOs, and other provisions that have posed obstacles to enrolling American Indian recipients who live on reservations into PMAP. The legislation allows American Indian beneficiaries who are enrolled in managed care to receive covered services under Medical Assistance through an IHS or other tribal provider (commonly referred to as "638s") whether or not these providers are in the MCO's network.

Contracts with MCOs include provisions designed to facilitate access to providers for American Indian recipients, including direct access to IHS and 638 providers. IHS and 638 providers may refer recipients to MCO-network specialists without requiring the recipient to first see a primary care provider. DHS has implemented the PMAP+ out-of-network purchasing model for American Indian recipients of Medical Assistance who are not residents of reservations.

Summary Data. The following is a summary of the number of people identified as American Indians who were enrolled in Medical Assistance during calendar year 2014.

Medical Assistance Enrollees who are American Indian Calendar Year 2014	
Families and Children	36,723
Disabled	5,247
Elderly	1,204
Adults with no Children	9,887
Total	53,061

Tribal Health Workgroup. The quarterly Tribal Health Workgroup was formed to address the need for a regular forum for formal consultation between tribes and state employees. The workgroup meets on a quarterly basis and is regularly attended by Tribal Health Directors, Tribal Human Services Directors, and representatives from the Indian Health Service, the Minnesota Department of Health and the Minnesota Department of Human Services. The work group met in Prior Lake, Minnesota on November 18, 2015. A copy of the agenda is at Attachment A.

Operational and Policy Developments

There were no significant program developments or operational issues for populations covered under this waiver during the quarter ending December 31, 2015.

Budget Neutrality Developments

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10. Please see Attachment B for an updated budget neutrality spreadsheet.

Member Month Reporting

Member months for "MA One-Year-Olds" and "Medicaid Caretaker Adults" for the period October 1, 2015 through December 31, 2015 are provided in the table below.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending December 31, 2015
Population 1: MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	43	47	45	135
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	2,102	2,112	2,143	6,357

Consumer Issues

County Advocates

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

Grievance System

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

Please refer to Attachment C for a summary of state fair hearings closed in the fourth quarter of calendar year 2015.

Quality Assurance and Monitoring

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 system, grievance procedures, service delivery plan, and summary of health utilization information.

Quality Strategy

In accordance with 42 C.F.R. §438.202(a), the state's quality strategy was developed to monitor and oversee the quality of PMAP and other publicly funded managed care programs in Minnesota.

This quality strategy assesses the quality and appropriateness of care and services provided by MCOs for all enrollees in managed care. It incorporates elements of current MCO contract requirements, state health maintenance organization (HMO) licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 C.F.R. §438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) are at the core of DHS's quality strategy. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcomes of these quality improvement activities are included in the Annual Technical Report (ATR).

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

External Review Process

Each year, as the state Medicaid agency, DHS must conduct an external quality review of 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 charge of the review organization is to identify areas of strength and weakness and to make recommendations for change. Where the technical report describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's ATR. The technical report is published on the DHS website at Managed Care Reporting.

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The survey results are published annually and are available on the DHS website at Managed Care Reporting.

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 Managed Care Reporting.

Update on Comprehensive Quality Strategy

Minnesota's Comprehensive Quality Strategy is an overarching comprehensive and dynamic continuous quality improvement strategy integration all aspects of the quality improvement programs, processes and requirements across Minnesota's Medicaid program. Minnesota has incorporated into its Comprehensive Quality Strategy measures and processes related to the

programs affected by this waiver. An initial draft of Minnesota's Comprehensive Quality Strategy was submitted to CMS in February 2015. DHS plans to submit an updated draft in May of 2016.

Demonstration Evaluation

The evaluation plan for the PMAP+ waiver period from January 1, 2015 through December 31, 2018 was submitted with Minnesota's PMAP+ waiver extension request in December of 2014. A copy of the evaluation plan is included at Attachment D.

State Contact

The state contact person for this waiver is Stacie Weeks. She can be reached by telephone at (651) 431-2151, or fax at (651) 431-7421, or email at stacie.weeks@state.mn.us.

Attachment A

Tribal Health Director's Meeting
SMSC – The Link Conference Center
2200 Trail of Dreams
Prior Lake, MN 55372

Wednesday, November 18, 2015
1:00 PM to 3:00 PM

1:00 – 1:15 p.m.
Welcome/Opening Prayer and Introductions
Prayer: Leonard Wabasha – Cultural Resources SMSC

MDH Agenda Items:

1:15 -1:45 p.m.
MN Tribal Health Research Collaboration
Dr. Mary Owens UMD

1:45 – 2:15 p.m.
MDH HIV/STD Partner Services Program &
Increase in 2014 syphilis cases in American Indians
Allison LaPointe & Marcie Babcock & Guests

2:15 – 2:30 p.m.
Indian Health Services Update
Bemidji Area IHS Director Keith Longie

DHS Agenda Items:

2:30 – 3:00 p.m.
Integrated Care for High Risk Pregnancies (ICHRP) Initiative Grant Program
Fritz Ohnsorg

3:00 – 3:30 p.m.
DHS MDH Listening Sessions on HIV/AIDS
Thomas Ruter

3:30 – 3:45 p.m.
Medicaid Waiver Update & State Plan Amendment Update
Jan Kooistra (DHS)

Agenda items for next meeting

Adjourn

Tribal Health Directors Meeting Dates 2016
Thursday, February 25th
Thursday, May 26th
Thursday, August 25th
Wednesday, November 16th (Tentative)
&Thursday, November 17th

***November 18-19, 2015 starting on Nov. 18th @ 4 p.m. to Nov. 19th ending @ 2 p.m.**
MN Indian Health Symposium – Stage II Action Planning – INVITE ONLY- Please see separate agenda

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 (Greater Than 133% FPG)

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%

Current Waiver MEGs

MA One-Year-Olds (Income Greater Than 275% FPG and TPL)

SFY	Member Mo	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
2010	263		255.05		62,004	5,073	67,077		
2011	513		356.76		177,735	5,284	183,020		39.88%
2012	378		239.48		80,702	9,822	90,524		-32.87%
2013	376		164.71		51,085	10,846	61,931		-31.22%
2014	700	182.65	182.65		122,132	5,727	127,858		10.89%
2015	527	182.65	111.56	96,259	51,535	7,259	58,795	37,464	-38.92%
2016	553	182.65	118.16	100,963	58,053	7,262	65,315	35,648	5.91%
2017	571	182.65	104.94	104,326	55,177	4,761	59,937	44,389	-11.19%
2018	572	182.65	118.27	104,512	62,747	4,926	67,673	36,839	12.71%
2019	289	182.65	127.53	52,782	31,727	5,127	36,854	15,928	7.83%

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		3,957,623	360,261	4,317,884		-1.41%
2013	8,945	476.54	447.89		3,650,671	355,691	4,006,362		-6.01%
2014	13,309	476.54	429.45		5,384,791	330,723	5,715,514		-4.12%
2015	24,114	476.54	489.56	11,491,165	11,412,124	393,181	11,805,305	-314,140	14.00%
2016	17,701	476.54	548.61	8,435,086	8,996,780	714,173	9,710,953	-1,275,867	12.06%
2017	18,291	476.54	516.29	8,716,097	8,551,106	892,225	9,443,330	-727,233	-5.89%
2018	18,323	476.54	572.38	8,731,659	9,724,313	763,474	10,487,787	-1,756,128	10.86%
2019	9,254	476.54	617.20	4,409,771	4,916,946	794,539	5,711,484	-1,301,714	7.83%

Annual ceiling less expenditures, all waiver groups

	MinnesotaCare Pregnant Women	MinnesotaCare Children	MinnesotaCare Caretaker Adults	MinnesotaCare Adults w/o Kids	MA 1-Year-Olds	MA Parents with Youngest Child 18-Years-Old	Total	Cumulative	
1996	2,692,881	9,250,752			2,158,358		14,101,991	14,101,991	**Trend scenario**
1997	2,832,636	10,201,710			2,050,449		15,084,795	29,186,786	**PW/Parents** **Kids**
1998	4,910,528	19,557,636			1,522,966		25,991,130	55,177,916	**5.30%** **4.90%**
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	**Trend scenario**
2001	4,199,164	2,672,021	-18,714,932		843,571		-11,000,176	44,176,473	**MA Parents**
2002	8,144,885	-15,745,463	-28,010,530		595,744		-35,015,364	9,161,109	**MA With Young**
2003	-39	-1,758	-1,985		12		-3,770	9,157,339	**One-Year-Olds Child = 18**
2004	-90,686	2,155,155	-1,052,319		839,648		1,851,798	11,009,137	**0.00%** **0.00%**
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		59,190,950	300,906,465	
2015	-576,070	-7,775,955	85,693,920	67,942,465	37,464	-314,140	145,007,685	445,914,149	
2016	0	-562,051	-15,703,841	-24,117,771	35,648	-1,275,867	-41,623,882	404,290,267	
2017					44,389	-727,233	-682,844	403,607,423	
2018					36,839	-1,756,128	-1,719,289	401,888,134	
2019					15,928	-1,301,714	-1,285,785	**400,602,349**	**<= Bottom line cost neutrality**
Sum	39,604,788	78,281,206	208,683,767	51,095,922	28,311,747	-5,375,082	400,602,349		

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	127,858	5,715,514	618,788,191	309,394,096
2015	576,070	15,152,933	132,068,566	192,689,731	58,795	11,805,305	352,351,400	176,175,700
2016	0	562,051	15,703,841	24,117,771	65,315	9,710,953	50,159,931	25,079,965
2017					59,937	9,443,330	9,503,268	4,751,634
2018					67,673	10,487,787	10,555,461	5,277,730
2019					36,854	5,711,484	5,748,338	2,874,169
Sum	165,989,985	2,012,629,261	1,837,465,484	947,857,315	127,591,207	52,874,374	5,144,407,627	2,583,106,130

NOTES

1. Payments through December 2015 are actual data.
2. MA one-year olds--enrollment is actual through December 2015.
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. FY2019 reflects a six month waiver period: July-December 2018.
10. FY2019 expenditures reflect the State's obligation to pay back the HMO withhold collected during CY2018.

March 9, 2016

Attachment C

State Fair Hearings Closed in Quarter 4 of 2015 by Metro and Non−Metro Areas

	Number of SFHs
Area	
Eleven County Metro Area	154
Non-Metro Area	49
Total	**203**

State Fair Hearings Closed in Quarter 4 of 2015 by Type, Service Category and Outcome

Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	State affirmed	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category							
Health Plan Change		1			1	1	**3**
Mandatory Participation	1						**1**
Restricted Recipient	3		4	1			**8**
Total	**4**	**1**	**4**	**1**	**1**	**1**	**12**

Billing Type by Service Category and Outcome

Outcome	Dismissed	Health Plan prevailed	Resolved after hearing	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category						
DME-Medical Supplies		1		1	1	**3**
Dental					1	**1**
Emergency Room				2		**2**
Hearing Services				1		**1**
Home Care	1					**1**
Hospital		1			1	**2**
Mental Health				2	1	**3**
Pharmacy				2		**2**
Professional Medical Services	3		1	7		**11**
Therapies/Rehabilitation				1		**1**
Transportation	1		1			**2**
Urgent Care				1		**1**
Vision Services				2		**2**
Total	**5**	**2**	**2**	**19**	**4**	**32**

Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved after hearing	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category								
DME-Medical Supplies	1			2		2		**5**
Dental	3	2		4	1	1	1	**12**
EW Services				2		1	1	**4**
Emergency Room						1		**1**
Home Care	11	17	3	38		23	2	**94**
Pharmacy	6			3		8		**17**
Professional Medical Services	4	1		7		6	2	**20**
Therapies/Rehabilitation	1			3			1	**5**
Transportation				1				**1**
Total	**26**	**20**	**3**	**60**	**1**	**42**	**7**	**159**

Access Type by Service Category and Outcome

No values were returned for this table.

Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved after hearing	Resolved before hearing	State affirmed	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category									
DME-Medical Supplies	1			3		3		1	**8**
Dental	3	2		4	1	1		2	**13**
EW Services				2		1		1	**4**
Emergency Room						3			**3**
Health Plan Change		1					1	1	**3**
Hearing Services						1			**1**
Home Care	12	17	3	38		23		2	**95**
Hospital				1				1	**2**
Mandatory Participation	1								**1**
Mental Health						2		1	**3**
Pharmacy	6			3		10			**19**
Professional Medical Services	7	1		7	1	13		2	**31**
Restricted Recipient	3			4		1			**8**
Therapies/Rehabilitation	1			3		1		1	**6**
Transportation	1			1	1				**3**
Urgent Care						1			**1**
Vision Services						2			**2**
Total	**35**	**21**	**3**	**66**	**3**	**62**	**1**	**12**	**203**

Summary of SFHs Closed in Quarter 4 of 2015 by Outcome

Outcome	Number of SFHs
Dismissed	
Enrollee prevailed	21
HP Partially Upheld/Member Partially Denied	3
Health Plan prevailed	66
Resolved after hearing	3
Resolved before hearing	62
State affirmed	1
Withdrawn	12
Total	**203**

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

Attachment D

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

Evaluation Plan 2015 to 2018

1. Introduction

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

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

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

3. PMAP+ Section 1115 Waiver Renewal January 1, 2016 through December 31, 2018

On June 30, 2015 DHS submitted a request to renew the PMAP+ waiver for the time period beginning January 1, 2016, and ending December 31, 2018. The proposed waiver extension seeks to continue federal authority for the following:

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

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

4. Waiver Populations and Expenditure Authorities for PMAP+ 2015-2018 Evaluation

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

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

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

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

Pregnant Women
The Patient Protection and Affordable Care Act (ACA) established the hospital presumptive eligibility (PE) program effective January 2014 allowing qualified hospitals to make Medical Assistance eligibility determinations for people who meet basic criteria. Under hospital PE, covered benefits for pregnant women during a presumptive eligibility period are limited to

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

5. Hypotheses, Research Questions and Evaluation Metrics

5.1 MA One-Year-Olds

Hypothesis: The number of children from age 12 months through 23 months, with incomes above 275% and at or below 283% of the FPL who qualify for Medicaid each year as a result of the MA one-year-old provision under the PMAP+ waiver will be maintained during the demonstration.

To evaluate the impact of the provision allowing Medical Assistance coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medical Assistance with incomes above 275% and at or below 283% of the FP, the following questions will be addressed.

- How many individuals qualify for Medical Assistance each year due to the MA One-Year-Old provision?
- Of those, how many would not have qualified for Medical Assistance under the approved state plan or under CHIP?
- What coverage would these children qualify for if not covered under this category?

Research Question	Metrics	Data Source
How many individuals qualify for Medical Assistance each year due to the MA One-Year-Old provision?	Number of children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medicaid program in calendar year 2015 through 2018.	MNsure, MMIS and MAXIS via DHS Data Warehouse
Of those, how many would not have qualified for Medicaid under the approved state plan or under CHIP?	Number of children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medicaid program in calendar year 2015 through 2018	MNsure, MMIS and MAXIS via DHS Data Warehouse

What coverage would these children qualify for if not covered under this category?	Children age 12 to 23 months with incomes above 275% and at or below 283% of the FPL enrolled in Minnesota's Medical Assistance program in calendar year 2015 through 2018.	MNsure, MMIS and MAXIS via DHS Data Warehouse

5.2 Medicaid Caretaker Adults with 18 –Year- Old

Hypothesis: The provision under the PMAP+ waiver covering caretaker adults with an 18 year old will result in administrative savings during the demonstration.

To evaluate the impact of the provision allowing Minnesota to waive the requirement to track the full-time student status of children age 18 living with a caretaker, the following questions will be addressed:

- What is the estimated number of individuals who qualify for medical assistance each year due to the provision covering caretaker adults with an 18 year old?
- What is the nature of the administrative savings resulting from this provision?

Research Question	**Metrics**	**Data Source**
What is the estimated number of individuals who qualify for Medical Assistance each year due to the provision covering caretaker adults with an 18 year old?	Number of caregiver adults enrolled in Minnesota's Medicaid program in calendar year 2105 through 2018. Estimate percentage of caregiver adults enrolled in Minnesota's Medicaid program with a youngest or only child age18 in calendar year 2015 through 2018.	MMIS claims and enrollment data
What is the nature of the administrative savings resulting from this provision?	Case worker average hourly compensation in calendar year 2015 through 2018. Case worker average time saved per case as a result of simplified procedures in calendar year 2015 through 2018.	MMIS claims and enrollment data Minnesota Social Services Information System (SSIS)

5.3 Medical Education and Research Costs (MERC) Trust Fund

Hypothesis: The ratio of primary providers in rural Minnesota as compared to providers in urban areas will be maintained during the demonstration.

Hypothesis: The number of training slots supported through MERC will be maintained during the demonstration.

To evaluate the impact of the provision allowing alternative funding and payment approaches to support graduate medical education through the MERC fund, the following questions will be addressed:

- How do the recipients of payments issued through the MERC fund use those monies?
- How many graduate medical training slots are supported through MERC?
- What is the impact of MERC on the number of providers available to serve the needs of the Medicaid eligible population?
- Did the number of primary providers increase in rural Minnesota as compared to provides in urban counties?
- What is the advantage of distributing payments from a medical education trust fund, compared to making GME subsidy payments directly to providers?

Research Question	Metrics	Data Source
How do the recipients of payments issued through the MERC fund use those monies?	Aggregate level data on the use of MERC funds by recipients in calendar year 2015 through 2018.	MERC Expenditure reporting data
How many graduate medical training slots are supported through MERC?	Aggregate level data on the number of training slots in each eligible profession in calendar year 2015 through 2018.	MERC program data
What is the impact of MERC on the number of providers available to serve the needs of the Medicaid eligible population?	Providers in MERC- eligible professions enrolled in Medicaid Percent of medical residents whose training occurs in MERC-supported facilities Comparing of physician and primary care provider supply with other states.	MERC and Medicaid data MERC and Association of American Medical Colleges Annual report on resident numbers and location. Minnesota Department of Health and HRSA Bureau of Health Professions

	Change in number of MERC supported trainees over time Percent of MERC trainees who remain in Minnesota to practice upon completing training (where available)	MERC annual and historical program data MERC program data; sponsoring institution data on alumnae
Did the number of primary providers increase in rural Minnesota as compared to provides in urban counties?	Number and location of primary care providers.	Minnesota Department of Health Health Professional Shortage Area data - Minnesota Department of Health and HRSA

The evaluation will include a discussion of the advantages of distributing payments from a medical education trust fund compared to making graduate medical education subsidy payments directly to providers.

5.4 Pregnant Women in a Presumptive Eligibility Period

Hypothesis: Pregnant women will receive services in addition to ambulatory prenatal care during a hospital presumptive eligibility period during the demonstration.

To evaluate the impact of the provision allowing pregnant women to receive the full MA benefit during their presumptive eligibility period, the following questions will be addressed:

- What covered services do pregnant women receive during a hospital presumptive eligibility period with the full Medicaid benefit?
- What services would not be covered during a hospital presumptive eligibility period if the benefit was limited to ambulatory prenatal care?
- What is the cost of any additional services?
- What is the impact of providing full Medicaid benefits on access to care and quality of care?

Research Question	Metrics	Data Source
What services did pregnant women receive during an HPE period with the full MA benefit?	Number of services received by pregnant women during a presumptive eligibility span in calendar year 2015 through 2018.	MMIS claims and enrollment data

	Cost of services received by pregnant women during an HPE eligibility span in calendar year 2015 through 2018.	MMIS claims and enrollment data
Of the services received by pregnant women during an HPE period, what services would have been covered if the benefit was limited to ambulatory prenatal care?	Number of services received by pregnant women during a presumptive eligibility span that were not ambulatory prenatal care in calendar year 2015 through 2018. Cost of services received by pregnant women during an HPE eligibility span, that were not ambulatory prenatal care in calendar year 2015 through 2018.	MMIS claims and enrollment data MMIS claims and enrollment data

The evaluation will include a discussion of the impact of providing full Medicaid benefits on access to care and quality of care for pregnant women during a hospital presumptive eligibility period. MMIS data will be accessed via the DHS data warehouse to assess demographic characteristics of enrollees, as well as to measure utilization and changes in enrollment status, for this evaluation.

Evaluation data will be drawn from the following sources

Medicaid Management Information System (MMIS) is the electronic claims processing and information retrieval system used by DHS. MMIS contains recipient, eligibility, and claims payment data. MAXIS is the legacy eligibility system for Medical Assistance and other public assistance. SSIS is Minnesota's case management and data collection system for all county social services programs. The DHS Data Warehouse allows DHS employees to access data sets from MAXIS, MMIS and other systems in order to customize reports and answer specific questions rather than relying on the routine reports generated from the larger statewide systems.

6. Evaluation Implementation Strategy and Timeline

DHS will conduct the waiver evaluation and review results over the first half of calendar years 2016, 2017, 2018 and 2019 with an interim report submitted to CMS at the end of 2016, 2017 and 2018 and a final report submitted to CMS by the end of 2019.

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

Demonstration Year 21
Third Quarter Report
January 1, 2016 through March 31, 2016

Submitted to:

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

Submitted by:

Minnesota Department of Human Services
540 Cedar Street
St. Paul, Minnesota 55164-0983

State of Minnesota
Department of Human Services

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ATTACHMENTS

FORWARD

As required by the terms and conditions approving §1115(a) waiver No. 11 -W-00039/5, entitled "Minnesota Prepaid Medical Assistance Project Plus (PMAP+)," this document is submitted to the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services as the third quarter report for the period of January 1, 2016 through March 31, 2016. This document provides an update on the status of the implementation of the PMAP + Program.

Introduction

Background

The PMAP+ Section 1115 Waiver has been in place for 30 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care coverage through Medicaid funding for people with incomes in excess of the standards in the Medical Assistance program. On January 1, 2015, MinnesotaCare was converted to a basic health plan, under section 1331 of the Affordable Care Act. As a basic health plan, MinnesotaCare is no longer funded through Medicaid. Instead, the state receives federal payments based on the premium tax credits and cost-sharing subsidies that would have been available through the health insurance exchange.

The PMAP+ waiver also provided the State with longstanding federal authority to enroll certain populations eligible for Medical Assistance into managed care who otherwise would have been exempt from managed care under the Social Security Act. In December of 2014, CMS notified the Department of Human Services (DHS) that it would need to transition this portion of its PMAP+ waiver authority to a section 1915(b) waiver. Therefore, on October 30, 2015, DHS submitted a request to transfer this authority to its Minnesota Senior Care Plus section 1915(b) waiver.

During this process, DHS determined that continued waiver authority was unnecessary for all of the groups historically included under the PMAP+ waiver. Because of the state's updated eligibility and enrollment processes for Medical Assistance, some of these populations are no longer mandatorily enrolled into managed care. Instead, they can enroll in managed care on a voluntary or an optional basis.

Therefore, the amendment to the MSC+ 1915(b) waiver only sought to continue federal waiver authority to require the following groups to enroll in managed care:

- American Indians, as defined in 25 U.S.C. 1603(c), who otherwise would not be mandatorily enrolled in managed care;

- Children under age 21 who are in state-subsidized foster care or other out-of-home placement; and

- Children under age 21 who are receiving foster care under Title IV-E.

CMS approved the amendment to the MSC+ waiver on December 22, 2015 with an effective date of January 1, 2016.

PMAP+ Waiver Renewal

The PMAP+ waiver continues to be necessary to continue certain elements of Minnesota's Medical Assistance program. On February 11, 2016, CMS approved DHS's request to renew the PMAP+ waiver for the period of January 1, 2016 through December 31, 2020.

The current waiver provides continued federal authority to:

- Cover children as "infants" under Medical Assistance who are 12 to 23 months old with income eligibility above 275 percent and at or below 283 percent of the federal poverty level (FPL) (referred to herein as "MA One Year Olds");
- Waive the federal requirement to redetermine the basis of Medical Assistance eligibility for caretaker adults with incomes at or below 133 percent of the FPL who live with children age 18 who are not full-time secondary school students;
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility; and
- Fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

Enrollment Information

Please refer to the table below for PMAP+ enrollment activity for the period January 2016 through March 2016.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter March 31, 2016	Current Enrollees (as of data pull on May 9, 2016)	Disenrolled in Current Quarter (January 1, 2016 through March 31, 2016)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	45	59	26
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	1,994	1,988	819

Pregnant Women in a Hospital Presumptive Eligibility Period		
Eligibility Month	**Eligibility Year**	**Unique Enrollees**
January	2016	34
February	2016	41
March	2016	40

Outreach and Marketing

Education and Enrollment

On October 1, 2013, DHS converted to a common streamlined application for Medical Assistance, MinnesotaCare and MNsure coverage. Medical Assistance and MinnesotaCare

applicants have the option of applying online through the MNsure website or by mail with a paper application.

The MNsure website provides information on Minnesota's health care programs. The site is designed to assist individuals with determining their eligibility status for insurance affordability programs in Minnesota. The site provides a description of coverage options through qualified health plans, Medical Assistance and MinnesotaCare. It also provides information about the application, enrollment and appeal processes for these coverage options.

In-person assisters and navigators are also available to assist individuals with the eligibility and enrollment process through the MNsure website. MNsure has a navigator grantee outreach program that does statewide activities to help individuals with enrollment.

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

PMAP Purchasing

Coverage for a large portion of enrollees in Medical Assistance is purchased on a prepaid capitated basis. The remaining recipients receive services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities. DHS contracts with MCOs in each of Minnesota's 87 counties.

PMAP Purchasing for American Indian Recipients

The Minnesota Legislature enacted a number of provisions, subsequently authorized by CMS, to address issues related to tribal sovereignty that prevent Indian Health Service (IHS) facilities from entering into contracts with MCOs, and other provisions that have posed obstacles to enrolling American Indian recipients who live on reservations into PMAP. The legislation allows American Indian beneficiaries who are enrolled in managed care to receive covered services under Medical Assistance through an IHS or other tribal provider (commonly referred to as "638s") whether or not these providers are in the MCO's network.

Contracts with MCOs include provisions designed to facilitate access to providers for American Indian recipients, including direct access to IHS and 638 providers. IHS and 638 providers may refer recipients to MCO-network specialists without requiring the recipient to first see a primary care provider. DHS has implemented the PMAP+ out-of-network purchasing model for American Indian recipients of Medical Assistance who are not residents of reservations.

Summary Data. The following is a summary of the number of people identified as American Indians who were enrolled in Medical Assistance during calendar year 2015.

Medical Assistance Enrollees who are American Indian Calendar Year 2015	
Families and Children	38,668
Disabled	5,058
Elderly	1,229
Adults with no Children	11,580
Total	56,535

Tribal Health Workgroup. The quarterly Tribal Health Workgroup was formed to address the need for a regular forum for formal consultation between tribes and state employees. The workgroup meets on a quarterly basis and is regularly attended by Tribal Health Directors, Tribal Human Services Directors, and representatives from the Indian Health Service, the Minnesota Department of Health and the Minnesota Department of Human Services. The work group met in Prior Lake, Minnesota on February 25, 2016. A copy of the agenda is at Attachment A.

Operational and Policy Developments

There were no significant program developments or operational issues for populations covered under this waiver during the quarter ending March 31, 2016.

Budget Neutrality Developments

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10. Please see Attachment B for an updated budget neutrality spreadsheet.

Member Month Reporting

Member months for "MA One-Year-Olds" and "Medicaid Caretaker Adults" for the period January 1, 2016 through March 31, 2016 are provided in the table below.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending March 31, 2016
Population 1: MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	46	43	45	134
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	2,056	1,991	1,994	6,041

Consumer Issues

County Advocates

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

Grievance System

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

Please refer to Attachment C for a summary of state fair hearings closed in the first quarter of calendar year 2016.

Quality Assurance and Monitoring

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 system, grievance procedures, service delivery plan, and summary of health utilization information.

Quality Strategy

In accordance with 42 C.F.R. §438.202(a), the state's quality strategy was developed to monitor and oversee the quality of PMAP and other publicly funded managed care programs in Minnesota.

This quality strategy assesses the quality and appropriateness of care and services provided by MCOs for all enrollees in managed care. It incorporates elements of current MCO contract requirements, state health maintenance organization (HMO) licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 C.F.R. §438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) are at the core of DHS's quality strategy. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcomes of these quality improvement activities are included in the Annual Technical Report (ATR).

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

External Review Process

Each year, as the state Medicaid agency, DHS must conduct an external quality review of 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 charge of the review organization is to identify areas of strength and weakness and to make recommendations for change. Where the technical report describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's ATR. The technical report is published on the DHS website at Managed Care Reporting.

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The survey results are published annually and are available on the DHS website at Managed Care Reporting.

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 Managed Care Reporting.

Update on Comprehensive Quality Strategy

Minnesota's Comprehensive Quality Strategy is an overarching comprehensive and dynamic continuous quality improvement strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota's Medicaid program. Minnesota has incorporated into its Comprehensive Quality Strategy measures and processes related to the

programs affected by this waiver. An initial draft of Minnesota's Comprehensive Quality Strategy was submitted to CMS in February 2015.

Demonstration Evaluation

The evaluation plan for the PMAP+ waiver period from January 1, 2015 through December 31, 2018 was initially submitted with Minnesota's PMAP+ waiver extension request in December of 2014.

State Contact

The state contact person for this waiver is Stacie Weeks. She can be reached by telephone at (651) 431-2151, or fax at (651) 431-7421, or email at stacie.weeks@state.mn.us.

Attachment A

Tribal Health Director's Meeting
SMSC – The Link Conference Center
2200 Trail of Dreams
Prior Lake, MN 55372

Wednesday, February 25, 2016
10:00 am to 3:00 pm

Welcome/Opening Prayer and Introductions

MDH Agenda Items:

10:15 – 10:45 a.m.
Commissioner Ed Ehlinger

10:45 – 11:00 a.m.
Report on Tribal Health Director Workgroup activities
Jackie Dionne and Workgroup Leads

11:00 – 11:15 a.m.
Update on activities on the increase in syphilis cases
Marcie Babcock, Dawn Ginzl and Jan Scott

11:15 – 11:30 a.m.
American Indian Cancer Foundation and MDH Cancer Control Unit
Proposed American Indian Statewide Report on Cancer – Executive Director Kris Rhodes

11:30– 11:45 a.m.
Crisis Standards of Care (not confirmed)
Erin McLachlan (MDH)

11:45 – Noon
Zoonotic Division and Canine Brucellosis and other diseases
Tory Whitten (MDH)

NOON to 12:30 p.m.
LUNCH BREAK

DHS Agenda Items:

12:30 – 1:00 p.m.
Spousal Impoverishment Rule
TBD

1:00 – 1:30 p.m.
ElderCare Development Program (EDP)
Peggy Roy (MCT)

1:30 – 1:45 p.m.
Sanford Research Conference
Victoria Grey Owl

1:45 – 2:00 p.m.

Great Lake Inter-Tribal Epi Center and Midwest IHB Director Update
New Director
Update on Activities

2:00 – 2:15 p.m.

Medicaid Waiver Update & State Plan Amendment Update
Jan Kooistra (DHS)

Adjourn

Agenda items for next meeting

Tribal Health Directors Meeting Dates 2016

Thursday, February 25th
Thursday, May 26th
Thursday, August 25th
Thursday, November 17th

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 (Greater Than 133% FPG)

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%

Current Waiver MEGs

MA One-Year-Olds (Income Greater Than 275% FPG and TPL)

SFY	Member Mo	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
2010	263		255.05		62,004	5,073	67,077		
2011	513		356.76		177,735	5,284	183,020		39.88%
2012	378		239.48		80,702	9,822	90,524		-32.87%
2013	376		164.71		51,085	10,846	61,931		-31.22%
2014	700	182.65	182.65		122,132	5,727	127,858		10.89%
2015	527	182.65	111.56	96,259	51,535	7,259	58,795	37,464	-38.92%
2016	553	182.65	118.16	100,963	58,053	7,262	65,315	35,648	5.91%
2017	571	182.65	104.94	104,326	55,177	4,761	59,937	44,389	-11.19%
2018	572	182.65	118.27	104,512	62,747	4,926	67,673	36,839	12.71%
2019	289	182.65	127.53	52,782	31,727	5,127	36,854	15,928	7.83%

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		3,957,623	360,261	4,317,884		-1.41%
2013	8,945	476.54	447.89		3,650,671	355,691	4,006,362		-6.01%
2014	13,309	476.54	429.45		5,384,791	330,723	5,715,514		-4.12%
2015	24,114	476.54	489.56	11,491,165	11,412,124	393,181	11,805,305	-314,140	14.00%
2016	17,701	476.54	548.61	8,435,086	8,996,780	714,173	9,710,953	-1,275,867	12.06%
2017	18,291	476.54	516.29	8,716,097	8,551,106	892,225	9,443,330	-727,233	-5.89%
2018	18,323	476.54	572.38	8,731,659	9,724,313	763,474	10,487,787	-1,756,128	10.86%
2019	9,254	476.54	617.20	4,409,771	4,916,946	794,539	5,711,484	-1,301,714	7.83%

Annual ceiling less expenditures, all waiver groups

	MinnesotaCare Pregnant Women	MinnesotaCare Children	MinnesotaCare Caretaker Adults	MinnesotaCare Adults w/o Kids	MA 1-Year-Olds	MA Parents with Youngest Child 18-Years-Old	Total	Cumulative	
1996	2,692,881	9,250,752			2,158,358		14,101,991	14,101,991	**Trend scenario**
1997	2,832,636	10,201,710			2,050,449		15,084,795	29,186,786	**PW/Parents** **Kids**
1998	4,910,528	19,557,636			1,522,966		25,991,130	55,177,916	**5.30%** **4.90%**
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	**Trend scenario**
2001	4,199,164	2,672,021	-18,714,932		843,571		-11,000,176	44,176,473	**MA Parents**
2002	8,144,885	-15,745,463	-28,010,530		595,744		-35,015,364	9,161,109	**MA With Young**
2003	-39	-1,758	-1,985		12		-3,770	9,157,339	**One-Year-Olds Child = 18**
2004	-90,686	2,155,155	-1,052,319		839,648		1,851,798	11,009,137	**0.00%** **0.00%**
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		59,190,950	300,906,465	
2015	-576,070	-7,775,955	85,693,920	67,942,465	37,464	-314,140	145,007,685	445,914,149	
2016	0	-562,051	-15,703,841	-24,117,771	35,648	-1,275,867	-41,623,882	404,290,267	
2017					44,389	-727,233	-682,844	403,607,423	
2018					36,839	-1,756,128	-1,719,289	401,888,134	
2019					15,928	-1,301,714	-1,285,785	**400,602,349**	**<= Bottom line cost neutrality**
Sum	39,604,788	78,281,206	208,683,767	51,095,922	28,311,747	-5,375,082	400,602,349		

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	127,858	5,715,514	618,788,191	309,394,096
2015	576,070	15,152,933	132,068,566	192,689,731	58,795	11,805,305	352,351,400	176,175,700
2016	0	562,051	15,703,841	24,117,771	65,315	9,710,953	50,159,931	25,079,965
2017					59,937	9,443,330	9,503,268	4,751,634
2018					67,673	10,487,787	10,555,461	5,277,730
2019					36,854	5,711,484	5,748,338	2,874,169
Sum	165,989,985	2,012,629,261	1,837,465,484	947,857,315	127,591,207	52,874,374	5,144,407,627	2,583,106,130

NOTES

1. Payments through December 2015 are actual data.
2. MA one-year olds--enrollment is actual through December 2015.
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. FY2019 reflects a six month waiver period: July-December 2018.
10. FY2019 expenditures reflect the State's obligation to pay back the HMO withhold collected during CY2018.

March 9, 2016

Attachment C

State Fair Hearings Closed in Quarter 1 of 2016 by Metro and Non−Metro Areas

	Number of SFHs
Area	
Eleven County Metro Area	134
Non-Metro Area	35
Total	**169**

State Fair Hearings Closed in Quarter 1 of 2016 by Type, Service Category and Outcome

Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category						
Health Plan Change				1	1	**2**
Restricted Recipient	4	1	5			**10**
Total	**4**	**1**	**5**	**1**	**1**	**12**

Billing Type by Service Category and Outcome

Outcome	Dismissed	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category					
Chiropractic			2		**2**
DME-Medical Supplies		1	2		**3**
Dental	1		4	1	**6**
Emergency Room	1		1		**2**
Home Care	1				**1**
Hospital			2		**2**
Mental Health	3		2	1	**6**
Pharmacy	1		2		**3**
Professional Medical Services			11	1	**12**
Vision Services	1	1	1		**3**
Total	**8**	**2**	**27**	**3**	**40**

Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs

Service Category							
Chemical Dependency	1	1					2
DME-Medical Supplies	3					1	4
Dental	2			4	4	1	11
EW Services		1	1		1		3
Home Care	6	16	3	21	15	4	65
Pharmacy	1	2		1	5	2	11
Professional Medical Services	4			4	5	1	14
Restricted Recipient					1		1
Therapies/Rehabilitation	2				1		3
Transportation	1	1		1			3
Total	**20**	**21**	**4**	**31**	**32**	**9**	**117**

Access Type by Service Category and Outcome

No values were returned for this table.

Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category							
Chemical Dependency	1	1					2
Chiropractic					2		2
DME-Medical Supplies	3			1	2	1	7
Dental	3			4	8	2	17
EW Services		1	1		1		3
Emergency Room	1				1		2
Health Plan Change					1	1	2
Home Care	7	16	3	21	15	4	66
Hospital					2		2
Mental Health	3				2	1	6
Pharmacy	2	2		1	7	2	14
Professional Medical Services	4			4	16	2	26
Restricted Recipient	4	1		5	1		11
Therapies/Rehabilitation	2				1		3
Transportation	1	1		1			3
Vision Services	1			1	1		3
Total	**32**	**22**	**4**	**38**	**60**	**13**	**169**

Summary of SFHs Closed in Quarter 1 of 2016 by Outcome

	Number of SFHs
Outcome	
Dismissed	32
Enrollee prevailed	22
HP Partially Upheld/Member Partially Denied	4
Health Plan prevailed	38
Resolved before hearing	60
Withdrawn	13
Total	**169**

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

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

Demonstration Year 21
Fourth Quarter Report
April 1, 2016 through June 30, 2016

Submitted to:

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

Submitted by:

Minnesota Department of Human Services
540 Cedar Street
St. Paul, Minnesota 55164-0983

State of Minnesota
Department of Human Services

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ATTACHMENTS

FORWARD

As required by the terms and conditions approving §1115(a) waiver No. 11 -W-00039/5, entitled "Minnesota Prepaid Medical Assistance Project Plus (PMAP+)," this document is submitted to the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services as the fourth quarter report for the period of April 1, 2016 through June 30, 2016. This document provides an update on the status of the implementation of the PMAP + Program.

Introduction

Background

The PMAP+ Section 1115 Waiver has been in place for 30 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care coverage through Medicaid funding for people with incomes in excess of the standards in the Medical Assistance program. On January 1, 2015, MinnesotaCare was converted to a basic health plan, under section 1331 of the Affordable Care Act. As a basic health plan, MinnesotaCare is no longer funded through Medicaid. Instead, the state receives federal payments based on the premium tax credits and cost-sharing subsidies that would have been available through the health insurance exchange.

The PMAP+ waiver also provided the State with longstanding federal authority to enroll certain populations eligible for Medical Assistance into managed care who otherwise would have been exempt from managed care under the Social Security Act. In December of 2014, CMS notified the Department of Human Services (DHS) that it would need to transition this portion of its PMAP+ waiver authority to a section 1915(b) waiver. Therefore, on October 30, 2015, DHS submitted a request to transfer this authority to its Minnesota Senior Care Plus section 1915(b) waiver.

During this process, DHS determined that continued waiver authority was unnecessary for all of the groups historically included under the PMAP+ waiver. Because of the state's updated eligibility and enrollment processes for Medical Assistance, some of these populations are no longer mandatorily enrolled into managed care. Instead, they can enroll in managed care on a voluntary or an optional basis.

Therefore, the amendment to the MSC+ 1915(b) waiver only sought to continue federal waiver authority to require the following groups to enroll in managed care:

- American Indians, as defined in 25 U.S.C. 1603(c), who otherwise would not be mandatorily enrolled in managed care;

- Children under age 21 who are in state-subsidized foster care or other out-of-home placement; and

- Children under age 21 who are receiving foster care under Title IV-E.

CMS approved the amendment to the MSC+ waiver on December 22, 2015 with an effective date of January 1, 2016.

PMAP+ Waiver Renewal

The PMAP+ waiver continues to be necessary to continue certain elements of Minnesota's Medical Assistance program. On February 11, 2016, CMS approved DHS's request to renew the PMAP+ waiver for the period of January 1, 2016 through December 31, 2020.

The current waiver provides continued federal authority to:

- Cover children as "infants" under Medical Assistance who are 12 to 23 months old with income eligibility above 275 percent and at or below 283 percent of the federal poverty level (FPL) (referred to herein as "MA One Year Olds");
- Waive the federal requirement to redetermine the basis of Medical Assistance eligibility for caretaker adults with incomes at or below 133 percent of the FPL who live with children age 18 who are not full-time secondary school students;
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility; and
- Fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

Enrollment Information

Please refer to the table below for PMAP+ enrollment activity for the period April 2016 through June 2016.

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter June 30, 2016	Current Enrollees (as of data pull on XXX, 2016)	Disenrolled in Current Quarter (April 1, 2016 through June 30, 2016)
MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	27	49	27
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	1,869	1,785	1,537

Pregnant Women in a Hospital Presumptive Eligibility Period		
Eligibility Month	**Eligibility Year**	**Unique Enrollees**
April	2016	42
May	2016	36
June	2016	38

Outreach and Marketing

Education and Enrollment

On October 1, 2013, DHS converted to a common streamlined application for Medical Assistance, MinnesotaCare and MNsure coverage. Medical Assistance and MinnesotaCare

applicants have the option of applying online through the MNsure website or by mail with a paper application.

The MNsure website provides information on Minnesota's health care programs. The site is designed to assist individuals with determining their eligibility status for insurance affordability programs in Minnesota. The site provides a description of coverage options through qualified health plans, Medical Assistance and MinnesotaCare. It also provides information about the application, enrollment and appeal processes for these coverage options.

In-person assisters and navigators are also available to assist individuals with the eligibility and enrollment process through the MNsure website. MNsure has a navigator grantee outreach program that does statewide activities to help individuals with enrollment.

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

PMAP Purchasing

Coverage for a large portion of enrollees in Medical Assistance is purchased on a prepaid capitated basis. The remaining recipients receive services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities. DHS contracts with MCOs in each of Minnesota's 87 counties.

PMAP Purchasing for American Indian Recipients

The Minnesota Legislature enacted a number of provisions, subsequently authorized by CMS, to address issues related to tribal sovereignty that prevent Indian Health Service (IHS) facilities from entering into contracts with MCOs, and other provisions that have posed obstacles to enrolling American Indian recipients who live on reservations into PMAP. The legislation allows American Indian beneficiaries who are enrolled in managed care to receive covered services under Medical Assistance through an IHS or other tribal provider (commonly referred to as "638s") whether or not these providers are in the MCO's network.

Contracts with MCOs include provisions designed to facilitate access to providers for American Indian recipients, including direct access to IHS and 638 providers. IHS and 638 providers may refer recipients to MCO-network specialists without requiring the recipient to first see a primary care provider. DHS has implemented the PMAP+ out-of-network purchasing model for American Indian recipients of Medical Assistance who are not residents of reservations.

Summary Data. The following is a summary of the number of people identified as American Indians who were enrolled in Medical Assistance during calendar year 2015.

Medical Assistance Enrollees who are American Indian Calendar Year 2015	
Families and Children	38,668
Disabled	5,058
Elderly	1,229
Adults with no Children	11,580
Total	56,535

Tribal Health Workgroup. The quarterly Tribal Health Workgroup was formed to address the need for a regular forum for formal consultation between tribes and state employees. The workgroup meets on a quarterly basis and is regularly attended by Tribal Health Directors, Tribal Human Services Directors, and representatives from the Indian Health Service, the Minnesota Department of Health and the Minnesota Department of Human Services. The work group met in Prior Lake, Minnesota on May 26, 2016. A copy of the agenda is at Attachment A.

Operational and Policy Developments

There were no significant program developments or operational issues for populations covered under this waiver during the quarter ending June 30, 2016.

Budget Neutrality Developments

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10. Please see Attachment B for an updated budget neutrality spreadsheet.

Member Month Reporting

Member months for "MA One-Year-Olds" and "Medicaid Caretaker Adults" for the period April 1, 2016 through June 30, 2016 are provided in the table below.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending June 30, 2016
Population 1: MA One-Year-Olds with incomes above 275% FPL and at or below 283% FPL	43	41	27	111
Medicaid Caretaker Adults with incomes at or below 133% FPL living with a child age 18	1,929	1,936	1,869	5,734

Consumer Issues

County Advocates

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

Grievance System

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

Please refer to Attachment C for a summary of state fair hearings closed in the second quarter of calendar year 2016.

Post Award Public Forum on PMAP+ Waiver

DHS held a post award public forum on June 29, 2016 to provide the public with an opportunity to comment on the progress of the PMAP+ demonstration. A notice was published on the DHS Public Participation web site on May 17, 2016 informing the public of the date, time and location of the forum. An email was also sent to all PMAP+ waiver stakeholders on May 17, 2016 announcing the date, time and location of the forum. There were two members of the public in attendance at the forum. DHS provided an overview of the current PMAP+ waiver program. No public comments were received by DHS.

Quality Assurance and Monitoring

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 system, grievance procedures, service delivery plan, and summary of health utilization information.

Quality Strategy

In accordance with 42 C.F.R. §438.202(a), the state's quality strategy was developed to monitor and oversee the quality of PMAP and other publicly funded managed care programs in Minnesota.

This quality strategy assesses the quality and appropriateness of care and services provided by MCOs for all enrollees in managed care. It incorporates elements of current MCO contract requirements, state health maintenance organization (HMO) licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 C.F.R. §438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) are at the core of DHS's quality strategy. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcomes of these quality improvement activities are included in the Annual Technical Report (ATR).

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

External Review Process

Each year, as the state Medicaid agency, DHS must conduct an external quality review of 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 charge of the review organization is to identify areas of strength and weakness and to make recommendations for change. Where the technical report describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's ATR. The technical report is published on the DHS website at Managed Care Reporting.

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The survey results are published annually and are available on the DHS website at Managed Care Reporting.

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 Managed Care Reporting.

Update on Comprehensive Quality Strategy

Minnesota's Comprehensive Quality Strategy is an overarching comprehensive and dynamic continuous quality improvement strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota's Medicaid program. Minnesota has incorporated into its Comprehensive Quality Strategy measures and processes related to the programs affected by this waiver. An initial draft of Minnesota's Comprehensive Quality Strategy was submitted to CMS in February 2015.

Demonstration Evaluation

The evaluation plan for the PMAP+ waiver period from January 1, 2015 through December 31, 2018 was initially submitted with Minnesota's PMAP+ waiver extension request in December of 2014. In May of 2016 the evaluation plan was revised and updated to reflect an end date of 2020 to align with the approved terms of our waiver. Additional revisions to the evaluation plan are currently underway in response to CMS's most recent comments received on June 9, 2016.

State Contact

The state contact person for this waiver is Stacie Weeks. She can be reached by telephone at (651) 431-2151, or fax at (651) 431-7421, or email at stacie.weeks@state.mn.us.

Attachment A

Tribal Health Director's Meeting
SMSC – The Link Conference Center
2200 Trail of Dreams
Prior Lake, MN 55372

Thursday, May 26, 2016
10:00 am to 3:00 pm

AGENDA

10:00 – 10:15 a.m.
Welcome/Opening Prayer and Introductions

10:15 – 10:45 a.m.
Report on Tribal Health Director Workgroup activities

HealthCare Finance and Policy	
Tribal State Agreement	**Sam Moose and/or Jennifer Dupuis**
ACA Sub-Committee	**Linda Bedeau**
Workforce Committee	**Dr. Don Warne, Laura McLain**
Survey	**Nitika Moibi**
Opiate Prevention and Treatment	**Cheri Hample**
Communications and Engagement	**Paula Schaefbauer**
American Indians and Health – Changing the Narrative	

10:45 – 11:15 a.m.
Tribal Money Follows the Person Update – Jeanne Nelson and John Anderson

11:15 – 11:30 a.m.
DHS SPA/Waiver Updates – Jan Kooistra

11:30 – 12:30 p.m.
MDH Legislative Updates and Health Equity Updates - Deputy Commissioner Dan Pollock

12:30 – 1:00 p.m.
LUNCH BREAK

1:00 – 1:30 p.m.
EIDBI Autism Program Update – Maychee Mua and Linda Monchamp

1:30 – 2:30 p.m.
Updates on drug overdose investigations and policy development – Mark Kinde, Jon Roesler and Nate Wright

2:30 – 3:00 p.m.
Tribal SHIP and Tribal Tobacco Measurements Discussion – Chris Tholkes, Ann Zukoski, Sarah Brokenleg and LaRaye Anderson

Agenda items for next meeting

Tribal Health Directors Meeting Dates 2016

Thursday, February 25th
Thursday, May 26th
Thursday, August 25th
Thursday, November 17th

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 (Greater Than 133% FPG)

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%

Current Waiver MEGs

MA One-Year-Olds (Income Greater Than 275% FPG and TPL)

SFY	Member Mo	PMPM Cap*	PMPM	PMPM Ceiling	Expenditures	Withhold Payments	Total Expenditures	Difference	PMPM % Change
2010	263		255.05		62,004	5,073	67,077		
2011	513		356.76		177,735	5,284	183,020		39.88%
2012	378		239.48		80,702	9,822	90,524		-32.87%
2013	376		164.71		51,085	10,846	61,931		-31.22%
2014	700	182.65	182.65		122,132	5,727	127,858		10.89%
2015	527	182.65	111.56	96,259	51,535	7,259	58,795	37,464	-38.92%
2016	553	182.65	118.16	100,963	58,053	7,262	65,315	35,648	5.91%
2017	571	182.65	104.94	104,326	55,177	4,761	59,937	44,389	-11.19%
2018	572	182.65	118.27	104,512	62,747	4,926	67,673	36,839	12.71%
2019	289	182.65	127.53	52,782	31,727	5,127	36,854	15,928	7.83%

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		3,957,623	360,261	4,317,884		-1.41%
2013	8,945	476.54	447.89		3,650,671	355,691	4,006,362		-6.01%
2014	13,309	476.54	429.45		5,384,791	330,723	5,715,514		-4.12%
2015	24,114	476.54	489.56	11,491,165	11,412,124	393,181	11,805,305	-314,140	14.00%
2016	17,701	476.54	548.61	8,435,086	8,996,780	714,173	9,710,953	-1,275,867	12.06%
2017	18,291	476.54	516.29	8,716,097	8,551,106	892,225	9,443,330	-727,233	-5.89%
2018	18,323	476.54	572.38	8,731,659	9,724,313	763,474	10,487,787	-1,756,128	10.86%
2019	9,254	476.54	617.20	4,409,771	4,916,946	794,539	5,711,484	-1,301,714	7.83%

Annual ceiling less expenditures, all waiver groups

	MinnesotaCare Pregnant Women	MinnesotaCare Children	MinnesotaCare Caretaker Adults	MinnesotaCare Adults w/o Kids	MA 1-Year-Olds	MA Parents with Youngest Child 18-Years-Old	Total	Cumulative	
1996	2,692,881	9,250,752			2,158,358		14,101,991	14,101,991	**Trend scenario**
1997	2,832,636	10,201,710			2,050,449		15,084,795	29,186,786	**PW/Parents** **Kids**
1998	4,910,528	19,557,636			1,522,966		25,991,130	55,177,916	**5.30%** **4.90%**
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	**Trend scenario**
2001	4,199,164	2,672,021	-18,714,932		843,571		-11,000,176	44,176,473	**MA Parents**
2002	8,144,885	-15,745,463	-28,010,530		595,744		-35,015,364	9,161,109	**MA With Young**
2003	-39	-1,758	-1,985		12		-3,770	9,157,339	**One-Year-Olds Child = 18**
2004	-90,686	2,155,155	-1,052,319		839,648		1,851,798	11,009,137	**0.00%** **0.00%**
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		59,190,950	300,906,465	
2015	-576,070	-7,775,955	85,693,920	67,942,465	37,464	-314,140	145,007,685	445,914,149	
2016	0	-562,051	-15,703,841	-24,117,771	35,648	-1,275,867	-41,623,882	404,290,267	
2017					44,389	-727,233	-682,844	403,607,423	
2018					36,839	-1,756,128	-1,719,289	401,888,134	
2019					15,928	-1,301,714	-1,285,785	**400,602,349**	**<= Bottom line cost neutrality**
Sum	39,604,788	78,281,206	208,683,767	51,095,922	28,311,747	-5,375,082	400,602,349		

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	127,858	5,715,514	618,788,191	309,394,096
2015	576,070	15,152,933	132,068,566	192,689,731	58,795	11,805,305	352,351,400	176,175,700
2016	0	562,051	15,703,841	24,117,771	65,315	9,710,953	50,159,931	25,079,965
2017					59,937	9,443,330	9,503,268	4,751,634
2018					67,673	10,487,787	10,555,461	5,277,730
2019					36,854	5,711,484	5,748,338	2,874,169
Sum	165,989,985	2,012,629,261	1,837,465,484	947,857,315	127,591,207	52,874,374	5,144,407,627	2,583,106,130

NOTES

1. Payments through December 2015 are actual data.
2. MA one-year olds--enrollment is actual through December 2015.
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. FY2019 reflects a six month waiver period: July-December 2018.
10. FY2019 expenditures reflect the State's obligation to pay back the HMO withhold collected during CY2018.

March 9, 2016

Attachment C

State Fair Hearings Closed in Quarter 2 of 2016 by Metro and Non−Metro Areas

	Number of SFHs
Area	
Eleven County Metro Area	126
Non-Metro Area	54
Total	**180**

State Fair Hearings Closed in Quarter 2 of 2016 by Type, Service Category and Outcome

Admin Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	Health Plan prevailed	Resolved before hearing	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category					
Health Plan Change	1		2	6	**9**
Restricted Recipient	1	1	3		**5**
Total	**2**	**1**	**5**	**6**	**14**

Billing Type by Service Category and Outcome

Outcome	Dismissed	Health Plan prevailed	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category					
DME-Medical Supplies			1		**1**
Dental			1		**1**
Emergency Room	1		1		**2**
Home Care			1		**1**
Hospital			1		**1**
Pharmacy		1	1	1	**3**
Professional Medical Services	4		6	1	**11**
Transportation	1				**1**
Total	**6**	**1**	**12**	**2**	**21**

Service Type by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved after hearing	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category								
Chemical Dependency				1				**1**
DME-Medical Supplies	3			1		2		**6**
Dental	4			5		4	2	**15**

EW Services		2		2		1		**5**
Health Plan Change						1		**1**
Hearing Services	1							**1**
Home Care	9	13	2	16	1	17	6	**64**
Hospital						1		**1**
Nursing Facility							1	**1**
Pharmacy	2	1		2		14	2	**21**
Professional Medical Services	4			8		9		**21**
Restricted Recipient	1							**1**
Therapies/Rehabilitation	2			2		1		**5**
Transportation				1				**1**
Vision Services	1							**1**
Total	**27**	**16**	**2**	**38**	**1**	**50**	**11**	**145**

Access Type by Service Category and Outcome

No values were returned for this table.

Total All Types by Service Category and Outcome

Outcome	Dismissed	Enrollee prevailed	HP Partially Upheld/Member Partially Denied	Health Plan prevailed	Resolved after hearing	Resolved before hearing	Withdrawn	Total
	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs	Number of SFHs
Service Category								
Chemical Dependency				1				**1**
DME-Medical Supplies	3			1		3		**7**
Dental	4			5		5	2	**16**
EW Services		2		2		1		**5**
Emergency Room	1					1		**2**
Health Plan Change	1			2		7		**10**
Hearing Services	1							**1**
Home Care	9	13	2	16	1	18	6	**65**
Hospital						2		**2**
Nursing Facility							1	**1**
Pharmacy	2	1		3		15	3	**24**
Professional Medical Services	8			8		15	1	**32**
Restricted Recipient	2	1		3				**6**
Therapies/Rehabilitation	2			2		1		**5**
Transportation	1			1				**2**
Vision Services	1							**1**
Total	**35**	**17**	**2**	**44**	**1**	**68**	**13**	**180**

Summary of SFHs Closed in Quarter 2 of 2016 by Outcome

	Number of SFHs
Outcome	
Dismissed	35
Enrollee prevailed	17
HP Partially Upheld/Member Partially Denied	2
Health Plan prevailed	44
Resolved after hearing	1
Resolved before hearing	68
Withdrawn	13
Total	**180**

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