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DEPARTMENT OF HUMAN SERVICES

# Minnesota Medicaid Managed Care Comprehensive Quality Strategy

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## Executive summary

The Minnesota Medicaid Managed Care Comprehensive Quality Strategy provides an overview of the different methods the Department of Human Services uses to assess the performance of Minnesota's Medicaid managed care program, including program improvement activities, results, achievements and opportunities. The Department of Human Services (DHS) has continuously engaged in various quality improvement initiatives for different components of the Medicaid managed care program. This document ties these various components together into one comprehensive strategy. Creating one overarching quality improvement strategy provides an opportunity to gather and enumerate the numerous quality improvement efforts occurring throughout the department and move toward coordination of all the initiatives.

DHS aims to ensure access to quality health care for all Medicaid managed care enrollees and to work with enrollees, the state's External Quality Review Organization, managed care organizations, providers and other state agencies, such as the Minnesota Department of Health, to improve access, quality and continuity of care. DHS strives to achieve results in seven essential outcomes through its Minnesota Medicaid Managed Care Comprehensive Quality Strategy:

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

DHS uses standing advisory and stakeholder groups, including the MCO Quality Workgroup, to review the strategy and its components. Comments from the general public will also be solicited.

DHS will review and update this comprehensive quality strategy at the end of each calendar year for submission by the end of the first quarter of the following year. DHS will solicit input from multiple internal and external stakeholders through workgroups and posting a draft of the comprehensive quality strategy document on its website for public review and comment.

## Introduction

The Minnesota Medicaid Managed Care Comprehensive Quality Strategy provides an overview of the different methods the Department of Human Services uses to assess the performance of Minnesota's Medicaid managed care program, including program improvement activities,

results, achievements and opportunities. The Department of Human Services (DHS) has continuously engaged in various quality improvement initiatives for different components of the Medicaid managed care program through:

- The Managed Care Quality Strategy.
- The quality framework for Minnesota's five home- and community-based services waivers:
  - Developmental Disability waiver.
  - Community Access for Disability Inclusion waiver.
  - Community Alternative Care waiver.
  - Brain Injury waiver.
  - Elderly waiver.
- The evaluation of two of Minnesota's section 1115 demonstration waivers:
  - Reform 2020.
  - Prepaid Medical Assistance Project Plus.

This document ties these various components together into one comprehensive strategy. Creating one overarching quality improvement strategy provides an opportunity to gather and enumerate the numerous quality improvement efforts occurring throughout the department and move toward coordination of all the initiatives.

## History of managed care in Minnesota Health Care Programs

Most Minnesotans enrolled in Medicaid receive services through the state's contracted managed care organizations (MCOs), which include both health maintenance organizations and county-based purchasing plans. The remaining enrollees receive services through the traditional fee-for-service system, where providers receive a payment from the Department of Human Services (DHS) directly for each service provided to an enrollee. In 2016, about 280,000 people were enrolled in the state's fee-for-service system in any given month with just over 807,000 people enrolled in managed care.

View a timeline and read a report that details the history of managed care in Minnesota. The timeline begins on Page 50.

**Minnesota Medicaid and MinnesotaCare MCO contracts**

| Program | Federal authority | Name of contract | Type of enrollment | Number of contracts |
|---|---|---|---|---|
| Medical Assistance | State plan and 1115 PMAP+ waiver; mandatory enrollment with exclusions | Families and children contract | Mandatory enrollment with exclusions | 7 |
| MinnesotaCare | Basic Health Plan under the Affordable Care Act | Families and children contract | Mandatory enrollment with exclusions | 7 |

| Program | Federal authority | Name of contract | Type of enrollment | Number of contracts |
|---|---|---|---|---|
| Minnesota Senior Health Options (MSHO) | State plan | Seniors contract | Voluntary enrollment | 7 |
| Minnesota Senior Care Plus (MSC+) | 1915(b) MSC+ waiver and 1915(c) home- and community-based services waivers | Seniors contract | Mandatory enrollment with exclusions | 7 |
| Special Needs Basic Care (SNBC) | State plan | SNBC contract | Voluntary enrollment | 6 |

## Objectives of the comprehensive quality strategy

DHS aims to ensure access to affordable, high quality health care for all Medicaid managed care enrollees and to work with enrollees, the state's External Quality Review Organization, managed care organizations, providers and other state agencies, such as the Minnesota Department of Health, to improve access, quality and continuity of care. To achieve quality health care services, there must be measurable improvement in enrollee health outcomes to affect cost.[1]

DHS based its comprehensive quality strategy on these continuous quality improvement principles:

### Accountability and transparency

As stewards of public funds, DHS must hold the managed care organizations (MCOs) accountable for the quality of the health care services provided. The quality strategy holds MCOs accountable through the use of consistent quality and performance measures reported to DHS, enrollees and the public. The measures review many aspects of care and service with a particular focus on the ability to obtain the greatest health improvement at the lowest cost, balanced by conformity with social and cultural preferences.

### Value

The worth of services provided will be determined in relation to long-term health care outcomes and satisfaction of principal consumers, the managed care enrollees. The quality strategy will

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

repeatedly ask and evaluate findings to the question: "Did the delivery system provide care and services in the appropriate quantity, quality and timing to realize the maximum attainable health care improvement at the most advantageous balance between cost and benefit?"

## Consumer informed choice and responsibility

The most effective and efficient health care delivery system includes the patient in the health care decision process. In order for patients to participate, they must be provided with the prerequisite health care information. Patients must also assume responsibility as informed consumers to make responsible choices and reduce high-risk behaviors in order to realize optimum outcomes. A measured, thoughtful, strategic and systematic patient-centered approach must be employed to achieve sustained improvement.

DHS strives to achieve results in seven essential outcomes through its Medicaid Managed Care Comprehensive Quality Strategy:

1. Purchase high quality health care services.
2. Protect the health care interests of managed care enrollees through monitoring of care and services.
3. Assist in the development of affordable health care.
4. Review and realign any DHS policies and procedures that act as unintended barriers to the effective and efficient delivery of health care services.
5. Focus health care improvements on enrollee demographics and cultural needs.
6. Improve the health care delivery system's capacity to deliver desired medical care outcomes though process standardization, improvement and innovation.
7. Strengthen the relationship between patients and health care providers.

## Reform 2020 waiver-specific outcomes

The Reform 2020 demonstration will assist the state in its goals to:

- Achieve better health outcomes.
- Increase and support independence and recovery.
- Increase community integration.
- Reduce reliance on institutional care.
- Simplify the administration of the program and access to the program.
- Create a program that is more fiscally sustainable.

## Minnesota Family Planning Program-specific outcomes

1. Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.
2. Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.
3. Increase the average age of mother at first birth among MHCP enrollees.

4. Reduce the teen birth rate among MHCP enrollees.

### Olmstead Plan

The Olmstead Plan is Minnesota's program to improve the integration of citizens with disabilities into the community and address disparities, inequities, and community concerns. The Olmstead Implementation Office (OIO) leads these efforts. The Minnesota Olmstead website provides additional information.

The ultimate success of the Olmstead Plan will be measured by an increase in the number of people with disabilities who, based upon their choices, live close to their friends and family, and as independently as possible; work in competitive, integrated employment; are educated in integrated school settings; and fully participate in community life. While there is much work to be done to achieve the goals of the Olmstead Plan, significant strides have been made in the last year. It is anticipated that future reports will include additional indicators of important progress towards these larger goals. The March 2020 Revision to the plan contains the most recent information pertaining to the Plan.

## Components of the comprehensive quality strategy

### Technical and regulatory monitoring

The DHS Managed Care Quality Strategy was developed in accordance with federal Medicaid managed care regulations (42 CFR §438.340), which require state agencies to have a written strategy for assessing and improving the quality of health care services offered by MCOs. The quality strategy encompasses the following managed care health care programs and contracts:

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

Each year, the External Quality Review Organization [EQRO] (IPRO of New York State in 2018) performs an overall external quality review of Minnesota's managed care system. The review includes current contract requirements, federal Medicaid managed care regulations and state law, including health maintenance organization (HMO) licensing requirements.

The Minnesota Department of Health (MDH) licenses HMOs and regulates county-based purchasing entities doing business in Minnesota. MDH conducts a triennial quality assurance examination of all MCOs to monitor and assess compliance with state HMO licensing regulations. While the primary purpose of the exam is to monitor compliance with Minnesota's HMO licensing regulations, some of the information collected and assessed is used by the EQRO

to assess DHS and CMS requirements.[2] DHS and MDH work collaboratively to assure that, when possible, information collected for the MDH Quality Assurance Examination includes information consistent with federal external quality review requirements to avoid the duplication of mandatory data collection. This additional information not specifically outlined in state law but required by CMS is also collected and reported by MDH within the Triennial Compliance Assessment.

If MDH discovers an MCO deficiency, a corrective action and mid-cycle follow-up review is required to ensure all deficiencies are resolved. The External Quality Review Organization uses information from the Quality Assurance Exam, Triennial Compliance Assessment report and follow-up deficiency audits to determine MCO compliance with DHS and CMS requirements. DHS also collects other contractually required reports directly from the MCO for its external quality review, including the annual MCO Quality Work Plan and Evaluation.

The External Quality Review Organization is charged with assessing the strengths and weaknesses of MCOs and reporting on their:

- Quality, access and timeliness of health care services they provided under managed care.
- Conformity with contract requirements.
- Compliance with state and federal Medicaid and Medicare managed care requirements.
- Validation of performance measures and performance improvement projects.
- Enrollee satisfaction.

The External Quality Review Organization provides the MCOs with recommendations for improvement for areas of weakness and assesses the degree to which each MCO addressed problems previously identified. When necessary, DHS imposes corrective actions and appropriate sanctions if MCOs are out of compliance with requirements and standards.

The External Quality Review Organization also provides comparative information about all MCOs, offers technical support to the MCOs which deliver services through DHS contracts, and advises DHS on opportunities for improvement.

The External Quality Review Organization details its findings, outcomes and recommendations for improvement in the Annual Technical Report. See Appendix B for further detail on the managed care quality strategy.

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

DHS reviews and reports on the effectiveness of the Managed Care Quality Strategy at least annually. Significant modifications will be published in the State Register to obtain public comment, presented to key Medicaid advisory groups, and reported to CMS.

As is the current practice, performance improvement project activities are included in the annual External Quality Review Organization report. In future years, as new healthcare issues emerge, additional clinical or nonclinical focused quality improvement studies may be undertaken.

## Performance Improvement Projects

Managed care plans must conduct three year performance improvement projects designed to improve care and services provided to enrollees. The 2018-2020 PIPs focus on Reducing New Chronic Opioid Users. DHS publishes the summary reports online.

## Opioid Prescribing Improvement Program

The Opioid Prescribing Improvement Program is a statewide initiative proposed in the 2015 legislative session. The program's goal is to reduce the opioid dependency and substance use of Minnesotans due to or related to the prescribing of opioid analgesics by health care providers. This program is a collaborative effort between the Department of Human Services (DHS) and Minnesota Department of Health (MDH), building upon recommendations made by DHS' Health Services Advisory Council (HSAC), DHS' Emergency Department Utilization Work Group, and other community initiatives.

As part of this legislation, an Opioid Prescribing Work Group (OPWG) was established to recommend development of prescribing protocols, sentinel measures, and patient educational resources to help reduce overprescribing of opioids. Non-voting members of OPWG include: a representative of MDH, DHS' Minnesota Health Care Programs (MHCP) medical director, a representative of DHS pharmacy program, and the medical director for the Minnesota Department of Labor and Industry. OPWG's voting members include:

- At least two consumer members who individually or in their families have been impacted by opioid abuse disorder or opioid dependence disorder.
- A licensed and actively practicing physician.
- A licensed and actively practicing pharmacist.
- A licensed and actively practicing nurse practitioner.
- A licensed and actively practicing dentist.
- A licensed and actively practicing non-physician health care professional whose practice includes treating pain.
- A licensed and actively practicing health or mental health professional whose practice includes treating patients with chemical dependence or substance abuse.
- A medical examiner for Minnesota county.
- A voting member of DHS' HSAC.

- At least one medical director of a health plan doing business in Minnesota.
- At least one pharmacy director of a health plan doing business in Minnesota.
- A representative of law enforcement in Minnesota.

The Statewide Opioid Prescribing Improvement Program focuses on improving the health and quality of care of MHCP recipients by implementing the following activities:

- OPWG will recommend opioid quality improvement standard thresholds and MHCP opioid disenrollment standards pertaining to opioid prescribers and provider groups.
- DHS, on annual basis, will collect and report to MHCP prescribers the data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers.
- DHS will notify MHCP opioid prescribers and the MHCP opioid prescribers' provider groups when their prescribing patterns exceed MHCP opioid quality improvement standard thresholds. Each MHCP opioid prescriber and provider group will submit a quality improvement plan for DHS' review and approval. The goal of which shall be to bring MHCP opioid prescribers' practices into alignment with community standards. The quality improvement plans should include, but not be limited to: components of the Statewide Opioid Prescribing Improvement Program such as appropriate opioid prescribing protocols and use of educational messages with patients; internal practice-based measures to review the prescribing practice of the MHCP opioid prescriber, and where appropriate, any or all other MHCP opioid prescribers who are employed by or affiliated with the provider group(s); and appropriate use of the Minnesota Prescription Monitoring Program.
- If, after a year from DHS' initial notice, the MHCP opioid prescriber's practice does not improve to the degree necessary to consider it consistent with community standards, DHS will take any or all of the following steps: monitor performance more frequently than annually; monitor more aspects of prescribing practices than the sentinel measures; and/or require additional quality improvement efforts including, but not limited to, mandatory use of the Minnesota Prescription Monitoring Program.
- DHS will dis-enroll from Minnesota Health Care Programs all MHCP prescribers and provider groups that meet applicable MHCP opioid disenrollment standards.

This program (upon legislative approval and implementation) will allow DHS, MDH, and the larger provider community the opportunity to build on and synergize existing quality improvement efforts among health systems, other provider groups, and professional associations. The most immediate hurdle is receiving support and passing this proposed legislation.

## Integrated Care for High Risk Pregnant Women

Adverse birth outcomes result in high care costs due to intensive treatment requirements for newborns, related to prematurity, low birthweight, and maternal substance abuse, especially

opiates. The proposed program will target resources for prenatal prevention and treatment to improve birth outcomes.

Minnesota has excellent birth outcomes overall, with among the lowest rates nationally for prematurity, low birth weight, and infant mortality. However, the state has some of the nation's highest disparities for these outcomes for African Americans and American Indians, in comparison to Whites. Also, Neonatal Abstinence Syndrome (NAS), which occurs when newborns withdraw from opiates due to maternal opiate use during pregnancy, is rapidly growing in Minnesota. There is an 8-fold higher rate of NAS in Minnesota among infants born to American Indians. Prematurity, low birth weight and NAS are the leading causes of costly neonatal intensive care unit (NICU) admissions, and these adverse birth outcomes are known to be strongly associated with behavioral risks and disadvantaged social conditions. Integrated prenatal care that links risk assessment with community-supported interventions has been shown to result in lower rates of these adverse outcomes.

Integrated Care for High Risk Pregnant Women is a grant program designed to provide targeted, integrated services for pregnant mothers who are at high risk of poor birth outcomes due to drug use or low birth weight in areas of high need. A state funded grant program allows us to target resources for Medicaid recipients. These services are expected to improve birth outcomes, reducing the number of low birth weight infants and the use of costly neonatal intensive care (NICU) services in the Medical Assistance program within the target population. Based on experience from similar interventions across the country, this proposal is expected to reduce the number of days infants stay in the NICU by nearly 600 in the affected areas.

Participating mothers will be connected to existing maternal health and substance abuse services through community and public health programs. The program will work with community organizations, lay and professional providers to develop local systems of care that are community held, community monitored and maintained with appropriate state oversight. Participating clinics will include tribal health providers and community clinics; local public health and social service agencies; and substance abuse treatment providers.

Project goals include:

- Early identification of opiate dependency and abuse during pregnancy, effectively coordinated referral and follow-up of identified patients to evidence-based treatment, and integrated perinatal care services with behavioral health and substance abuse services.
- Access to, and effective use of, needed services by bridging cultural gaps within systems of care, through integration of community-based paraprofessionals such as doulas and community health workers, as a component of perinatal care.
- Patient education including prenatal care, birthing, and postpartum care, nutrition, reproductive life planning, breastfeeding, parenting, and documentation of the processes used to educate patients.

- Systematized screening, care coordination, referral, and follow up for behavioral and social risks known to be associated with poor birth outcomes and prevalent within the targeted populations, such as substance abuse, homelessness, domestic violence and abuse, chronic mental illness, and poorly developed self-care knowledge and skills.
- Facilitated ongoing continuity of care, including postpartum coordination and referral for interconception care, provision for ongoing substance abuse treatment, identification and referral for maternal depression, continued medical management of chronic diseases, and appropriate referral to tribal or county-based social and public health nursing services.

Within four years of implementing the recommendations, DHS anticipates:

- Lower rates of untreated maternal opiate and other substance use disorders at birth.
- A decline in rates of prematurity and LBW within targeted areas, resulting in lowered statewide disparities for these outcomes.
- A decline in child protection findings driven by untreated substance abuse in mothers of newborns.
- A reduction in the incidence of newborns exposed to illicit or abused substances.
- Better integration of existing resources for high risk maternity populations.
- Development of a mechanism to sustain this work via a Medicaid payment model.

The project is expected to serve nearly 1,200 pregnant mothers at risk of poor birth outcomes through the end of State Fiscal Year 2019. Legislation was approved in 2015.[3]

## Delivery System and Payment Reform: Value-Based Payment Program

The MN DHS value-based purchasing initiative is called the Integrated Health Partnership (IHP) program. The IHP program uses direct contracts with providers to enhance accountability through shared savings and shared risk, creating incentives for quality improvement. The program operates across both fee-for-service and managed care (under 65 non-duals).

The IHP model (IHP Legacy) has been in operation since 2013. Beginning in 2018, DHS launched IHP 2.0 which includes a population-based payment which all IHP 2.0 participants (both Tracks 1 and 2) receive and a total cost of care risk-based payment that only Track 2 IHP 2.0 participants may receive.

### *IHP Legacy*

In the IHP legacy contracts, a portion of an IHP's potential shared savings is contingent on their overall quality score. An IHP's overall quality score is calculated based on their compliance with

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[3] Minn. Statutes § 256B.79

the reporting requirements, and, from year 2 onward, their performance rates. In years 1 and 2, the overall quality score impacts 25% of an IHP's shared savings; this portion increases to 50% beginning in year 3. Measures are organized into the following categories: clinical quality at a clinic and at a hospital; and patients' experience of care at a clinic and at a hospital. Points are awarded for improvement and achievement.

### *IHP 2.0 Track 1 – Population Based Payment*

For the purpose of the population-based payment in tracks 1 and 2, IHPs are evaluated on health equity, quality, and utilization measures to determine eligibility to continue participation after the conclusion of each three-year cycle. Each IHP is required to design interventions to address social risk factors and health disparities. The health equity measures gauge the effectiveness of each intervention and IHP's cooperation with community partners. These equity measures are agreed upon by DHS and the IHP based on community-specific data; DHS provides data to help facilitate this, in collaboration with the IHP. These data demonstrate the prevalence of social risk factors and the prevalence of correlated negative health outcomes among IHP-attributed population of patients. Some examples of current IHP health equity interventions include: community collaborative to fight food insecurity, integration of behavioral and physical health to support adolescents who screen positive for depression, and an opioid management program.

### *IHP 2.0 Track 2 – Total Costs of Care*

For the purpose of the total costs of care model in track 2, IHPs are evaluated on a core set of measures to determine how much shared savings an IHP receives. In each demonstration year fifty percent of IHP's portion of shared savings is contingent on its overall quality score. The overall quality score is calculated based on IHP performance on measures organized into the following categories: Care Quality (Prevention & Screening; Effectiveness of Care for at Risk Populations, Behavioral Health; Access to Care; Patient-centered Care; Patient Safety; for IHPs starting in 2019 Quality of Outpatient Care was added), Health Information Technology (Meaningful Use of EHR: Care Coordination objective and Health Information Exchange objective). Pilot Measures (e.g. patient engagement, care coordination, opioid use or specialty measures) were included for IHPs in 2018 and have since been removed.

## Home- and community-based services

### *A. Managed care contracts*

DHS contracts with MCOs to provide certain Medicaid services including waiver and home care services. The contracts between DHS and MCOs specify the home and community-based services activities that the MCOs are responsible for and the required standards. The contracts

provide a basis to require corrective action should a compliance issue be identified. Contract managers at DHS are available to provide technical assistance to MCOs.

### *B. Care plan and care system audits*

The contracts between DHS and Managed Care Organizations (MCOs) require the MCOs to annually audit a sample of care plans for all enrollees. The MCO must use a protocol approved by DHS. The protocol includes reviewing performance of delegated administrative functions, required waiver case management and care coordination tasks, addressing corrective actions as needed, and providing audit results to DHS. A randomly selected, representative sampling method is used for care plan audits. DHS reviews and approves corrective action plans related to care plan audit findings annually.

If MCOs use a care system model where entities such as clinics, counties, and tribes provide care coordination for enrollees, DHS requires MCOs to audit the care systems that provide contracted services. The audits include care plan reviews to monitor whether care plans are comprehensive, assessments are complete, and enrollees are offered choice, as required by the waiver. The MCOs submit a summary report to the department that includes action plans to address any areas identified as needing improvement. The reports and improvement plans require the MCOs to actively monitor and respond to quality issues. The audit tools and protocols, sampling, and thresholds for corrective action plans are the same under care plan audits and care system audits. DHS reviews corrective action plans related to care system audit findings.

### *C. Triennial Compliance Review*

The Minnesota Department of Health (MDH) completes a triennial review of MCOs, with a mid-cycle review to assure corrective actions issued in the triennial review are in process or completed. DHS receives a report after each review, with additional corrective actions issued by DHS as determined necessary. The MCOs submit evidence to DHS of completed corrective actions; MDH also confirms corrective actions at the mid-cycle review.

### *D. MMIS data analysis*

DHS uses MMIS data for a variety of quality assessment and program improvement purposes. MMIS data includes information about assessed needs and planned services for all participants. DHS annually and continually monitors encounter claims data for managed care enrollees.

### *E. Fair hearing requests (State Appeal)*

DHS monitors fair hearing requests to identify patterns or trends that may indicate problems. DHS staff contact MCOs if concerned about an individual appeal issue that does not appear to be consistent with DHS policies or procedures. When possible, these contacts are made in

advance of the hearing to resolve the issue before the hearing. Managed care enrollees may also submit grievances to the MCO. This does not affect their fair hearing rights.

### *F. Consumer Surveys*

1. National Core Indicators - Aging and Disability (NCI-AD): DHS uses NCI-AD to survey EW and home care participants. Results are used to support Minnesota's efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life and outcomes of older adults, including EW and home care participants. To measure and track results over time, Minnesota implements the NCI-AD survey on a yearly basis for varying populations, with older adult sampling occurring every other year. Survey sampling methods allow DHS to look at survey results for MCO enrollees.
2. Long Term Services and Supports Improvement Tool: In 2017, DHS launched the Long-Term Services and Supports (LTSS) Improvement Tool to gather feedback from older adults and people with disabilities who receive long-term services and supports. EW participants who receive adult day, customized living, or foster care services under managed care provide feedback about their experiences in these settings through a brief survey conducted by MCO care coordinators as part of annual reassessment. Survey results help DHS measure and improve quality and outcomes for home and community-based services. The tool is built on recommendations from the National Quality Forum report, *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*.
3. Assisted Living Report Card: In 2019, DHS received funding from the Minnesota Legislature to develop and implement an Assisted Living Report Card. Assisted living is one service available through the Elderly Waiver and is used by approximately 40% of EW participants. The report card will provide information and ratings on assisted living quality at the provider setting level across a number of measures. Measures related to resident quality of life, experience, and outcomes will be supported by an annual resident survey. Measures related to family satisfaction and regulatory compliance will be support by a family survey and regulatory data from DHS and the Minnesota Department of Health.

## Nursing Home Quality

Minnesota administers four coordinated quality strategies for nursing homes. All are managed by the Nursing Facility Rates and Policy Division of the Department of Human Services (DHS).

### *Minnesota Nursing Home Report Card*

In 2006, the Minnesota Department of Health (MDH) and DHS collaborated with the University of Minnesota to create the Minnesota Nursing Home Report Card. The Report Card was a response to state legislative actions calling for greater transparency about nursing home quality.

The Report Card provides comprehensive quality information in areas that matter to people needing care and their families, and includes all facilities certified to participate in the Medical Assistance (MA) Program.[4]

The Report Card has multiple features to help users:

- Separate short and long stay search paths.
- Ability to search by location and to display results by the user's quality priorities.
- Over five years of performance history for each facility.
- Detailed information in break out tables.
- Cost information, including surcharges for private rooms.
- Convenient functionality (e.g. mapping, downloading, printing).

The Report Card compares facilities on a variety of outcome and process measures. Currently, these include long-stay resident quality of life interviews; short-stay resident experience surveys; family satisfaction surveys; comprehensive clinical quality indicators; hospitalizations and community discharges; state inspections; direct care staff measures (hours, retention and temporary nursing staff); and proportion of single bedrooms. Minnesota regularly updates its measures to reflect emerging priorities and concerns.

Minnesota uses the following guidelines when selecting measures:

- Relevant - items and topics are important to people who use services and their families.
- Credible - based on research.
- Transparent - methods are clear and easily defined.
- Understandable - educational resources and assistance are available.
- Comprehensive – multidimensional.
- Actionable - DHS works with facilities to find their opportunities for most improvement, through consultation and facility performance reports.

The national Informed Patient Institute (IPI) has given the Report Card its highest grade (A). IPI credits the Report Card for the breadth of information included; the ability to individualize the site to the user's preferences; and the use of star ratings.

Maintaining the Report Card is a challenge, requiring several staff for ongoing data analysis and reporting and additional personnel contracted to conduct approximately 30,000 in-person and mailed user surveys each year. The use of multiple quality measures requires considerable

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[4] MDH and DHS are in discussion to add the state's Veteran's Administration facilities in the future.

attention to data integrity, necessitating audit and quality assurance processes on a scheduled basis and as issues arise.

### *Value-Based Reimbursement (VBR)*

Value-Based Reimbursement (VBR) is a major change to the way the state sets Medicaid and private-pay daily rates for nursing facilities in Minnesota. Enacted by the 2015 Legislature and effective January 1, 2016, VBR sets rates based on facilities' reported costs.

VBR means to:

- Improve quality of care and quality of life for residents.
- Improve employees' standard of living.
- Address workforce needs.
- Improve facility environments for residents/employees.
- Support nursing facility access throughout the state.
- Make the payment system more understandable.

Nursing facility daily rates under VBR have four parts:

- Care Related (pays for nursing, social services, activities, food).
- Other Operating (pays for dietary, housekeeping, laundry, utilities, plant operations and administration).
- External Fixed (pays for employee health insurance costs, surcharge and license fees, facility employee scholarships, unused bed closure incentives, property taxes, public union costs, Minnesota quality incentive programs).
- Property.

The Care Related part of the VBR payment rate aims to reward higher facility quality. DHS staff calculate a quality score with a possible value between 0 and 100. If the facility's quality score = 0, the facility can spend 89.375% of the Twin Cities seven-county median (or $105.40/resident day for the first rate-year). If their quality score = 100, the facility can spend 145.625% of the median, or $171.74. The quality score comprises quality of care, quality of life and regulatory measures included on the Minnesota Nursing Home Report Card.

The Other Operating part of the VBR payment rate aims to reward higher facility value. DHS staff calculate one price for all facilities, set at 105% of the median of the costs of the Twin Cities seven-county area. This set price gives facilities an incentive to spend efficiently on dietary, housekeeping, laundry, utilities, plant operations and administration.

VBR has dramatically increased payments for care-related costs while also improving direct-care staff salaries and benefits. However, a 2019 independent evaluation requested by the Legislature found that VBR does not provide effective financial incentives for facilities to improve quality. DHS is monitoring VBR to determine its effect on quality, costs, staffing issues, and access to care as this information becomes available.

*Performance-based Incentive Payment Program (PIPP)*

The Performance-based Incentive Payment Program (PIPP) was established by the Minnesota Legislature in 2006. PIPP strives to improve nursing home quality and to increase the quality improvement (QI) capacity of nursing facility providers. PIPP has $18 million annually, available in increased payments given to nursing facilities that develop and successfully implement QI projects after a competitive selection process. Total funding includes state, federal matching, and private payments. Individual facility improvement targets are negotiated with DHS, establishing a portion of incentive payments at risk if performance targets aren't met.
DHS' goals for PIPP are to:

- Provide more efficient, higher quality care within the long-term care community.
- Encourage nursing facilities to experiment and innovate.
- Equip facilities with organizational tools and expertise to improve their quality of care.
- Motivate facilities to invest in better care.
- Share successful PIPP strategies throughout the nursing home industry.

To date, nursing facility providers have focused on a wide variety of topics across 300 projects:

- Clinical Quality (123 projects): Fall reduction, strength training, sleep, pain management, osteoporosis, bathing, skin care, congestive heart failure, wound care, pressure sore prevention, incontinence, and targeted therapy.
- Psychosocial (65 projects): Dance program, music therapy, art therapy, healing touch, behavior management, cognitive care, and hearing loss.
- Transitions (24 projects): Community transition skills, rehabilitation, and Alzheimer's-related community caregiver support.
- Organizational Change (66 projects): Person-centered care, culture change, and staff mentoring.
- Technology (22 projects): Safe patient handling, call or alarm systems, environmental modifications, and electronic health records.

All individual facility improvement projects are one or two years in length. Facilities track their progress using quality reports posted on a secure state Provider Portal website. Additionally, facilities are encouraged to develop audit tools for their own use. All facilities are required to submit semiannual status reports to share successes and challenges.

Most PIPP projects use Minnesota Report Card quality measures as their outcomes. These measures are risk adjusted, audited by state staff and flexible for multiple projects focusing on clinical, psychosocial, transition or other topics. Projects use national measures when no state measure is available or when it is the best fit for the topic.

DHS hosts an annual PIPP Boot Camp to facilitate collaborative learning among providers as they develop their QI project(s). PIPP has been independently evaluated through an Agency for Healthcare Research and Quality (AHRQ) grant, with the conclusion that PIPP leads to successful

outcomes in areas specifically targeted by PIPP-funded projects and closely associated with more improved quality overall at participating nursing facilities. The use of state-maintained quality measures has improved data efficiency and integrity, but the process is still a major challenge requiring substantial knowledge of measures and resources to administer the program.

### *Quality Improvement Incentive Payment Program (QIIP)*

The Minnesota Quality Improvement Incentive Payment Program (QIIP) was established by the Minnesota Legislature in 2013. QIIP's purpose is to recognize quality improvement efforts, and to ensure that all Medical Assistance-certified nursing facilities in the state have the opportunity to receive financial rewards for improving their quality of care or quality of life.

Facilities voluntarily select a Minnesota Nursing Home Report Card measure in the area of quality of care or quality of life to improve using their choice of intervention(s). After one year, DHS calculates the QIIP payment based on the amount of improvement achieved from an established baseline. To earn the maximum incentive payment of $3.50 per day, facilities must improve their performance one standard deviation compared to the baseline or reach the statewide 25$^{th}$ / 75$^{th}$ percentile, whichever goal represents more improvement. This cycle is repeated annually.

To date:

- Almost 100% of providers participate annually.
- About 80% of facilities choose clinical outcomes while 20% work on quality of life.
- About 75% of providers earn a full or partial payment (average QIIP for providers with any improvement is $2.65).

There is significant interest among NFs to participate in QIIP. Providers can select the same measure over multiple cycles of the program, allowing them incremental reward as they work towards long-term goals. QIIP's data management needs are lessened by the streamlined nature of the program, and the ability to automate many more components of the reporting and tracking compared to other programs.

## Behavioral Health Homes Model

The Patient Protection and Affordable Care Act of 2010 (ACA) created an optional "health home" benefit so that states could better coordinate care for Medicaid enrollees with chronic conditions. Behavioral Health Homes (BHH) Initiative is Minnesota's version of the federal "health home" benefit for Medical Assistance (MA) enrollees. BHH is a DHS project, jointly managed by the Health Care Administration and the Community Supports Administration (Adult and Children's Mental Health). The goals of the health home framework are to:

Improve health outcomes (preventative, routine, treatment of health conditions) of individuals enrolled.

- Improve experience of care for the individual.
- Improve the quality of life and wellness of the individual.
- Reduce health care costs.

Behavioral Health Home services will be made available to the following MA enrollees:

- Adults with serious mental illness.
- Adults with a serious and persistent mental illness.
- Children and youth who experience a severe emotional disturbance.

In Minnesota, DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS will build on this framework to serve other complex populations in the future.

In Minnesota, within the MA population, individuals with serious mental illness, and children and youth with severe emotional disturbance are two to three times the medical cost risk and use more impatient services. In 2012, of the adults with serious mental illness, 25 percent had at least one chronic health condition and 13 percent had at least two. BHH offers an opportunity to provide more person-centered care in order to deliver better health outcomes for adults and children with serious mental illness.

"Health Home Services" as articulated by the Affordable Care Act, Section 2703 and in Minnesota State law (256B.0757)5 requires:

- Comprehensive care management, using team-based strategies.
- Care coordination and health promotion.
- Comprehensive transitional care between health care and community settings.
- Individual and family support, including authorized representatives.
- Referral to community and social support services.
- The use of health information technology to link services, as feasible and appropriate.

Evidence suggests that better coordination and integration of primary and behavioral health care will result in: improved access to primary care services; improved prevention, early identification and intervention to reduce the incidence of serious physical illnesses including chronic disease; and increased availability of integrated holistic are for physical and behavioral disorders as well as better overall health status for individuals. Behavioral health homes services have begun in July, 2016 contingent upon federal approval.

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[5] Minn. Statutes § 256B.0757

Providers will address MA enrollees' comprehensive physical and behavioral health needs in a coordinate manner. Behavioral health home services will:

- Use a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care.
- Better meet the needs of individuals experiencing serious mental illness and their families by addressing the individual's physical, mental, substance use and wellness goals.
- Take a person-centered approach, and engage and respect individuals and families in their health care, recovery and resiliency.
- Respect, assess and use the cultural values, strengths, languages, and practices of individuals and families in supporting an individual's health goals.

DHS will certify Behavioral Health Homes. A provider must be enrolled as an MA provider and meet federal and state standards to become certified as a Behavioral health home. Behavioral health homes must serve as the central point of contact for MA enrollees and ensure consumer-centered development of a health action plan.

Minnesota established a group of providers from across the state to be the first implementers of Behavioral Health Home services. This group of first implementers, interested in becoming certified behavioral health homes, will share best practices about how to best meet a person's individual needs under the behavioral health home model. Best practices include person-centered planning and supporting integrated service delivery. BHH likely candidates include community mental health centers, pediatric clinics, and fully integrated primary care clinics. First implementers will also receive support from DHS as they prepare for certification. The current list of first implementers includes:

- Amherst H. Wilder Foundation.
- Avera Marshall.
- CentraCare Health Plaza/ Behavioral Health Clinic St Cloud Hospital.
- Canvas Health, Inc.
- Central Minnesota Mental Health Center.
- Fairview Clinics- Integrated Primary Care.
- Fraser.
- Greater Minnesota Family Services.
- Guild Incorporated.
- Headway Emotional Health Services.
- HCMC/Aqui Para Ti.
- Human Development Center.
- Indian Health Board of Minneapolis.
- Lakeland Mental Health Center, Inc.
- Mental Health Resources, Inc.
- Mental Health Systems, PC.
- Natalis Counseling and Psychology Solutions.

- North Homes, Inc. DBA: Children and Family Services.
- Northern Pines Mental Health Center.
- Northland Counseling Center Inc.
- Northwestern Mental Health Center.
- Range Mental Health Center.
- Range Regional Health Services.
- RESOURCE.
- Sanford Medical Center, Thief River Falls.
- South Central Human Relations Center.
- South Lake Pediatrics.
- South Metro Human Services.
- Southwestern Mental Health Center, Inc.
- Stellher Human Services, Inc.
- Touchstone Mental Health.
- University of Minnesota/ Community University Health Care Center (CUHCC).
- Vail Place, Inc.
- Valhalla Place, Inc.
- Washburn Center for Children.
- Western Mental Health Center.
- Woodland Centers.
- Woodland Hills.
- Zumbro Valley Health Center.

DHS has engaged stakeholders and community members to ensure that the behavioral health home model addresses the needs of MA enrollees with serious mental illness. DHS held a short-term advisory workgroup for initial input on planning in 2013. DHS also convened a long-term advisory group in August 2013. This long-term group meets quarterly to provide input into the model planning and design, and the group represents over 26 different stakeholder groups. Learn more about stakeholder and community engagement.

Additionally, to develop the BHH model, DHS entered into an agreement with the National Alliance on Mental Illness Minnesota to gather feedback from MA enrollees living with mental illness across the state. Focus group participants concentrated on several topics. DHS is using the feedback from these focus groups to shape behavioral health home policy.

- Access to physical and mental health care.
- Transition of care experiences.
- Methods of obtaining health information.
- Opinions about the facets of integrated care.
- Inclusion of individual, cultural, spiritual and gender values into the care process.

BHH will monitor avoidable hospital admissions, cost savings from improved care management, and the use of health information technology. Quality measures for this initiative include CMS core set of measures and additional Minnesota state measures.

## Integrated Care System Partnerships

Special Needs Plans (SNPs) build on current state initiatives to improve performance of primary care, behavioral health and care coordination models by shifting some of their delivery systems to be more in line with a value based purchasing (VBP) model through the Integrated Care System Partnerships (ICSP). Since 2013, State Medicaid contracts for managed care services with Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs BasicCare (SNBC) managed care organizations (MCOs) have required the development and implementation of ICSPs. ICSPs align with Integrated Health Partnerships (IHPs) and other statewide reform efforts in Medicaid. An additional bonus with ISCPs contracted with MSHO plans and the two integrated SNBC plans is that Medicare dollars may also be leveraged.

The State contract with MCOs has given MCOs flexibility over ICSP models, implementation and payment design. The State requires MCOs to build and expand on previous successes of MCO provider contracting arrangements to improve health care access, coordination and health outcomes through payment reform by establishing partnerships between primary, acute, long-term care and mental health providers serving seniors and people with disabilities enrolled in MSHO, MSC+ and SNBC.

MCOs submitted ICSP proposals for review. DHS has approved over fifty ICSPs and continue to grow serving thousands of enrollees. The goal of ICSPs is to pay for outcomes, quality care and to reward strongly performing providers. ICSPs differ based on population served, geographic area, care coordination models, performance measures and financial incentives. The MCO provider contract with the ICSP may use a range of combined payment mechanisms such as per member per month (PMPM), virtual sub-capitations for total cost of care, pay for performance (P4P), incentive pools, or risk and gain sharing options.

Examples of the assortment of ICSPs implemented with various providers, target populations and payment models under different MCOs:

- Traditional Accountable Care Organizations (ACOs).
- Sub-capitation for all services with risk and gain sharing.
- Fairview Partners, Accountable Rural Community Health (ARCH).
- Health Care Homes (HCH).
- Primary care and care coordination PMPM with risk/gain sharing, may include gain. sharing against virtual cap for key services.
- Essentia or Bluestone.
- Community Behavioral Health Providers.
- PMPM for integrated Care Coordination with P4P.
- Mental Health Resources (MHR), Guild, Touchstone Mental Health.
- HCH/Rehabilitation Facility Combo.

PMPM with P4P for primary Care and related support services:

- Courage Center.
- Long Term Care Organizations.
- P4P on gain sharing.
- Care Choice, Presbyterian Homes.

All ICSPs are subject to state contract requirements for care coordination, quality metrics, and reporting. Providers told DHS they wanted some alignment of measures with the advice of a clinical workgroup, DHS developed a set of performance measures from which ICSPs may choose.

Examples of outcome measures ICSPs may choose:

- Improve member experience, health outcomes and quality of care.
- Reduction in hospital admits and readmissions.
- Medication reconciliation and follow-up with member after discharge.
- Evidence of integration of behavioral, mental and physical health.
- Advance Directives.
- Flu shots.
- Reduce falls with fracture, falls prevention.
- Patient Activation Measurement implementation (PAM).
- Care coordination to avoid fragmentation of service delivery.
- Reduce per capita costs of health care.
- Reduce all cause hospital readmissions.
- Reduce use of high risk medications.
- Anti-depression medication management.

MCOs must report annually on a standardized template each ICSP including the payment model, performance measures, outcomes and next steps planned to increase effectiveness of each ICSP. It is too early in the implementation of ICSPs to have meaningful data. Some key takeaways are:

- State sets the larger vision and the MCO in cooperation with the providers move forward together through the ICSPs to foster a culture of learning to 1) support improved provider performance, 2) incentivize provider efficiency, 3) reduce unnecessary spending, and 4) improve health outcomes.
- Flexibility is important as MCOS move providers of various sizes, serving diverse populations to a higher degree of integration, accountability and increased risk; The goal is to pay for good outcomes, high quality care and to reward strongly performing providers.
- ICSPs are an opportunity to provide quality health care for Minnesotans while transforming the relationship among health care users, providers and payers.

Reports show some arrangements are seeing some success and are saving dollars, but comprehensive information as to which arrangements yield the most promising results is not yet available.

## Consumer satisfaction

DHS sponsors an annual satisfaction survey of enrollees using the Consumer Assessment of Health Plans Survey (CAHPS®) instrument and methodology to assess and compare the satisfaction of enrollees with services and care provided by MCOs. The survey is conducted using a four-wave mail plus telephone data collection method. The CAHPS vendor works toward the goal of collecting 300 completed surveys from enrollees in each MCO health plan product and fee-for-service enrollees for a total of at least 6,600 completed surveys. DHS also sponsors an annual satisfaction survey for senior enrollees in the Medicare-integrated MSHO program. DHS and CMS collaborate to send MSHO enrollees a single, annual CAHPS survey, to which DHS adds questions on topics of special interest to the state. CMS then sends the CAHPS survey to MSHO enrollees. See the survey results.

## Managed care grievances summary

DHS compiles an annual report summarizing data on enrollee grievances and appeals filed with MCOs; notices of MCO denials, terminations or reductions (DTRs); and managed care State Fair Hearings (State Appeal) filed with DHS. See the report.

## 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. See the most recent results from examinations of each health plan.

## HEDIS report

The Minnesota Department of Health also compiles an annual report using the Health Care Effectiveness Data Information Set (HEDIS) tool to compare how health plans perform in quality of care, access to care, and member satisfaction. The MDH methodology includes hybrid data, which includes medical records reviews. Read the reports online.

DHS conducts an annual technical validation of its ability to use MCO claims data to monitor HEDIS measures used in the Annual Technical Report (ATR) and to support various policy development and quality improvement initiatives across the department. The latest ATR can be found on the DHS website.

## Self-reported MCO quality improvement initiatives

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

As of calendar year 2016, MCOs established website pages describing quality improvement activities that have resulted in measurable, meaningful, and sustained improved health care outcomes for the contracted populations. The website links:

- Blue Plus: www.bluecrossmn.com/qualityimprovement
- HealthPartners: www.healthpartners.com/hp/about/understanding-cost-and-quality/quality-improvement/index.html
- Itasca Medical Care: www.co.itasca.mn.us/657/Community
- Medica: www.medica.com/providers/quality-and-cost-programs/quality-improvement-program
- Hennepin Health: www.hennepinhealth.org/quality
- PrimeWest Health: https://primewest.org/annual-report
- South Country Health Alliance: http://mnscha.org/?page_id=5924
- UCare: https://www.ucare.org/About/Pages/QualityHighlights.aspx

### Annual report of managed care in Minnesota Health Care Programs

This comprehensive report provides a summary of oversight activities in Minnesota's state managed care programs.

## Managed care regulations

### Federal regulation 42 CFR § 438

DHS' quality strategy has been developed to incorporate federal regulation governing managed care at 42 CFR §438.340. The DHS quality strategy:

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

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

## State and federal managed care regulations

The Managed Care Quality Strategy is organized to reflect the standards outlined in Subparts A, D, and E of the federal Medicaid Managed Care Regulation at 42 CFR § 438, which includes rules around:

- Availability of services.
- Assurances of adequate capacity and services.
- Coordination and continuity of care.
- Coverage and authorization of services.
- Provider selection.
- Enrollee information.
- Confidentiality.
- Grievance systems.
- Subcontractual relationships and delegation.
- Practice guidelines.
- Quality assessment and performance improvement program.
- Health information systems.

The parallel state law regarding managed care quality is located at Minnesota Statutes, § 256B.6927.

Each of the standards is described in Appendix B, including the methods used to assess compliance with the standards. Appendix B also describes other state and federal requirements.

## National Committee for Quality Assurance standards

To avoid duplication, the Managed Care Quality Strategy's assessment of mandatory activities includes information obtained from the National Committee for Quality Assurance (NCQA) in addition to the Minnesota Department of Health's triennial Quality Assurance Examination. DHS, the Minnesota Department of Health, MCOs and NCQA have spent considerable time meeting to determine how information gathered by NCQA and Medicare can be used to minimize the data collection burden and still provide the External Quality Review Organization information to complete its assessment consistent with 42 CFR §438.364.

Currently, five MCOs are accredited by NCQA; if an NCQA accreditation review indicates the MCO did not obtain 100 percent compliance with a standard (or element), MDH completes the entire review of that standard during their triennial onsite review. If the MCO is in 100 percent compliance with NCQA standards considered by DHS as equal or greater than state and federal requirements, then MDH will not audit the applicable section. Likewise, equivalent CMS

Medicare Audit Standards will be used to reduce the triennial audit data collection burden. Data collection burden is reduced since:

- MDH and DHS agree on joint aspects of the review, for example Credentialing, delegation oversight. MDH does the review for both entities.
- MDH and TCA review is done at the same time.
- Same Quality documents, annual work plan and annual evaluation – submitted to DHS only; MDH gets these document from DHS at time of audit. DHS accepts MDH review of written Quality plan.
- Overlapping requirement for UM, for example:
    - DTR requirements in §438.404 regarding timing of notice and written and oral notifications as well as 438.210 (coverage and authorization of services) as interpreted by DHS are consistent with MS §62M requirements as reflected in the contract.
    - Appeal requirements in §438.406 and 438.408 are reviewed in concert with MS §62M.06 requirements since requirements overlap.
- Same timelines for submission of audit materials and CAPs with submission to one agency.

Appendix A provides a current listing of comparable NCQA and CMS standards.

## Review of Minnesota Medicaid Managed Care Comprehensive Quality Strategy

DHS uses standing advisory and stakeholder groups, including the MCO Quality Workgroup, to review the strategy and its components. Comments from the general public will also be solicited.

DHS will review and update this comprehensive quality strategy at the end of each calendar year for submission by the end of the first quarter of the following year. DHS will solicit input from multiple internal and external stakeholders through workgroups and posting a draft of the comprehensive quality strategy document on its website for public review and comment. The feedback provided by stakeholders, including Medicaid enrollees and their representatives, will be taken into consideration and incorporated into the comprehensive quality strategy updates.

### Other factors requiring a review of the comprehensive quality strategy

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

- A material change in the numbers, types or timeframes of reporting.
- A pervasive pattern of quality deficiencies identified through analysis of the annual reporting data submitted by the MCOs, the quarterly grievance reports, the state's

annual compliance on-site surveys and desk reviews, and the enrollee complaints filed with the state.

- Changes to quality standards resulting from regulatory authorities or legislation at the state or federal level.
- A change in membership demographics or the provider network of 50 percent or greater within one year.

## Next steps

DHS is the single state agency for the administration of Medical Assistance. However, the department is composed of several administrations and aspects of the Medical Assistance program are distributed among the administrations. The comprehensive quality strategy provides an opportunity to investigate and enumerate the health quality improvement efforts occurring throughout the department. Future submissions of Minnesota's Medicaid Managed Care Comprehensive Quality Strategy will include descriptions of and reports of progress on the coordination of health quality improvement efforts throughout the department. Appendix G includes descriptions and reports of progress on many of these health quality improvement efforts throughout the department.

With the larger view of Medical Assistance program improvement efforts, the department will be in a position to assess the alignment and intersection of all the initiatives. Continued dialogue amongst the departments and stakeholders around updating the quality strategy towards aligning the various components where applicable will strengthen and make the strategy more consistent and cohesive. The progress of the updated strategy and continued updates of program improvement efforts will be included in the next annual report.

## List of appendices

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

- Appendix A: Data Collection Burden Reduction.
- Appendix B: Managed Care Core Quality Strategy Components.
- Appendix C: DHS Supplemental Triennial Compliance Assessment Elements.
- Appendix D: Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver.
- Appendix E: Proposed Evaluation for Reform 2020.
- Appendix F: Evaluation Plan Objectives and Indicators for Minnesota Family Planning Program §1115 Waiver.
- Appendix G: Medicaid Tribal Consultation Policy.
- Appendix H: State Public Notice Process.
- Appendix I: Ongoing DHS Performance Measurement.
- Appendix J: Directed Payment Arrangements.
- Appendix K: IHP Specific Measures.
- Appendix L: Initiatives Under Development.
- Appendix M: Catalog of Past Quality Improvement Efforts.

## Appendix A: Data Collection Burden Reduction

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

| Medicaid Regulation | 100% Compliance with the NCQA Standard |
|---|---|
| Utilization Review and Over/Under Utilization of Services 42 CFR §438.240 (b)(3) | UM 1-4, 10, 11, 13; QI 4 (Plans must show compliance with MS §62M for UM) |
| Health Information Systems 42 CFR §438.242 | Annual NCQA Certified HEDIS Compliance Audit 1 |
| Clinical Practice Guidelines 42 CFR §438.236 (b-d) | PHM 1-7 (2020 NCQA) |
| Case Management and Care Coordination 42 CFR §438.208 (b)(1-3) | PHM 5 Elements A, B, C, D, E |
| Confidentiality 42 CFR §438.208 (b)(4), §438.224, and 45 C.F.R. Parts 160 and 164, Part 431, Subpart F | RR5, Elements A-G |
| Credentialing and Re-credentialing 42 CFR §438.214 | CR 1 - 8 |

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

Beginning in 2020, DHS has replaced the Disease Management requirement with a Population Health Management (PHM) program.

# Appendix B: Managed Care Core Quality Strategy Components

Under 42 CFR 438.340, the state agency must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by its contracted MCOs. The elements of this strategy for Minnesota are described below.

## 42 CFR 438.206 Availability of services

*MCO Duties*

In a managed care delivery system, the MCO agrees to provide all services to enrollees through its contract with the State. Any services or benefits provided under the State Plan that are not covered though the contract are identified in the MCO's Member Handbook. The MCO must provide information to enrollees on how to access State Plan services not covered in the contract. Under the contract with the State, the MCO provides the same or equivalent services as provided in fee-for-service, or at its own expense may exceed the State limits provided through the FFS delivery system. The MCO may also provide additional or substitute services. The contracts specify availability of services including, but not limited to 24-hour, 7-days per week access to Medical Emergency, Post-Stabilization Care, and Urgent Care services. These services must be available during hours of operation at least equivalent to the level available to commercial or FFS enrollees.

Enrollees receive information in the Member Handbook regarding what services are covered and how to access those services through the MCO. Enrollees also receive information regarding their rights and responsibilities under managed care via information issued by DHS. MCOs are required to make enrollee materials available in predominant languages and to translate any MCO specific information vital to an enrollees understanding of how to access necessary services. These requirements ensure that information regarding MCO services and enrollee rights are available to enrollees with limited English proficiency (LEP). These documents are updated on a monthly, quarterly or annual basis. In addition to being sent to potential enrollees, the information is available on the individual MCO and DHS public websites.

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

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

network is unable to provide services required by an enrollee, the MCO must adequately and in a timely manner cover services outside the network for as long as the current MCO provider network is unable to provide the needed services.

The state agency offers special needs programs that either integrate Medicaid and Medicare benefits and requirements or combine Medicaid benefits with a Medicare Advantage Special Needs Plan (SNP) to serve persons with disabilities, or persons age 65 years and older, who often have comorbid chronic care needs. Through these special needs plans enrollees have access to coordinated benefits and care, including Medicare pharmacy benefits, to meet their specific health care needs. The State's special needs programs are described below:

**Minnesota Senior Health Options (MSHO):**

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

**Special Needs Basic Care (SNBC):**

SNBC is a voluntary managed care program for people age 18 to 64, who are certified disabled and eligible for Medical Assistance. SNBC incorporates Medicare Parts A, B and D for enrollees who qualify for that coverage. A care coordinator or navigator is assigned to each enrollee to help access health care and other support services. DHS contracts with six Medicare Advantage Special Needs Plans to provide SNBC. SNBC offers all medically necessary Medicaid State Plan Services with the exception of HCBS waivers, Personal Care Assistants, and private duty nursing (PDN). HCBS waiver services, PCA, and PDN services are paid by the MA fee-for-service program. If an enrollee is Medicare eligible, the MCO covers all Medicare services, including prescription drugs covered by Part D and any alternative services the MCO may choose to offer. The MCO pays for the first 100 days of nursing facility care for community enrollees who enter a nursing facility after enrollment. Blue Plus and Itasca Medical Care do not participate in the program.

### *Oversight Activities*

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

DHS uses specific protocols to review evidence of coverage (EOCs), PCNLs and provider directories. This includes review of information on what services may be accessed directly and services which require a referral. Availability of services are assessed including primary care, specialty care, women's health services, second opinions, access to out-of-network services, and transitional services. Other elements reviewed include limitation on cost-sharing not to exceed the in-network cost, and access to covered MA services not covered by the MCO contract.

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

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

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

### *Reports and Evaluation*

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

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

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

## 42 CFR §438.68 Network adequacy standards and 42 CFR §438.207 Assurance of adequate capacity and services

*State and MCO duties*

The state agency requires its contracted MCOs to comply with the standards for all HMOs in the state, which are in state law.[6] The state law and MCO contract requirements include distance and travel time standards for primary care, specialty care (including behavioral health and OB/GYN), hospitals, dental, optometry, laboratory, and pharmacy services. All other services must be as available to Medicaid enrollees as they are to the general population.

*MCO duties*

In a managed care delivery system, the MCO, through its contract with DHS, assures the state agency that it has the capacity to provide all health care services identified in the contract to publicly funded enrollees. The signed contract represents that assurance. The MCO also assures DHS that those services are sufficient to meet the health care needs of enrollees and have sufficient capacity to meet community standards.

On a monthly basis the MCO is required by the contract to provide a complete list to DHS of participating providers. The MCO must furnish on its web site a complete provider directory including the names and locations of primary care providers, hospital affiliations, whether providers are accepting new patients, languages spoken in the clinics, how to access behavioral health services, and other important information. As of 2018, the provider directories must also include cultural competency training and handicap accessibility indicators.

DHS requires MCOs to pay out-of-network providers for required services that the MCO is not able to provide within its own provider network. The MCO is required to provide enrollees with

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[6] Minnesota Statutes, § 62D.124; § 62Q.19.

common carrier transportation to an out-of-network provider if necessary. If a particular specialty service is not available within the MCO's immediate service area, the MCO must provide transportation. Treatment and transportation are provided at no cost to the enrollee except for permitted cost sharing arrangements.

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

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

### *Waiver services provider networks for MSHO and SNBC*

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

### *Oversight activities*

MDH reviews and approves provider networks during the initial MCO licensure process and any service area expansion of an MCO. MDH also reviews MCO provider networks during the QA Exam conducted every three years. MDH will conduct a follow-up evaluation if deficiencies are identified. MDH reviews the impact of provider terminations on an MCO's provider network.

MCO policies and procedures are reviewed for access requirements under Minnesota Statutes 62D (for HMOs). Minnesota access standards require that primary care providers are available within 30 minutes or 30 miles and specialty care within 60 minutes or 60 miles, unless there are no providers within those limits. In such cases, state law permits application of a community standard.

During site visits, MDH assesses appointment availability and waiting times. Utilization management activities are also reviewed. Grievances are audited to determine if any patterns resulting from access issues can be identified. The results of the MDH assessments are made available to DHS. DHS reviews the results to determine whether there are any issues that affect

contract compliance and if so, requires corrective action by the MCO. Results of the MDH QA Exam are also made available to the EQRO for review.

At the time of initial entry of an MCO into a region for a DHS contract, DHS reviews the MCO's proposed provider network for completeness. MCOs must have service area approval from MDH before a contract can be signed. DHS works with local county agency staff to develop requests for proposals for each geographic region, including the identification of major providers, any gaps in the service area for potential responders to the Request for Proposal.

County staff that have knowledge of recipient utilization and access patterns, also review initial provider network proposals and advise DHS of the relative strengths and weaknesses of the proposals. Minnesota Statutes § 256B.69 states that local county boards may review proposed provider networks and make recommendations to DHS regarding the number of MCOs and which MCOs should receive contracts with DHS. In addition, the law also specifically provides that county boards may work with DHS to improve MCO networks until additional networks are available.

In addition to the network adequacy reviews performed by MDH, DHS reviews provider directories monthly for accuracy. This review uses a protocol to ensure completeness of information required by 42 CRF § 438.207 (names, addresses, languages, providers that are closed and open to new enrollees). Materials provided to enrollees and potential enrollees by MCOs must be approved by DHS prior to distribution. MCOs are required to list a phone number in the materials so an enrollee or potential enrollee can get information on changes that occur after materials are printed. MCOs may also include this information on their websites. DHS also reviews and approves all MCO website content.

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

### *Reports and evaluation*

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's compliance with this standard. As of contract year 2019, an EQRO will conduct an annual retrospective review of network adequacy consistent with 42 CFR 438.358(b)(1)(iv).

The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

## 42 CFR §438.208 Coordination and continuity of care

*State and MCO duties*

In the event of a contract termination, the MCO contracts require the state agency and MCO to cooperate in transitioning enrollees to a new MCO (Minnesota has mandatory managed care enrollment, and the state agency not the MCO completes all enrollments). The contract requires a transition period of 150 days which has been sufficient to re-enroll large numbers of enrollees into new MCOs. Communication with the affected enrollees is through the state agency to ensure informed choice. Where the enrollee has an established relationship with a particular provider or in certain other situations, continuity of care is required of the enrollee's new MCO by payment for out-of-network services or by a planned transition to network providers.

*MCO duties*

MCOs are required to ensure coordination of all care provided to enrollees to promote continuity of care. This includes coordination of care and benefits when multiple providers, or provider systems or multiple payers are involved. DHS contracts with MCOs for a comprehensive range of Medical Assistance and MinnesotaCare benefits. DHS does not contract for partial benefit sets such as a behavioral health carve-out.

The MCO is required to have written procedures that ensure that each enrollee has an ongoing source of primary care appropriate for his or her needs and a provider formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. Coordination of care between acute care settings such as discharge planning for an inpatient stay is required by state law for providers, and the MCO is required to include such compliance in its provider contracts.

The MCO is responsible for the overall care management of all enrollees. The MCO's care management system must be designed to coordinate primary care and all other covered services to its enrollees and promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care, and fiscal and professional accountability.

The MCO must also have procedures for an initial screening, followed by a diagnostic assessment, as needed; development of an individual treatment plan based on the needs assessment; establishment of treatment goals and objectives; monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. For enrollees with identified special needs, a strategy to ensure that all enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment if an enrollee requires a treatment plan for any condition. The enrollee must be allowed to participate in the development and review of his or her plan to the extent possible according to the enrollee's health status.

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

Most dual-eligible enrollees get their Medical Assistance and Medicare services from the same MCO under a demonstration model that integrates care. MSC+ and some SNBC enrollees may receive their Medicare services from Original Medicare or by enrolling in a Medicare Advantage managed care plan different from their MSC+ MCO. The MCO must coordinate Medicare and Medicaid services.

*Oversight*

DHS reviews the EOCs to assess each MCO’s procedures for ensuring coordination and continuity of care and ensuring that each enrollee has access to a primary care provider. MSHO/ MSC+ MCOs are required to audit a sample of care plans of waiver enrollees to assess the implementation of care plan requirements for each care system and county care coordination system. The care plan audit examines evidence of comprehensive care planning as stipulated in the Comprehensive Care Plan Audit Protocol. DHS also reviews grievance and appeal data to identify whether access to primary care providers, care coordination or continuity of care are issues requiring systematic follow-up.
DHS follows up on a case-by-case basis on specific grievance and appeals regarding coordination and continuity of care.
The state agency contracts with the Minnesota Department of Health as the regulator for HMOs for a triennial “look behind” audit of a sample of MSHO/MSC+ MCO care plan audits to assess each MCO’s compliance with the standard outlined in the Comprehensive Care Plan Audit Protocol to identify areas for a closer examination.

*MCO duties*

According to their contract MCOs must identify enrollees who may need additional health care services through method(s) approved by DHS. These methods must include analysis of claims data for diagnoses and utilization patterns (both under and over) to identify enrollees who may have special health care needs. The initial screening required under 42 CFR 438.208(b)(3) is another resource for identifying enrollees who may have special health care needs.

In addition to claims data, the MCO may use other data to identify enrollees with special health care needs such as health risk assessment surveys, performance measures, medical record reviews, and enrollees receiving personal care assistant (PCA) services, requests for pre-

authorization of services and/or other methods developed by the MCO or its contracted providers.

The mechanisms implemented by the MCO must assess enrollees identified and monitor the treatment plan set forth by the treatment team. The assessment must utilize appropriate health care professionals to identify any ongoing special conditions of the enrollee that require specialized treatment or regular care monitoring. If the assessment determines the need for a course of treatment or regular health care monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist such as a standing referral or a pre-approved number of visits as appropriate for the enrollee's condition and identified needs.

*MSHO/SNBC*

The state agency has determined that all enrollees in MSHO and SNBC are considered to meet the requirements for enrollees with special health care needs. In MSHO and SNBC, all enrollees are screened and assessed to determine whether they have special needs.

In MSHO, the MCO is required to have providers with geriatric expertise and to provide Elderly Waiver home and community based services to eligible individuals.
In SNBC, the MCO must offer primary care providers with knowledge and interest in serving people with disabilities. The MCO also coordinates Community Alternatives for Disabled Individuals (CADI) and Brain Injury (BI) waiver services with counties for eligible individuals. Contracts with MCOs also require them to have mechanisms to pay for additional or substitute services. Contracts also ensure enrollee privacy in care coordination for Special Health Care Needs services.

*Oversight*

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

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

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

*Reports and evaluation*

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

## 42 CFR §438.210 Coverage and authorization of services

*MCO duties*

Article 6 of the MCO contracts specifies which services must be provided and which services are not covered. Medical necessity is defined. The contract requires that all medically necessary services[7] are covered unless specifically excluded from the contract. The MCO must have in place policies for authorization of services and inform enrollees how services may be accessed (whether direct access is permitted, when a referral is necessary, and from whom). In the contract, federal, and state laws specify time frames for decisions and whether standard or expedited. (See Grievances and Appeals in Article 8 of the contract). The EOC must inform enrollees how to access State Plan services not covered by the MCO's contract.

When a service is denied, terminated, or reduced, the MCO must notify the requesting provider and give the enrollee a notice of action including a description of the enrollees' rights with respect to MCO appeals and State Fair Hearing process. Decisions to deny or reduce services must be made by an appropriate healthcare professional.

*Oversight activities*

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

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

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

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

*MSHO /SNBC*

DHS has an interagency agreement with MDH for review of specified Medical Assistance requirements, including specific MSHO items. The MSHO contract requires that MCOs conduct on-site audits of provider care systems and provide information about care system performance at the State's annual site visit. DHS also reviews MSHO encounter data with comparisons to Families and Children MA and MA FFS. DHS developed a database combining Medical Assistance and Medicare data about dual-eligible enrollees to enable data analysis of the dual-eligible population. The state agency works with a collaborative created by MCOs participating in MSHO to track a core set of "Value Added" utilization measures. Implementation of SNBC began January 1, 2008 as well as analysis of utilization patterns of SNBC enrollees.

*Reports and evaluation*

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

## 42 CFR §438.214 Provider selection

*MCO duties*

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

The MCO is required to have a uniform credentialing and re-credentialing program that monitors and reviews the panel of providers for the quantity of provider types and the quality of providers offering care and service. The MCO's credentialing and re-credentialing program must follow National Committee for Quality Assurance (NCQA) standards. For organizational Providers, including hospitals, and Medicare certified home health care agencies, MCOs must adopt a uniform credentialing and re-credentialing process and comply with that process consistent with state law.

As of 2018, the MCO must ensure that its network providers are enrolled with the state as MHCP providers.[8] Network Providers must comply with the provider disclosure, screening, and enrollment requirements in 42 CFR § 455.

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

*Oversight activities*

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

*Reporting and evaluation*

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

## 42 CFR §438.10 Information requirements

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

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

*State duties*

DHS must ensure that enrollment notices, informational, instructional and marketing materials are provided at a 7th grade reading level. The state agency or local agency provides information to most potential enrollees through written enrollment materials. Potential enrollees may also choose to attend a presentation. This information is designed to help enrollees and potential enrollees understand the managed care program. The state agency must identify the prevalent non-English languages spoken throughout the state and make written information available in those languages. The state agency must make oral interpretation services available in any

[8] 42 CFR § 438.602(b),

language and must provide information about how to access interpretation services. Information must be available in alternative formats to address special needs, such as hearing or visual impairment, and must inform enrollees and potential enrollees about how to access those formats.

*MCO duties*

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

*Oversight activities*

The state agency provides model enrollment materials, which meet the requirements above, to the local agency for distribution to all enrollees or potential enrollees. By contract, the state agency must review and approve all MCO notices and educational/enrollment materials prior to distribution to enrollees or potential enrollees. MCO enrollees receive a membership card and other materials, including a Provider Directory and the Evidence of Coverage upon enrollment.

*Reporting and evaluation*

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

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

## 42 CFR §438.224 Confidentiality

*MCO duties*

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

*Oversight activities*

The state agency has incorporated the requirements of 45 CFR parts 160 and 164, subparts A and E into its contracts with MCOs. The state agency monitors MCO compliance with all applicable confidentiality requirements.

*Reporting and evaluation*

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

## 42 CFR §438.228 Grievance and appeal system

*MCO duties*

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

- MCOs are required to have a grievance and appeal system which includes an oral and written grievance process, an oral and written appeal process, and access to the State Fair Hearing system. The process must allow a provider to act on behalf of the enrollee with the enrollee's written permission.
- The MCO must assist enrollees, as needed, in completing forms and navigating the grievance and appeal process. The appeal process must provide that oral inquiries seeking to appeal an action be treated as an appeal with the opportunity to present evidence in person as well as in writing.
- The MCO must resolve each grievance and each appeal, whether orally or in writing, and provide notice, as expeditiously as the enrollee's health condition requires, but no later than the timeframes established by state and federal laws, and that are specified in the contract.
- A State Fair Hearing must be permitted as specified by the State. The MCO must be a party to the State Fair Hearing and comply with hearing decisions promptly and expeditiously.
- The MCO must send a notice of action to each enrollee when it denies, terminates, or reduces a service or when it denies payment for a service. The notice must state the action taken; the type of service or claim that is being denied, terminated, or reduced; the reason for the action; and the rules or policies which support the action. The notice must include a rights notice, explaining the enrollee's right to appeal the action.

Minnesota uses a model notice format with required language, from which the MCOs may not deviate. The MCO must continue to provide previously authorized benefits when an enrollee appeals the denial, termination, or reduction of those benefits and the timelines and other conditions for continuation of benefits are met, as specified in Section 8 of the contract.

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

*MSHO/Integrated SNBC:*

Enrollees of these programs also have access to Medicare grievance and appeals processes. In order to simplify access to both the Medicare and Medical Assistance grievance systems, the state agency has developed an integrated process in conjunction with CMS that allows the MCO to make integrated coverage decisions for both Medicare and Medical Assistance.

Enrollees continue to have access to grievance and appeal procedures under both programs.

*Oversight activities*

On a quarterly basis, the MCO must report specified information about each notice of action to the state Managed Care Ombudsman Office. This office reviews this information and tracks trends in the MCO's grievance and appeal system.

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

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

*Reporting and evaluation*

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

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

## 42 CFR §438.230 Sub-contractual relationships and delegation

*MCO duties*

The MCO may choose to delegate certain health care services or functions (e.g., dental, chiropractic, mental health services) to another organization with greater expertise for efficiency or convenience, but the MCO retains the responsibility and accountability for the function(s).

The MCO is required to evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. When the MCO delegates a function to another organization, the MCO must do the following:

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

*MSHO/ SNBC:*

MCOs are also required to audit their care systems annually.

*Oversight activities*

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

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

*MSHO/ SNBC:*

The MDH QA Exam reviews MCO subcontracts for compliance with contract requirements.

*Reporting and evaluation*

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

## 42 CFR §438.236 Practice guidelines

*MCO duties*

Adoption and application of practice guidelines are essential to encourage appropriate provision of health care services and promote prevention and early detection of illness and disease.[9] Providers that agree and follow guidelines based upon current clinical evidence have the potential to identify and change undesirable health care processes and reduce practice variation.

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

*Oversight activities*

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

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

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

*Reporting and evaluation*

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

## 42 CFR §438.330 Quality assessment and performance improvement program

*MCO duties*

The MCO contracts require each MCO to provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. The MCO must then implement the quality improvement plan, and conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations. This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standard measures and MCO's performance improvement projects. The MCO must submit the written evaluation to the state agency.

Conducting quality improvement projects provides a mechanism for the MCO to target high risk, high volume or problem prone care or service areas that can be improved with a focused strategic intervention(s).[10] These projects are designed to identify and subsequently introduce evidence- based interventions to improve the quality of care and services for the at-risk enrollees. Quality improvement projects reflect continuous quality improvement concepts including identifying areas of care and service that need improvement, conducting follow-up, reviewing effectiveness of interventions, making additional changes, and repeating the quality improvement cycle as needed.

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

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

- Have a favorable effect on health outcomes,
- Use measurements of performance that are objective quality indicators,
- Implement system interventions to achieve improvement in quality,
- Evaluate the effectiveness of the interventions, and

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

- Plan and initiate activities that will increase or sustain the improvements obtained.

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

*Oversight activities*

Each year the MCO selects a project topic and submits to DHS a project proposal describing the project to be undertaken beginning in the next calendar year. The project usually spans a three to four year period with an annual interim report, due upon request, leading to a final project report. DHS reviews and recommends changes as appropriate and submits the final reports to the EQRO for evaluation to determine if significant improvement has been achieved and if it will be sustained over time. The 2018 – 2020 PIP focuses on Reducing New Chronic Opioid Users.

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

*Reporting and evaluation*

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

## 42 CFR §438.242 Health information systems

*MCO duties*

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

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

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

The Health Information System is required to possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, incorporate safeguards

against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status.

*Oversight activities*

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

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

*Reporting and evaluation*

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

Annually, the EQRO summarizes and evaluates all information gathered and assess each MCO's compliance with this standard. The EQRO also makes recommendations for improving the quality of health care services furnished by each MCO. This includes evaluation of the HEDIS rates calculated by DHS and validated by the agency's NCQA Certified HEDIS Auditor.

## §438.340(b)(6) Health disparities reduction

The state agency works to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The state agency strives to identify this demographic information for each enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. Age and sex indicators are included in all enrollment files, along with the basis for eligibility which includes disability status. Identification of race, ethnicity, and primary language are requested as part of the enrollment process and provided to the MCOs; improving the quality of these data is an ongoing process of training enrollment workers.

The Health Care Disparities Report provided by Minnesota Community Measurement (MNCM), provides performance rates on clients enrolled in Minnesota Health Care Programs (MHCP). The purpose of this report is to provide transparency on data, specifically on performance and health outcomes, to optimize system-wide changes. The Health Care Disparities Report is inclusive of 11 medical group and clinic level measures, which also presents analysis based on

race, ethnicity, and region. The report also aligns with the Minnesota Statutes, section 256B.072(d), "Performance Reporting and Quality Improvement System". The Health Care Disparities Report includes analysis on comparison between MHCPs and Other Purchasers, in order to ensure equity of care, access, and utilization of services. It is published and posted on the Minnesota Community Measurement and the MN Department of Human Services websites. By making this document available, it provides an insight on current challenges and identifies opportunities to reduce health disparities in the state.

## 42 CFR §438.700 Basis for imposition of sanctions

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

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

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

The type of sanctions included in the contract satisfies most of the requirements of 42 C.F.R. §438.700.

## § 438.702 Types of intermediate sanctions and § 438.704 Amount of civil money penalties

The state agency may impose temporary management of the MCO. The contract has provisions for due process for the MCOs, including the opportunity to cure a breach and access to a mediation panel. The State's rights to terminate a contract are defined in the contract.

# Appendix C: DHS Supplemental Triennial Compliance Assessment Elements

## Information gathered during the MDH QA Examination, July 2020

During the QA Examination, MDH will collect and validate MCO compliance information for DHS publicly funded managed care programs.[11] The compliance information will be gathered and reported for each publicly funded program (Families & Children MA, MinnesotaCare, MSHO/MSC+ and SNBC) as appropriate. MDH will produce a written summary of the information gathered during the MCO's QA Examination. Listed below are the areas that MDH will gather compliance information for DHS Supplemental Triennial Compliance Assessment (TCA).

*Calendar Year 2020 TCA Elements*

1. **Quality Assessment and Performance Improvement Program – 2020 Contract Section 7.1[12], (7.1.1 and 7.1.2)**

   A. The MCO shall provide an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees, ensuring the delivery of quality health care. The Quality Assessment and Performance Improvement Program must be consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR § 438, subpart E, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, 62Q and 256B and related rules, including Minnesota Rules, parts 4685.1105 through 4685.1130, and applicable NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" as specified in 2020 Contract.

   **B. Scope and Standards:** The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR § 438, Subpart E, (Quality Measurement and Improvement; External Quality Review). At least annually, the MCO must assess program standards to determine the quality and appropriateness of care and services furnished to all Enrollees. This assessment must include monitoring and evaluation of compliance with STATE and CMS standards and performance measurement.

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[11] DHS/MCO Contracts and current NCQA Standards and Guidelines for the Accreditation of Health Plans.

[12] Families and Children MA, Seniors (MSHO/MSC+), and Special Needs Basic Care (SNBC) Contract Section 7.1 and sub-sections; MSHO/MSC+ Contract Section 7.1 also includes the requirement that the MCO must comply with requirements of "*Quality Framework*," for EW services, including those found in the CMS "*Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers*" published in March 2014.

C. **Accreditation Status:**[13] The MCO must inform the State whether it has been accredited by a private independent accrediting entity through an annual report due August 1 of the contract year, in a format determined by the STATE. If the MCO holds an accreditation, the MCO must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, including accreditation status, survey type, and level; accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. The report is due in conjunction with the Triennial Compliance Audit conducted by the state as provided in the protocols provided for the Triennial Compliance Examination. [42 CFR §438.332(a) (b)].

**2. Information System – 2020 Contract Section 7.1.3.**[14]

The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data, and can achieve the following objectives: (1) Collect data on Enrollee and provider characteristics, and on services furnished to Enrollees; (2) Ensure that data received from Providers is accurate and complete by: (a) Verifying the accuracy and timeliness of reported data; and (b) Screening or editing the data for completeness, logic, and consistency; and (c) Collecting service information in standardized formats to the extent feasible and appropriate; (3) Make all collected data available to the STATE and CMS upon request.

**3. Utilization Management -2020 Contract Section 7.1.4.**

A. The MCO shall adopt a utilization management structure consistent with state and federal regulations and 2020 NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." Pursuant to 42 CFR § 438.330(b)(3), this structure must include an effective mechanism and written description to detect both under- and over-utilization of services. The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and over-utilization. The MCO shall submit to the STATE upon request a written report that includes performance measurement data summarizing identified under-utilization and over-utilization of services. The MCO shall:

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

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[13] Note: DHS understands the impact of the outbreak on health plan reporting and accreditation efforts and therefore asks the MDH auditors to take that into consideration when performing TCA audits which cover the time impacted by the COVID-19 outbreak. DHS is implementing the exception for March 1-September1, 2020 timeframe.

[14] §438.242 Health information systems, Contract Section 7.1.3; [SSA 1904(r)(1); 42 CFR §438.242]

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

(3) Examine possible explanations for all data not within thresholds.

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

(5) Take action to address identified problems of under or overutilization and measure the effectiveness of its interventions. [15]

B. The following are the 2020 NCQA Standards and Guidelines for the Accreditation of Health Plans UM 1-4, 10-11, and UM 13, effective July 1, 2020.

(1) ***NCQA Standard UM 1: Utilization Program Structure***

The organization's UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.

(a) Element A: Written Program Description

(b) Element B: Annual Evaluation

(2) ***NCQA Standard UM 2: Clinical Criteria for UM Decision***

The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.

(a) Element A: UM Criteria

(b) Element B: Availability of Criteria

(c) Element C: Consistency in Applying Criteria

(3) ***NCQA Standard UM 3: Communication Services***

The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

(a) Element A: Access to Staff

[15] 42 CFR §438.330(b)(3)

(4) ***NCQA Standard UM 4: Appropriate Professionals***

Qualified licensed health professionals assess the clinical information used to support UM decisions.

(a) Element A: Licensed Health Professionals
(b) Element B: Use of Practitioners for UM Decisions
(c) Element C: Practitioner Review of Non-Behavioral Healthcare Denials
(d) Element D: Practitioner Review of Behavioral Healthcare Denials
(e) Element E: Practitioner Review of Pharmacy Denials
(f) Element F: Use of Board-Certified Consultants

*(5)* ***NCQA Standard UM 10: Evaluation of New Technology***

The organization evaluates the inclusion of new technologies and the new application of existing technology in its benefits plan, including medical and behavioral healthcare procedures, pharmaceuticals and devices.

(a) Element A: Written Process

(b) Element B: Description of the Evaluation Process

(6) ***NCQA Standard UM 11: Procedures for Pharmaceutical Management***

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

(a) Element A: Pharmaceutical Management Procedures

(b) Element B: Pharmaceutical Restrictions/Preferences

(c) Element C: Pharmaceutical Patient Safety Issues

(d) Element D: Reviewing and Updating Procedures

(e) Element E: Considering Exceptions

(7) ***NCQA Standard UM 13: Delegation of UM***

If the organization delegates UM activities, there is evidence of oversight of the delegated activities.

(a) Element A: Delegation Agreement

(b) Element B: Pre-delegation Evaluation

(c) Element C: Review of the UM Program

(d) Element D: Opportunities for Improvement

**4. Special Health Care Needs – 2020 Contract Section 7.1.5 (7.1.5.1 – 7.1.5.4)**[16, 17]

The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.[18] If the MCO has in place an alternative mechanism(s), or is proposing a new mechanism(s) that meets or exceeds the requirements of section 7.1.5.1, the MCO must submit a written description to the STATE for approval. If the MCO's mechanism(s) have been approved by the STATE and there has been a material change, the MCO must timely submit a revised description to the STATE for approval (see also section 3.11.4).

(7.1.5.1) **Mechanism to Identify Persons with Special Health Care Needs**. The MCO must identify Enrollees that may need additional services through method(s) approved by the STATE.

(1) The MCO must analyze claim data for diagnoses and utilization patterns (both under- and over-utilization) to identify Enrollees who may have special health care needs. At a minimum the MCO must quarterly analyze claim data to identify Enrollees eighteen (18) years and older for the following:

(a) Prevention Quality Indicators as described in the "*Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*" by AHRQ for bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease;
(b) Hospital emergency department utilization as determined by the MCO;
(c) Inpatient utilization stays for the MCO's identified key Minnesota Health Care Program diagnoses or diagnoses clusters;
(d) Hospital readmission for the same or similar diagnoses as defined by the MCO within a timeframe specified by the MCO;
(e) Individual Enrollee claims totaling more than one hundred thousand dollars ($100,000) per year; and
(f) Home Care Services utilization as determined by the MCO.

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[16] 42 CFR §438.330(b)(4)

[17] Families and Children MA, Seniors (MSHO/MSC+), and SNBC Contract Section 7.1.5 and the sub-sections.

[18] The definition of special health care needs is different among the three contracts. For MSHO/MSC+ and SNBC, all enrollees are considered to have special health care needs.

(2) In addition to claims data, the MCO may use other methods, such as: 1) health risk assessment surveys; 2) performance measures; 3) medical record reviews; 4) Enrollees receiving PCA services; 5) requests for Service Authorizations; and/or 6) other methods developed by the MCO or its Network Providers.

(7.1.5.2) **Assessment of Enrollees Identified**. The MCO must implement mechanisms to assess Enrollees identified and monitor the treatment plan set forth by the MCO's treatment team, as applicable. The assessment must utilize appropriate Health Care Professionals to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

(7.1.5.3) **Access to Specialists**. If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs. [Minnesota Statutes, §62Q.58]

(7.1.5.4) **Annual Reporting to the STATE**. The MCO shall incorporate into, or include as an addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in section 7.1.8) a Special Health Care Needs summary describing efforts to identify Enrollees that may need additional services and the following items:

(1) The number of Adults identified in section 7.1.4(A) with special health care needs;
(2) The annual number of assessments completed by the MCO or referrals for assessments completed; and
(3) If the MCO adds the information in this section as an addendum, the addendum must include an evaluation of items 7.1.5.1 through 7.1.5.3.

**5. Practice Guidelines – 2020 Contract Section 7.1.6 (1-2)**[19]

The MCO shall adopt, disseminate and apply practice guidelines, as required by 42 CFR §438.236.

(7.1.6.1) **Adoption of Practice Guidelines**. The MCO shall adopt guidelines that: 1) are based valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) are adopted in consultation with contracting Health Care Professionals; and 4) are reviewed and updated periodically as appropriate.

(7.1.6.2) The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees.

[19] Families and Children MA, Seniors (MSHO/MSC+), and SNBC Contract Section 7.1.6 and the sub-sections.

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

**6. Annual Quality Assurance Work Plan – 2020 Contract Section 7.1.7**

*A.* On or before May 1st of the Contract Year, the MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and 2020 NCQA "*Standards and Guidelines for the Accreditation of Health Plans.*" If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner. (*See also section 3.11.4)*

B. **NCQA QI 1, Element B :** An annual work plan that reflects ongoing progress on QI activities throughout the year and addresses:

(1) Yearly planned QI activities and objectives for improving:
- Quality of clinical care
- Safety of clinical care
- Quality of service
- Members' experience

(2) Time frame for each activity's completion

(3) Staff members responsible for each activity

(4) Monitoring of previously identified issues

(5) Evaluation of the QI program

**7. Annual Quality Assessment and Performance Improvement Program Evaluation – 2020 Contract Section 7.1.8**[20, 21]

A. (7.1.8) The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and 2020

[20] 42 CFR 438.330(b), (d); Families and Children MA, Seniors (MSHO/MSC+) and SNBC Contract Section 7.1.8

[21] MSHO/MSC+ Contract Section 7.1.8 also includes the requirement that the MCO must include the "*Quality Framework for the Elderly Waiver*" in its Annual Evaluation

NCQA "*Standards and Guidelines for Accreditation of Health Plans.*" This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standard measures (example: Organization-specific data, CHAPS, HEDIS®) and MCO's performance improvement projects. The MCO must submit the written evaluation to the STATE by May 1st of the Contract Year.

B. **NCQA QI 1, Element C**: There is an annual written evaluation of the QI program that includes the following information:

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

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

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

## 8. Performance Improvement Projects (PIPs) – 2020 Contract Sections 7.2, 7.2.1[22, 23]

The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and CMS protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects*." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

**7.2.1 New Performance Improvement Project Proposal**: In 2018, the STATE selected the Preventing Chronic Opioid Use topic for the PIP to be conducted over a three year period (calendar years 2018, 2019, and 2020). The PIP must be consistent with CMS' published protocol entitled *"Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects,"* STATE requirements, and include steps one through seven of the CMS protocol.

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[22] §438.330(b)(1), §438.330(d); Contract Section 7.2 and its sub-sections

[23] CMS Protocols, EQR Protocol 3: Validating Performance Improvement Projects (PIPs)

**7.2.1.1**. The MCO shall provide annual PIP progress reports to the STATE. For the 2018-2020 PIPs, the second interim report will be due September 1, 2020. The second interim report will be due September 1, 2020.

**7.2.1.2**. For the 2018-2020 PIPs, the final report will be due September 1, 2021.

## 9. Population Health Management (PHM) – 2020 Contract Section 7.3 (7.3.1 – 7.3.5) [24]

The MCO shall create and report annually to the STATE a Population Health Management Strategy[25] or any amendment[26] to the original PHM strategy by July 31 of the contract year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The MCO must inform the STATE within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.4, Service Delivery Plan.

**7.3.1 PHM Strategy**: The MCO's PHM Strategy shall be consistent with 2020 NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" pursuant to the 2020 Standards for Population Health Management (PHM). At a minimum, the comprehensive PHM Strategy shall describe: (1) Measurable goals and populations targeted for each of the four areas of focus; (2) Programs and services offered to members for each area of focus; (3) At least one activity that is not direct member intervention (an activity may apply to more than one areas of focus); (4) How member programs are coordinated across potential settings, Providers, and levels of care to minimize the confusion for Enrollees being contacted from multiple sources (coordination activities may apply across the continuum of care and to other organization initiatives); and (5) How Enrollees are informed about available PHM programs and services (for example, by interactive contact and/or distribution of materials).

**A.** The PHM Strategy shall include the following areas of focus:

- Keeping Enrollees healthy,
- Managing Enrollees with emerging risk,
- Patient safety or outcomes across settings, and
- Managing multiple chronic illnesses.

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[24] Families and Children MA, Seniors (MSHO/MSC+), SNBC Contracts Section 7.3 and the sub-sections

[25] For MCOs who are in their first year of PHM in 2020

[26] For MCOs who are in their second year of PHM in 2020 and making amendments in their PHM Strategies, after conducting an impact analysis

**B.** The following are the 2020 NCQA Standards and Guidelines for the Accreditation of Health Plans Population Health Management (PHM) 1 - 7, effective July 1, 2020.

(1) ***NCQA Standard PHM 1: PHM Strategy***

The organization outlines its PHM strategy for meeting the care needs of its member population.

(a) Element A: Strategy Description
(b) Element B: Informing Members (e.g. using interactive contacts)

Factor 1: How members become eligible to participate

Factor 2: How to use program services

Factor 3: How to opt in or opt out of the program

(2) ***NCQA Standard PHM 2: Population Identification***

The organization systematically collects, integrates and assesses member data to identify and inform groups for its population health management programs and determines actionable categories for appropriate intervention (e.g. documented process or infrastructure, reports, and materials).

(a) Element A: Data Integration

(b) Element B: Population Assessment

Factor 1: Assesses the characteristics and needs, including social determinants of health, of its member population.

Factor 2: Identifies and assesses the needs of relevant member Sub-populations.

Factor 3: Assesses the needs of child and adolescent members

Factor 4: Assesses the needs of members with disabilities.

Factor 5: Assesses the needs of members with serious and persistent mental illness (SPMI).

(c) Element C: Activities and Resources

(d) Element D: Segmentation (e.g. Population segmentation, Risk stratification)

(3) ***NCQA Standard PHM 3: Delivery System Supports***

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

(a) Element A: Practitioner or Provider Support
(b) Element B: Value-Based Payment Arrangements

(4) ***NCQA Standard PHM 4: Wellness and Prevention***

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

(a) Element A: Frequency of Health Appraisal Completion (*year 1*)
(b) Element B: Topics of Self-Management Tools

Factor 1: Healthy weight (BMI) maintenance

Factor 2: Smoking and tobacco use cessation

Factor 3: Encouraging physical activity

Factor 4: Eating healthy

Factor 5: Managing stress

Factor 6: Avoiding at-risk drinking

Factor 7: Identifying depressive symptoms

*(5)* ***NCQA Standard PHM 5: Complex Case Management***

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

(a) Element A: Access to Case Management

(b) Element B: Case Management Systems

(c) Element C: Case Management Process

(d) Element D: Initial Assessment

(e) Element E: Case Management: Ongoing Management

(6) ***NCQA Standard PHM 6: PHM Impact***[27]

The organization annually measures the effectiveness of its PHM Strategy and has a systematic process to evaluate whether it has achieved its goals and to gain insights into area needing improvement. The organization uses results from the PHM Impact analysis to annually identify opportunities for improvement.

(a) Element A: Measuring Effectiveness

Factor 1: Quantitative results for relevant clinical, cost/utilization and experience measure (not CHAPS)

Factor 2: Comparison of results with a benchmark or goal

Factor 3: Interpretation of results / actions

(b) Element B: Improvement and Action

(7) ***NCQA Standard PHM 7: Delegation of PHM***

If the organization delegates PHM activities, there is evidence of oversight of the delegated activities.

(a) Element A: Delegation Agreement

(b) Element B: Pre-delegation Evaluation

(c) Element C: Review of the PHM Program

(d) Element D: Opportunities for Improvement

***7.3.2 PHM Reporting:***

7.3.2.1: The MCO shall annually describe its methodology for segmenting or stratifying its Enrollee population, including the subsets to which Enrollees are assigned (for example, high risk pregnancy) and provide to the STATE a report specifying the following: (1) number of Enrollees in each category and (2) number of programs or services for which these Enrollees are eligible.

7.3.2.2: The MCO shall annually report to the STATE a comprehensive analysis of the impact of its PHM strategy that includes at least the following factors:

(1) Quantitative results for relevant:

[27] A comprehensive analysis of the impact of its PHM strategy in consecutive years

- Clinical measures (outcome or process measures);
- Cost of care or utilization measures; and
- Enrollee experience measures (for example, complaints or Enrollee feedback, using focus group or a satisfaction survey).
- Comparison of results, including with a benchmark or goal;
- Interpretation of results, including interpretation of measures.
- The Impact Analysis report is due by July, 31 of the contract year.

**10. Advance Directives Compliance – 2020 Contract Section Article 14 Advance Directives Compliance (14.1 – 14.5)**[28, 29]

1. **Enrollee Information**: The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:

   A. Information regarding the enrollee's right to accept or refuse medical or surgical treatment; and to execute a living will, durable power of attorney for health care decisions, health care directives or other Advance Directive;

   B. Written policies of the MCO respecting the implementation of the right;

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

   D. Information that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128 as required in 42 CFR 438.(3)(j).

2. **Providers Documentation**: To require MCO's Primary Care Providers; hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), and hospices to ensure that it has been documented in the enrollee's medical records whether or not an enrollee has executed an Advance Directive.

3. **Treatment**: To not condition treatment or otherwise discriminate on the basis of whether an enrollee has executed an Advance Directive.

4. **Compliance with State Law**: To comply with State law, whether statutory or recognized by the courts of the State, on Advance Directives, including Minnesota Statutes, Chapters

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[28] Families and Children MA, MSHO/MSC+ and SNBC Contract Article 14, sections 14.1 – 14.5.

[29] Pursuant to 42 U.S.C. 1396a(a)(57) and (58), 42 C.F.R. 489.100-104 and 42 CFR §438.3(j); (referring to 42 C.F.R. 422.128)

145B and 145C.

5. **Education**: To provide, individually or with others, education for MCO staff, providers and the community on Advance Directives.

**11. Validation of MCO Care Plan Audits for MSHO and MSC+: Article 6, Seniors Contract Sections 7.1.4, 7.8.3, 9.4.1**[30]

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

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

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

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

**12. Subcontractors – 2020 Contract Sections 9.3 (and its subsections) and 9.10.4** [31]

**(1) Written Agreement; Disclosures** All subcontracts must be current, in writing, fully executed, and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include:

**A. Disclosure of Ownership and Management Information (Subcontractors).** In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information:

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[30] Pursuant to MSHO/MSC+ 2019 Contract Sections 6.1.4-6.1.5, 7.8.3 and 9.4.1

[31] Families and Children MA, Seniors and SNBC Contract Sections 9.3 (and subsections) and 9.10.4

(1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address;

(2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.10.1.1is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;

(3) The name of any other disclosing entity in which a Person with an Ownership or Control Interest in the disclosing entity also has an ownership or control interest;

(4) The name, address, date of birth, and social security number of any managing employee of the disclosing entity.

(5) For the purposes of section 9.10, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its Contract with the STATE;

(6) MCO Disclosure Assurance. The MCO must submit to the STATE by September 1st of the Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all subcontractors, and reviewed by the MCO prior to MCO and subcontractor contract renewal. The letter should identify all databases that were included in the review. A data certification pursuant to section 11.6 is required with this assurance; and

(7) Upon request, subcontractors must report to the MCO information related to business transactions. Subcontractors must be able to submit this information to the MCO within fifteen (15) days of the date of a written request from the STATE or CMS. The MCO must report the information to the STATE within ten (10) days of the MCO's receipt from the subcontractor.

**B**. **Written Agreements**: All subcontracts must be current, in writing, fully executed, and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include:

1. MCO subcontracts that include delegation of program integrity responsibilities must require Subcontractors to comply with program integrity obligations under state and federal law and section 9.9.1 of this contract. If an MCO engages with a subcontractor and does not delegate its program integrity responsibilities to the subcontractor, the MCO shall remain responsible for all program integrity responsibilities under state and federal law and section 9.9.1.1 with respect to the

Subcontractor's services.

2. Current and fully executed agreements for all subcontractors, including bargaining groups, must be maintained for all administrative services that are expensed to MHCP. Subcontractor agreements determined to be material, as defined by the STATE, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to MHCP.
3. Upon request, the STATE shall have access to all subcontractor documentation under this section.
4. Nothing in this section shall allow release of information that is nonpublic data pursuant to section Minnesota Statutes, §13.02.

**(2) Exclusions of Individuals and Entities; Confirming Identity – 2020 Contract Sections 9.10.1, 9.3.6, and Article 15 (15.1)**[32] [33]

**(A)** (1) The MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or Managing Employee of the MCO or its Subcontractors, or an affiliate upon contract execution or renewal and credentialing, through routine checks of state and Federal databases. The databases to be checked are the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and the Excluded Provider Lists maintained by the STATE.

(2) The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), and the Excluded Provider Lists maintained by the STATE, for any Providers, agents, Persons with an Ownership or Control Interest and Managing Employees to verify that these persons:

(1) Are not excluded from participation in Medicaid by the STATE nor under §§ 1128 or 1128A of the Social Security Act; and

(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the Social Security Act. [42 CFR §§455.436; 438.602(d); 438.610]

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[32] Families and Children MA, Seniors and SNBC Contract Sections 9.10.1(and subsections); 9.3.6; 15.1

[33] 42 CFR §438.610 referring to 48 CFR §2.101; 42 CFR §455.436; Minnesota Statutes, §256B.064, subd. 3

(3) The MCO must require Subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this Contract.

(4) The MCO shall require all Subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the programs under Title XX services program, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.

(5) The MCO shall report any excluded Provider to the STATE within seven (7) days of the date the MCO receives the information, or determines that a Network Provider, Person with an Ownership or Control Interest of a Network Provider, agent or managing Employee of the MCO, Subcontractor or affiliate has become excluded or the MCO has inadvertently contracted with an excluded Provider.

(6) In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.

**(B)** The MCO shall ensure that its Subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of **Article. 15**.

***13. Other areas by mutual agreement.***

# Appendix D: Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver

## Evaluation Plan 2015 to 2020

*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.

*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 (MA) 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.

*PMAP+ Section 1115 Waiver Renewal January 1, 2016 through December 31, 2020*

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, 2020. The proposed waiver extension seeks to continue federal authority for the following An extension will be filed in early summer of 2020:

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

**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 federal poverty level (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% of the 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 MA 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.

## *Hypotheses, Research Questions and Evaluation Metrics*

**MA One-Year-Olds**

*Goal/Objective*

The goal of the demonstration is to ensure at least comparable access and quality of preventive care to the MA one-year-old child population as compared to other children enrolled in public health care programs.

*Research Question*

Did the MA one-year-old child population experience comparable utilization of services (i.e. childhood immunization status, well-child visits, and access to primary care practitioners) when compared to national Medicaid averages?

Do the rates for each of the measures vary by race within Minnesota's MA one-year-old child population?

*Hypothesis*

Providing health care coverage to the MA one-year-old child population, will result in access and quality of care for this population that is comparable to children enrolled in other public programs.

*Statistical Methods*

The evaluation will use selected HEDIS performance measures to evaluate care for the MA one-year-old child population compared to other children enrolled in public health care programs. A comparison and stratification of the selected HEDIS and other performance measures will be made between the MA one-year-old population and the Medicaid national child (12-24 months)

population to show the ongoing improvement in care for children enrolled in Medicaid in Minnesota. The HEDIS performance measures are rates that are generally defined as the sum of eligible individuals who received a service (numerator) divided by the total number of individuals who qualified for the service (denominator).

To address the first research question, each of the state's three overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these three areas relative to the other states in the nation.

For the second analysis, the individual-level state data will be stratified by race (Asian-Pacific Islander, Black, Hispanic, Native American, and White) and three separate tests for equality of proportions (one test per HEDIS rate), will be used to detect whether or not race influences quality and or access to care, as measured by the HEDIS rates.

**Medicaid Caretaker Adults with 18 –Year- Old**

*Goal/Objective*

The goal of the demonstration is to ensure at least comparable access and quality of prevention and chronic disease care for MA caretaker adults with an 18-year old child as compared to other adults who are enrolled in public health care programs.

*Research Questions*

1. Did the MA caretaker adult waiver population in Minnesota experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?
2. Did the MA caretaker adult waiver population in Minnesota experience comparable utilization of preventative and chronic disease care services for adults when compared to national Medicaid averages (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ambulatory health services)?

*Hypothesis*

Providing health care coverage to this adult caretaker waiver population will result in access and quality of prevention and chronic disease care for this population that is comparable to other adults enrolled in public health care programs.

*Statistical Methods*

The evaluation will use selected HEDIS performance measures to evaluate care for the MA caretaker adult waiver population compared to other adults enrolled in public health care programs. A comparison and race stratification of the selected HEDIS and other performance measures will be made between the waiver population and separate populations (i.e. other adults enrolled in MA in Minnesota to show the ongoing improvement in care for MA caretaker adults in Minnesota.

Since the populations of interest are completely independent, a series of tests for equality of proportions will be used to gauge the quality of care received by caretakers with children in MN and caretakers without children in MN.

To address the second research question, each of the state's five overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these five areas relative to the other states in the nation.

**5.3 Medical Education and Research Costs (MERC) Trust Fund**

*Goal/Objective*

There is an on-going need to support training opportunities for medical education in Minnesota. For nearly two decades, Minnesota has taken a unique approach to this issue through its section 1115 waiver authority under PMAP+. This authority is necessary to continue a grant payment structure for facilities accepting trainees to support the care of the Medicaid population. Without this grant program, many facilities, especially in rural areas, may not be able to participate in training activities for medical education, which help attract new providers ready to serve low-income and underserved areas of the state.

Through Minnesota's PMAP+ waiver, the MERC program supports the objectives of the Medicaid program by strengthening the state's provider network through residency grants to facilities serving the Medicaid population that accept trainees who will support patient care. This program also serves a variety of health professions, including training for professions where shortages exist for the Medicaid population. The amount of the grant available to the facility is relative to their Medicaid-patient volume, providing an incentive for these facilities to serve a higher volume of the Medicaid population.

The key advantage of this approach is that MERC allows for a broader set of facilities to participate than just teaching hospitals, helping the state reach a larger portion of the state. Under the traditional fee-for-service system, medical education payments to teaching facilities are higher than those to non-teaching facilities. This is done in an effort to offset a portion of the higher costs faced by facilities that provide clinical medical education.

*Hypothesis A*

Providing a dedicated trust fund for graduate medical education will maintain or increase training opportunities at facilities statewide to support the care of the Medicaid population in Minnesota.

*Research Questions*

1. Were the number of students and residents at clinical training sites receiving MERC grant funds maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?
2. How did the MERC fund grantees use the payments?

*Hypothesis B*

Providing a dedicated trust fund for graduate medical education will support training activities which help to maintain or increase the number of primary care providers serving the Medicaid population in Minnesota.

*Research Questions:*

1. Was the ratio of primary care providers in rural Minnesota to primary care providers in urban Minnesota maintained or improved during this waiver period compared to the previous waiver period?
2. Was the ratio of rural primary care providers per 10,000 rural beneficiaries maintained or improved during this waiver period compared to the previous waiver period?
3. Was the ratio of urban primary care providers per 10,000 urban beneficiaries maintained or improved during this waiver period compared to the previous waiver period?

Comparison Years are based on State Fiscal Years.

*Statistical Methods:*

The evaluation will use MERC program data to compare the annual number of students and residents at training sites in rural and urban areas of the state across the two waiver periods using chi-square tests for independence. The test will determine whether or not the number of students and residents change significantly over time or if they remain relatively constant. Grant fund distributions will be analyzed to determine utilization rates across health professions. Tests for equality of proportions will be used to assess whether or not the proportion of funds allocated to the program changed over time. The evaluation will use two equality of proportions tests to determine if the proportion of providers in rural and urban areas changed over time.

Ratios between providers in rural in urban areas will also be compared using chi square tests. Additional analysis will evaluate provider to beneficiary ratios within geographical regions of the state to determine if MERC has impacted ratios between the two waiver periods.

**Pregnant Women in a Presumptive Eligibility Period**

*Goal/Objective*

The goal of the demonstration is to ensure at least comparable access and quality of prenatal and postpartum care to pregnant women enrolled in MA through the PMAP+ waiver authority as compared to national Medicaid averages.

*Research Question*

1. Did the MA pregnant women waiver population experience comparable utilization of prenatal and postpartum care when compared to national Medicaid averages (i.e. prenatal visit within first trimester (or within 42 days of enrollment into MA) and postpartum visit between 21 and 56 days after delivery)?

*Statistical Methods*

The evaluation will use selected HEDIS performance measures to evaluate care for the waiver population compared to national averages. A comparison and stratification of the selected HEDIS and other performance measures will be made between the waiver population and national Medicaid averages for pregnant women to show the ongoing improvement in care for pregnant women enrolled in MA in Minnesota. Minnesota Managed Care HEDIS Hybrid data will also be utilized to determine differences in administrative versus hybrid rates for this measure.

Each of the state's two overall HEDIS rates, along with the full collection of national rates, will be used to generate a percentile rank that will assess how well the state performed in these two areas relative to the other states in the nation.

## *Qualifications of Staff Conducting Evaluation*

The qualifications of the staff conducting the evaluation include but are not limited to the following key personnel.

Kevan Edwards has been with DHS since 2016 and is currently the Research Director of Health Care Research and Quality Division/Research and Data Analysis Section. Dr. Edwards has a Ph.D. in Sociology, Health Services Research Supporting area from the University of Minnesota. Prior to his work at DHS, he was the Research Director, Health Economics Program at the Minnesota Department of Health working with the All Payer Claims Database. Areas of expertise include

risk adjustment of cost and quality measures, and disparities in health status, health access, and health care utilization.

Barbara Frank, a Research Supervisor in the Research and Data Analysis section, has twenty years of experience using health care claims data (Commercial/Medicare/Medicaid) including four years of experience in HEDIS reporting. Ms. Frank has over 15 years of SAS experience, primarily using SAS Base/EG with DHS data. She has a Masters of Public Health. Prior to coming to DHS, Ms. Frank was the Director of Assistance, and Director of Workshops, Outreach and Research for the CMS Contract Research Data Assistance Center (ResDAC).

James Kuiper, Agency Policy Specialist, has been with the DHS Research and Data Analysis team since 2014. He has circa 30 years of SAS Base/Stat/Macro programming in a variety of health care research settings (DHS warehouse, commercial health plans, and disease management) and is experienced in database programming in MS SQL Server, Access, and Proc SQL. Mr. Kuiper holds a Bachelor of Science in Mathematics and Statistics.

Monica Patrin, Agency Policy Specialist, has been with DHS since December 2016. After graduating from the University of Minnesota with a Masters in Statistics in 2013, she worked in education research and assessment as a data analyst/R programmer for almost three years. She has experience working with a variety of models used as the basis for teacher evaluations—(random effects models, error in variables models, multinomial logistic regression models, etc).

Diane Reger, State Program Administrator – Principal, has been with MDH since 2000. She has administered the MERC grant program for sixteen years. Prior to coming to MDH, she worked in the insurance industry for ten years, in underwriting and sales and marketing analysis.

Mark Schoenbaum, MSW, is Director of Minnesota's Office of Rural Health and Primary Care at the Department of Health. He has over 35 years of state government experience in program management, policy analysis and evaluation. He manages a portfolio of state health care workforce development and safety net programs that includes the MERC program.

### *Evaluation Implementation Strategy and Timeline*

**Waiver Populations under Sections 5.1, 5.2, and 5.4**

Beginning in 2021, performance measurement data will be extracted from DHS' managed care encounter and fee-for-service database to allow for a sufficient encounter/claim run-out period. Performance measurement rates for the baseline period (CY 2014 and 2015) will be calculated for the targeted populations and compared to CY 2016, 2017, 2018, 2019, and 2020. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass to compare performance of Minnesota's populations with national and other states' performance.

The DHS Health Care Research and Quality Division will conduct this component of the waiver evaluation and review results over the second half of calendar year 2021, with the draft final report submitted to CMS in December 2021.

Below is an overview of evaluation activities and timelines:

- August 2020: DHS will calculate measurement rates for baseline goals.
- September-October 2020: DHS will calculate and stratify HEDIS 2015-2019 performance measures.
- October 2021: HEDIS results will be reviewed and evaluated.
- November-December 2021: Draft final waiver report is written, reviewed and submitted to CMS.
- March 2022: CMS submits feedback to DHS.
- May 2022: DHS incorporates CMS feedback. Final report is submitted to CMS.

**Waiver Authority under Sections 5.3**

The Minnesota Department of Health and DHS will conduct this component of the waiver evaluation. MERC Program data for the baseline period (DY 19 and DY 20) will be compiled and compared to CY 2016, 2017, 2018, 2019, and 2020. Medicaid provider enrollment data for CY 2016 through 2020 will be extracted and analyzed. The results will be incorporated into the draft final report.

# Appendix E: Proposed Evaluation for Reform 2020 Section 1115 Demonstration Waiver

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

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

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

The PCA program has played a critical role in supporting people in their homes and avoiding institutional care, and has been important in rebalancing the system. The service was designed in the late 1970's to support adults with physical disabilities to live independently in the community. Over time, the Legislature expanded PCA as a cost-effective option to support people of all ages with physical, cognitive and behavioral needs. PCA services are available to people based on functional need, without enrollment limits or waiting lists. PCA services help people who need assistance with activities of daily living (i.e., bathing, dressing, eating, transferring, toileting, mobility, grooming, positioning) or instrumental activities of daily living (e.g. cooking, cleaning, laundry, shopping). The PCA program has grown from 200 participants in 1986 to over 30,000 today. In 2009, the Legislature authorized changes to the PCA program to manage costs, which resulted in changes in authorized levels of services for many people, both increases and reductions, and loss of access to 170 people. At times, in an effort to get a specific service (such as special equipment or modifications to a person's home) or additional supports beyond traditional PCA services, persons using PCA services have accessed one of the HCBS waivers (e.g. Developmental Disabilities or Elderly Waiver).

Minnesota has five home and community-based services waivers: Developmental Disability (DD)34, Community Alternatives for Disabled Individuals (CADI)35, Community Alternative Care (CAC)36, Brain Injury (BI)37 and Elderly Waiver (EW)38. Similar services to support individuals living in the community

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[34] DD: 2011 unduplicated enrollment was 15,761.

[35] CADI: 2011 unduplicated enrollment was 18,927 (reflects high turnover rate)

[36] CAC: 2011 unduplicated enrollment was 390

[37] BI: 2011 unduplicated enrollment was 1,513

[38] EW: 2011 unduplicated enrollment was 29,291 (managed care and fee-for-service)

are offered under each waiver, but since each was developed over time and under different constraints, opportunities, and different populations, HCBS waivers differ from one another in areas such as eligibility criteria and annual spending.

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

Minnesota's Reform 2020 demonstration enables the state to continue its history of on-going improvement to enhance its home and community-based service system in two ways.

First, the demonstration allows the state to provide preventive services to seniors who are likely to become eligible for Medicaid and who need an institutional level of care.

Second, the demonstration supports the state's efforts to reform the personal care benefit.

## Background on the Reform 2020 Section 1115 Waiver

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

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

The Reform 2020 demonstration also supports Minnesota's efforts to redesign the state plan PCA benefit and expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after Community First Choice. It will reduce pressure on the system as people use the flexibility within CFSS instead of accessing the more expanded service menu of one of the state's five home and community-based waivers to meet their needs. The new CFSS benefit will replace the existing PCA benefit. To ensure continuity of care and safety of enrollees, Minnesota must ensure that implementation of the consumer-directed option does not restrict eligibility for these services. Minnesota is currently negotiating with CMS to obtain authority for the CFSS benefit under state plan amendments utilizing

sections 1915(i) and 1915(k) of the Social Security Act. Once these state plan amendments are approved, Reform 2020 will provide authority to provide CFSS to two groups of people who would otherwise be ineligible to receive CFSS.

Minnesota is committed to implementing CFSS because all services should be designed in a way that is person-centered, and involves the person throughout planning and service delivery. The term self-direction in this context refers to a service model with increased flexibility and responsibility for directing and managing services and supports, including hiring and managing direct care staff to meet needs and achieve outcomes. Currently each of Minnesota's home and community-based waivers offers Consumer Directed Community Services and Supports (CDCS)39. This service option gives individuals receiving waiver services an option to develop a plan for the delivery of their waiver services within an individual budget, and purchase them through a fiscal support entity that manages payroll, taxes, insurance, and other employer-related tasks as assigned by the individual. CDCS allows individuals to substitute individualized services for what is otherwise available in the traditional menu of services in the waiver programs. Purchases fall into three categories: personal assistance, environmental modifications, and treatment and training.

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

## Alternative Care

The Reform 2020 waiver allows Minnesota to receive federal financial participation to provide Alternative Care services to people over age 65 whose functional needs indicate eligibility for nursing facility care but have combined adjusted income and assets exceeding state plan Medicaid standards for aged, blind and disabled categorical eligibility.

Alternative Care is available to eligible individuals who meet all of the following financial requirements:

Those with combined income and assets insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate.

Those not within an uncompensated transfer penalty period.

Those with home equity within the home equity limit applicable under the state plan.

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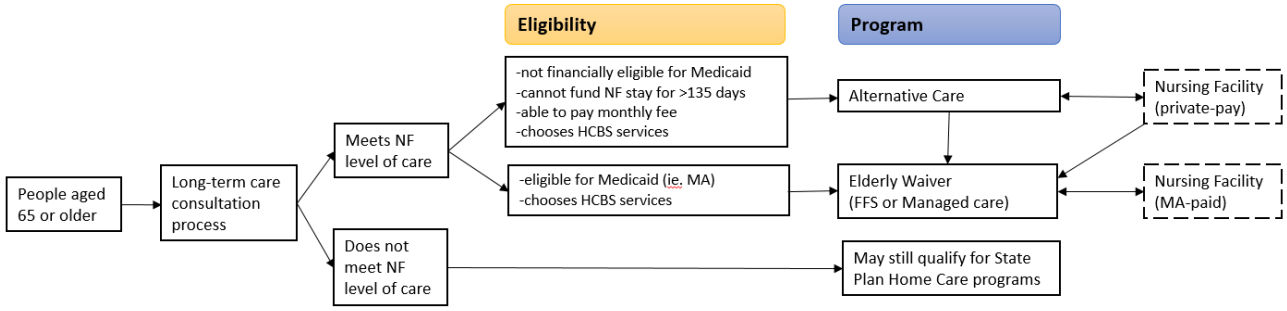
[39] As of March 31, 2011 recipients using CDCS by waiver: BI – 53; CAC – 139; CADI – 1167; DD – 1689

Functional eligibility for nursing home care and identification of needed services for Alternative Care is performed using the Long-term Care Consultation process, which is the same assessment tool and process that is used for the Elderly Waiver. Applicants for Alternative Care also discuss the option of qualifying for Medical Assistance under a medically needy basis (see Figure 1).

Figure 1. Minnesota Health Care Program Options for the Elderly




AC, alternative care program; FFS, fee-for-service; HCBS, home and community-based services; MA, Medical Assistance (Minnesota's Medicaid program); NF, nursing facility; SNF, skilled nursing facility

If an Alternative Care beneficiary is admitted to a nursing facility, his/her stay is either paid by Medicare (if eligble), other long-term care insurance, or out-of-pocket. If the person spends-down and becomes eligible for Medicaid, he/she can transition to the Elderly Waiver program where nursing facility use is a MA benefit. For details on how a person transitions from Alternative Care to Elderly Waiver program, refer to the "AC Operational Protocol".

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

The benefits available under Alternative Care are the same as the benefits covered under the federally approved Elderly Waiver, except:

- Alternative Care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits that meet primary and acute health care needs
- Alternative Care additionally covers nutrition services and discretionary benefits.

The comprehensive list of Alternative Care benefits is below:

- Adult day service/adult day service bath

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

An overview of the Alternative Care program, services, and outcomes are provided in Figure 2.

### *Program Goals*

The goals of the Alternative Care program are to:

1. Provide access to coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
2. Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
3. Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time.

Figure 2: Alternative Care Program Logic Model

| Inputs | | Outputs | | Outcomes | |
|---|---|---|---|---|---|
| **Resources** | **Legislative Oversight** | **Service and Access** | **Activities** | **Short-term** | **Long-term** |
| • LTCC/MnChoices assessors<br>• LTC screening assessment to determine whether a person qualifies for nursing facility level of care<br>• Training of staff (e.g. case managers, assessors)<br>• Continuing training (e.g. bulletins, webinars, video conferencing)<br>• Legislative authority<br>• State funding<br>• DHS administrative resources<br>• Local HCBS provider networks<br>• External evaluators and volunteers to survey AC beneficiaries | **Policy Changes**<br>• Changes in financial eligibility determination<br>• Changes in program fees<br>• Changes in covered services<br>• Changes in provider standards<br><br>**Budget Changes**<br>• Rate changes | Accessed in the person's home and community<br><br>**Covered Services**<br>• Adult Day service<br>• Case management<br>• Chore services<br>• Companion services<br>• Consumer-directed community supports<br>• Home health aides<br>• Home-delivered meals<br>• Homemaker services<br>• Changes to make homes and equipment accessible<br>• Nutrition services<br>• Personal care<br>• Respite care<br>• Skilled nursing<br>• Specialized equipment/supplies<br>• Personal emergency response system<br>• Training and support for family caregivers<br>• Nonmedical transportation<br>• Discretionary services | **State-level**<br>• Monitoring spending at a county-level*<br>• Monitor AC enrollment and program spending<br>• Issue policies, guidance, and resources<br>• On-site lead agency review of cases every 3 years to assure program compliance<br>• Further develop a HCBS provider network<br>• Add/remove/redesign services per stakeholder feedback<br>• Facilitate participant feedback surveys<br><br>**County-level**<br>• Assess program eligibility<br>• Determine financial eligibility (includes citizenship validation) †<br>• Develop a support plan to meet assessed needs<br>• Authorize services<br>• Monitor implementation of the support plan<br>• Feedback to DHS on barriers to AC use<br><br>**Provider-level**<br>• Support the person through provision of services | **Program Beneficiaries**<br>• Able to live in their homes and communities with necessary supports<br>• Direct their services and supports<br><br>**State-level**<br>• Collect and internally analyze AC enrollment across time | **Program Beneficiaries**<br>• Prevent and delay transitions to a nursing facility<br>• Prevent seniors from spending down their assets<br>• Increase the quality-of-life of seniors by spending more time in the community with their family and friends<br><br>**State-level**<br>• Save Medicaid dollars<br>• Change in expectations about the state's ability to serve older adults in the community rather than in institutions<br>• Rebalancing of public dollars away from institutions and toward HCBS for older adults<br>• Continued AC funding |

*Minnesota DHS stopped monitoring county spending on AC program at the 2015 legislative session.
†After the federal match for AC program, DHS began validating citizenship.

Evaluation

### *Evaluation Strategy for Alternative Care*

The Reform 2020 demonstration waiver is approved for the period October 18, 2013 through June 30, 2018. Since the federal waiver authorization has not resulted in any changes to the Alternative Care program structure, we propose the following hypotheses:

- The waiver will not change the fundamentals of the program: size and characteristics of the population with AC.
- The waiver will not change their conversion to Medicaid, particularly subsequent use of Elderly Waiver services; transition to and from nursing facilities and health events.
- The waiver will not change outcomes as indicated by use of acute care services.

To test these hypotheses, we will evaluate the AC program over time (i.e., 2010-2018) in order to examine changes if any in program behavior, particularly any unintended negative consequences and the expected benefits to program enrollees (see Figure 2). We will also compare the AC to the Elderly Waiver (EW) population over the same time period (Section 3.1). This comparison allows us to describe the degree of transitions between programs, i.e., AC clients converting to Medicaid and using the EW, and to assess the potential impact of secular trends that may be affecting both programs, such as other policy shifts or changes in the elderly population or their use of services.

The goals and associated metrics identified in section 2.1 will be evaluated by DHS and University of Minnesota using MMIS claims and beneficiary assessment data linked to Medicare data Although this will be an integrated effort, DHS will lead the descriptive component of the evaluation using readily available data sources, as part of its ongoing quality monitoring and management activities. The University will provide analyses of expanded data elements (including Medicare data) and employ more rigorous analysis methods.

### *AC and Comparison Population*

The populations included in the evaluation consist of Alternative Care (AC) program enrollees and Elderly Waiver enrollees. Elderly Waiver enrollees are very similar to Alternative Care program enrollees. Both groups: 1) are aged 65 and above, 2) must have an assessed need for an institutional level of care, and 3) are using home and community-based services to meet their needs and remain living in the community instead of in a nursing facility.

Some Elderly Waiver beneficiaries will use residential services (i.e., customized living, adult foster care, and residential care services). We will identify Elderly Waiver beneficiaries in non-residential settings by excluding beneficiaries with any claims for residential services. For this evaluation, we will focus on these comparison populations: 1) Elderly Waiver beneficiaries in total, and 2) Elderly Waiver beneficiaries without residential services use, who are most directly comparable to the AC beneficiaries. As a sub-analysis we will also draw comparisons with Elderly Waiver beneficiaries who have residential use to see how they might differ the primary comparison group.

Internal program monitoring and evaluation show that in the state fiscal year (July 2008-June 2009), there were approximately 4800 unique beneficiaries in the AC program and 25,500 unique beneficiaries in the Elderly Waiver program (of which 75% did not use any residential services). The number of AC enrollees has been declining slightly, while the number of Elderly Waiver enrollees has been increasing.

### *Goals and Objectives*

The objective of the evaluation is to determine if access, quality of care and program sustainability for Alternative Care recipients has changed before and after the introduction of the AC waiver. We also will draw comparisons over time to Elderly Waiver recipients in non-residential settings at each time point and trace program growth over time (Section 3.1). We will evaluate trends in the population served under the AC waiver, by exploring the level of need, ability to access and use consumer-directed services, rates of nursing facility admission and experience of negative health outcomes.

### *Hypotheses*

Research questions of interest include: 1) To what extent did access, quality of care, and program sustainability for Alternative Care recipients change before and after federal match? and 2) How do care and outcomes for Alternative Care beneficiaries compare to Elderly Waiver beneficiaries? We will evaluate changes over time (2010 to 2018) to the AC program in itself and in comparison to the Elderly Waiver program.

The level of need, demographic characteristics, and service use patterns for Alternative Care beneficiaries will not change over time, neither alone nor in comparison to Elderly Waiver beneficiaries in non-residential settings. This will be evaluated using the following measures:

- Case-mix status (low-need vs. high-need).[40]
- ADL dependencies and health functions.
- Acuity rate differences between AC and Elderly Waiver non-residential beneficiaries.
- Use of home and community-based services.
- Acute care services where available for AC beneficiaries and when there is comparability between AC and Elderly Waiver beneficiaries.

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[40] See section 3.42 for details on case-mix is determined and level of need is defined.

Alternative Care beneficiaries will experience equal or better access to consumer-directed service (CDS) options[41] over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings. This will be evaluated using the following measures:

- Authorized consumer-directed community supports.
- Difference in CDS use between AC and Elderly Waiver non-residential beneficiaries.

Alternative Care beneficiaries will experience equal or less nursing facility use over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings. This will be evaluated using the following measures:

- Proportion of recipient days spent in nursing facilities.
- Frequency of nursing facility admission, by length of stay.
- Case-mix adjusted nursing facility admission.
- Number of nursing facility days.
- Return to AC or Elderly Waiver programs from nursing facility.

Alternative Care beneficiaries will remain in the community for as long or longer over time, when examined alone and in comparison to Elderly Waiver beneficiaries. This will be evaluated using the following measures:

- Remaining enrolled in AC.
- Transition from AC to Elderly Waiver.
- Transition to Essential Community Supports42.
- Days alive in the community and not on Medicaid.
- Use of Medicare services.

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[41] Consumer directed services are available in the AC and Elderly Waiver programs. This measure will exclude discretionary services which are designed by the county (whereas the CDCS is a person's choice). Elderly Waiver beneficiaries in residential settings will not use CDCS.

[42] The Essential Community Supports Program (ECS) program was established by the Minnesota Legislature and became effective January 1, 2015. Initially designed to provide support for individuals who might lose their HCBS program eligibility as a result of changes to the nursing facility level of care criteria that also became effective January 1, 2015, it was also adopted as an ongoing program for individuals aged 65 and older with emerging needs for HCBS but who do not yet meet level of care criteria and who are not MA eligible but meet the AC financial eligibility criteria. This program has a relatively small basket of services and monthly budget.

*Metrics and Data Available*

**Data Sources**

*MMIS*

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the county – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs, which provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill. MMIS contain the following variables that will be used for the current evaluation:

- Program begin and end date.
- Claims for services (e.g. residential services, CDCS services).
- Death date.
- Living arrangement.
- In residential or non-residential setting.

*LTC Screening Document*

This form is used to document pre-admission screening and long-term care consultation (LTC) activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. These assessments contain the following variables that will be used for the current evaluation:

- Program type (i.e., indicates waivered program, change to another waivered program).
- Entry and exit from waivered programs (including death) and exit reasons.
- Continued use of waivered program at re-assessment.
- Case-mix.
- Health functions (e.g. activities of daily living (ADLs)).
- Level of care.
- Housing type (e.g. nursing facility, assisted living, foster care).
- Authorization of CDCS services.

*Minimum Data Set (MDS)*

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification

based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. These assessments contain the following variables that will be used for the current evaluation:

- Admission and discharge date.
- Admission source (e.g., acute care or community) and discharge destination (e.g. acute care transfer, community, or mortality).
- Post-acute Medicare stay, either alone or in combination with a subsequent long stay.
- Health and functional status at admission and the latest assessment before discharge back to the community, if applicable.

*Medicare Claims (fee-for-service)*

Medicare claims will provide utilization for non-Medicaid-covered services (particularly for AC recipients or for periods when a recipient is not covered by Medicaid), but otherwise will largely duplicate what we can learn from MMIS. We can also calculate HCC scores if we want to try to adjust for case-mix.

- Dates of acute hospital, emergency department, and home health use.
- Utilization outside of periods of Medicaid eligibility or for services not covered by Medicaid.
- Associated diagnoses and procedure codes.

**Metrics**

*Case-Mix*

Case mix is a classification tool that is used in both AC and EW programs to establish monthly budget limits for HCBS services. View the Case Mix Classification Worksheet describing the factors used to determine a case mix classification for all AC and EW recipients. The classification is based on assessed need in:

- Eight activities of daily living (ADLs): bathing, dressing, grooming, walking, toileting, positioning, transferring, and eating.
- The need for clinical monitoring in combination with a physician-ordered treatment.
- The need for staff intervention due to behavioral or cognitive needs.
- After assessment, the individual is assigned a case mix classification of A-L based on their combination of ADLs, clinical monitoring and behavioral/cognitive needs.
- Level of Need.

For purposes of this evaluation, the case mix classifications have been grouped as follows:

- Low Need (A, L): This group includes individuals with 0-3 ADL dependencies
- Moderate Need (B, D, E): This group includes individuals with 4-6 ADL dependencies and/or behavioral/cognitive needs.

- High Need (G, H, I, J): This group includes individuals with dependencies in 7 or 8 ADLs (G), and those with specific other needs in combination with 7-8 ADL dependencies.
- High Need Clinical (C, F, K, V): This group includes individuals with varying number of dependencies but who have an assessed need for clinical monitoring at least once every 8 hours.
- Other/Missing.

### *Design Approaches*

We propose the following methods to address the hypotheses within this evaluation. The sections below provide information about each approach, including the comparison group(s), metrics, and statistical methods. To compare efficiently across years (2010 through 2018), we will also report our measures as rates (e.g. per 1000 beneficiaries).

### *Cross-Sectional Analysis*

To test hypothesis 3.31 and 3.32, we will compare individuals in Alternative Care program to individuals in Elderly Waiver served in non-residential settings. For each fiscal year, we will identify AC and Elderly Waiver beneficiaries using LTC screening assessment data (also available in MMIS). We will further identify Elderly Waiver beneficiaries in non-residential settings by excluding beneficiaries with any claims for procedure codes denoting residential services (i.e., customized living, adult foster care, and residential care services). While living in the community, if an AC beneficiary uses CDCS, this information will be recorded in the MMIS claims data, as well as the total dollars paid for CDCS in a fiscal year. We will categorize acuity into two categories: low-need and high-need and calculate differences in case-mix for each year between AC and Elderly Waiver beneficiaries by acuity type.

To test hypotheses 3.33 and 3.34, we will calculate the number of nursing facility admission per person and determine the number of days spent in a nursing facility (i.e., length of stay). The LTC screening document indicates when an AC beneficiary leaves the community to enter a nursing facility, and if and when the person can choose to re-enter a HCBS program. The MDS is an additional source of information on nursing facility use. We will compare nursing facility admission use for AC and Elderly Waiver non-residential beneficiaries.

To test hypothesis 3.34, we will define a cohort of AC users at the start of each fiscal year and follow the cohort until the end of the fiscal year and determine their outcomes. We will calculate the proportion of individuals that remain enrolled in AC, those that switched to Elderly Waiver, and the days alive in the community and not on Medicaid (i.e., not using residential services). We will account for death and loss of AC eligibility.

Statistical Analysis: For all measures, we will report the denominator, number and percent of beneficiaries, and utilization rates, as appropriate. We will test the difference in means, using t-tests for each fiscal year and compare the t-statistic across the years (e.g. a line graph). We will

also compare the difference in means using ANOVA and post-hoc estimations. Covariates will include, but are not limited to, age, number of admissions to nursing facility in a given year, and case-mix. We will stratify AC and EW users in each year according to categories of these covariates, and then draw comparisons and statistical tests within strata.

### *External Evaluation Strategy*

**Independent Evaluation**

In addition to the designated activities to be conducted by DHS, DHS will contract with Center for Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management to conduct an evaluation of the impact of the continuation of the Alternative Care program under the waiver on access, quality and cost on the low-income senior population in the state. Greg Arling, PhD, Katherine Birck Professor, School of Nursing, Purdue University, will assist in the analysis.

**Evaluation Objective and Comparison Population**

This component of the evaluation will examine the same hypotheses as the internal evaluation but at a more granular beneficiary level and by using multivariable modeling and trend analysis (interrupted time series) to assess change over time and factors that may be accounting for change. It will include analysis of service use and payments during the period before the demonstration and during the demonstration. Analysis will also be conducted on the relationship of Alternative Care to prior nursing facility use, Medicaid conversion and subsequent nursing facility use and Elderly Waiver use. Elderly Waiver and Alternative Care will be compared to determine whether different types of clients are being served and different needs are being met. The evaluation will also compare Alternative Care and Elderly Waiver client characteristics and service use. It will utilize merged data files from Medicaid and Medicare to examine the use of acute care services.

**Data Availability**

For this evaluation, the following data sources will be utilized: Medicaid Management Information Systems (MMIS), Medicaid files, Minimum Data Set (MDS v3), Medicare claims, Board on Aging Title III service use records, Client surveys, Waiver recipient case studies, Program staff interviews, and long-term care consultation (LTC) assessment data.

**Analysis Plan**

In addition to the research questions listed in the paragraph above and in section 3.3, descriptive statistics will be used to analyze characteristics of waiver recipients in the pre-waiver period (where data are available) and during the period that waivers are in place. We will also compare waiver recipients with other Medicaid services users (e.g., Elderly Waiver). Changes in service use and costs will be examined with a time series trend analysis, either multilevel models of change or differencing models. We also will use regression models to test whether amount of

services at one point in time (T0) predict future outcomes for service use (HCBS, Title III), medical use, nursing home use, and functional status at a subsequent point in time (T1).

The planned analysis strategies will consist of multiple strategies involving descriptive statistics, cross-sectional comparisons at different time points, and longitudinal analysis of beneficiary-level care transitions, program transitions, and health outcomes. Comparisons will be made between AC and Elderly Waiver beneficiaries.

Repeated cross-sectional beneficiary-level analysis. Descriptive statistics will be prepared on the beneficiary population each year during baseline (2010-2018). Characteristics described will include demographics, health and functional status, transitions between care settings (private home, residential care setting or nursing home) and programs (AC and Elderly Waiver), service use and Medicaid expenditures, acute care use (Medicare and Medicaid), and other variables. Multi-variable logistic regression models will be applied in comparing AC and Elderly Waiver beneficiaries. Other multivariable models using link functions and distributional assumptions appropriate to the outcome variable, e.g. gamma distribution or negative binomial, will be applied to count and cost data when drawing comparisons between groups.

Interrupted time series analysis: In order to assess changes in major variables over time in the AC and Elderly Waiver populations, we will conduct an interrupted time series analysis where:

Outcomes: AC and Elderly Waiver service use, Medicaid expenditures; transitions between care settings; movement in, out and between AC and Elderly Waiver programs; and acute care service use.

Time Periods: The time periods for the longitudinal analysis will be months for some outcomes, e.g. transitions between care settings and movement in and out of AC and Elderly Waiver programs, and calendar quarters or years for other outcomes, e.g., Medicaid expenditures

Covariates: demographics, health and functional status, length of time in the AC or Elderly Waiver program, and other variables found to be significant in analysis step 1.

Two approaches will be used for the analysis difference-in-difference equations and mixed-effect growth models. With both approaches the change in the outcomes for beneficiaries will be modeled as a function of time, AC waiver period (before or after), covariates (fixed or time-varying).

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

| Variable | Description | Data Source |
|---|---|---|
| **AC use** | Amount and cost of AC services | MMIS, Medicare claims |
| **Health and functional status** | ADLs, cognitive impairment, service need | LTC Assessment, MDS for NH users |
| **Financial characteristics** | Financial characteristics | LTC Assessment |
| **Living arrangement** | Home alone, home with family, organized setting | LTC Assessment |
| **Medicaid payments** | By type of service | MMIS |
| **Disability level, function** | ADLs, IADLs | LTC Assessment |
| **Prior LTC use** | Long-term care history | MDS and MMIS |
| **NH use** | Days, dollars | MDS and MMIS |
| **Title III services** | List | Board on Aging |
| **Acute services** | Hospital, ER, SNF, DME, outpatient | Managed Care Plans, MMIS, Medicare |
| **Health outcomes** | Acute care use, death | Managed Care Plans, MMIS, Medicare |

Note: ADLs, activities of daily living; DME, durable medical equipment; ER, emergency room; IADLs, instrumental activities of daily living; NH, nursing home; SNF, skilled nursing facility.

## UNDER DEVELOPMENT

*Community First Services and Supports*

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

**Program Overview**

The CFSS is intended to expand consumer choice in the types of services they receive and the way they are provided, while offering clients consultation and financial management support to assist them in service planning and budgeting. All clients will receive:

- Consultation services.
- Worker training and development.
- Ability to purchases goods and technologies.
- Choice of caregivers – including relatives.

Clients can choose from two basic models: 1) Agency Model - traditional agency staff and administration, and 2) Budget Model – with an emphasis on self-direction of care (details in Section 4.42).

The CFSS replaces these current programs:

- Personal Care Assistance (PCA) -- Approximately 27,000 current PCA recipients will be transitioned to CFSS. The PCA service recipients will have an expanded choice of services and supports and greater consumer direction.
- Community Service Grants (CSG) – These grants will be eliminated and approximately 1,000 current CSG recipients will become eligible for CFSS, presumably choosing the budget model. The CFSS has larger dollar limit than CSG but less flexibility. Also, spouses and parents of minors can be paid as support workers through CFSS.
- Consumer Directed Consumer Supports (CDCS) waiver – It is not clear how clients with this waiver will be affected. They may opt for CFSS; they would have less choice but better benefits.

**Program Rationale**

While PCA services work well for many people, they are limited for others by only providing services that are doing “for” people in situations when individuals could learn to do more for themselves. In those cases, PCA provides some support but less optimally than possible. Similarly, in situations where technology or a home modification would enable a person to do more for him or herself and possibly substitute for a level of human assistance, people are unable to do so. This is because environmental modification services are only available today

through the waivers. Therefore, some people apply for home and community-based waiver services in order to access technology, modifications or more flexible services, triggering an administrative process to enroll. Consequently, some people who need these services cannot access the waiver when they need it due to: 1) not meeting institutional level of care requirements, or 2) delays in accessing waiver services due to limits set to manage growth.

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

Currently, there is a need to improve service coordination for our program beneficiaries: 1) individuals who are eligible but are not connected with the appropriate service, and 2) people who are accessing many services across multiple systems. Both of these situations can result in poor outcomes such as unstable housing, high medical costs, frequent crises, provider time spent in planning, re-planning and crisis management, and institutionalization. Data analysis shows that approximately 10% of people currently using PCA services utilize a variety of other systems and services that, when not well coordinated, result in fragmented, duplicative and/or inappropriate services, including use of more expensive services (e.g. emergency department visit, hospitalizations) and lead to poorer outcomes. Similarly, people who have high costs for avoidable services are often those who encounter the system at many points or have multiple needs. CFSS would allow people to access more useful services tailored to their needs.

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

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

**The CFSS Benefit**

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

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

**Person-centered assessment**

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

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

**CFSS service delivery models**

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

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

*Budget model:* Under this model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers, and obtain other supports and goods as defined in the service package. Participants will use a financial management services contractor for the billing and payment of services; for ensuring accountability of CFSS funds; for management of spending; and to serve as an agent to maintain compliance with employer-related duties, including federal and state labor and tax regulations. Participants may utilize the consultation service for assistance in developing a person-centered service delivery plan and budget; and for learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers.

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

**Services that may be accessed under the CFSS benefit**

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

- Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing.
- Acquisition, maintenance, or enhancement of skills necessary for the participant to accomplish ADLs, IADL's, and health-related tasks.
- Assistance in accomplishing instrumental activities of daily living (IADLs) related to living independently in the community and an assessed need: meal planning, preparation, and shopping for food; shopping for clothing or other essential items; cooking; laundry; housecleaning; assistance with medications; assistance with managing money; assist with individualized communication needs; arranging supports; assistance with participating in the community; and other appropriate IADL services.
- Assistance in health-related procedures and tasks that can be delegated or assigned by licensed health-care professionals under state law.
- Observation and redirection of Level I behaviors, defined as physical aggression towards self or others and/or destruction of property that requires the immediate response of another person.

- Back-up systems or mechanisms (such as the use of personal response systems or other mobile devices selected by the participant) to ensure continuity of the participant's services and supports. Specific risks and levels of back-up support needed are

addressed during the participant's initial and annual person-centered assessments, in the development of the community support plan and the service delivery plan. Each participant will have an individualized back-up plan that identifies service options and support people, both formal and informal, that can be called on when needed.

- Consultation services provide assistance to support the participant in making informed choices regarding CFSS services in general and self-directed tasks in particular; eliminate barriers to services and streamlines access; assist the person in developing a quality person centered service delivery plan, and offer support with compliance and quality outcomes. Consultation services provided to participants may include, but are not limited to: an orientation to CFSS, including assistance selecting a service model; assistance with the development, implementation, management and evaluation of the service delivery plan; assistance with recruiting, selecting, training, managing, directing, evaluating, supervising, and dismissing support workers; and facilitating the use of informal and community supports, goods or resources.
- Worker training and development services to enhance the support worker's skills as required by the participant's service delivery plan. Services provided to the direct support worker may include but are not limited to: training, education, direct observation, consultation, and performance evaluation.
- Expenditures for environmental modifications, or goods, including assistive technology. Such expenditures must relate to a need identified in a participant's CFSS community support plan; be priced at fair market value; increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed needs; and fit within the annual limit of the participant's approved service allocation or budget.
- Financial management services to provide payroll services for participants who choose the budget model.

CFSS does not cover:

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

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

**Eligibility for CFSS under Reform 2020 Waiver**

The Reform 2020 waiver allows Minnesota to receive federal financial participation to provide CFSS services to the following eligibility groups (Table 1):

- 1915(i)-like CFSS recipients: People who do not meet the Medicaid financial eligibility criteria to be eligible for the Section 1915(i) state plan benefit but are categorically eligible for Medical Assistance (i.e., have an assessed need for personal care assistance). (Demonstration waiver authority is necessary for this group because they do not meet the Medicaid financial eligibility criteria.)
- 1915(k)-like CFSS recipients: People who are financially eligible for Medical Assistance if they utilize the eligibility rules of one of Minnesota's home and community-based waivers but have chosen CFSS services in lieu of home and community-based waiver services. (Minnesota has been granted authority to extend Medicaid eligibility to this group to encourage utilization of CFSS instead of home and community-based services where appropriate. This group includes people who are: 1) Age 65 or over and eligible without a spend-down with income at or below 300% of SSI and spousal impoverishment rules; 2) Disabled, under age 65 and above age 20, and eligible without a spend-down with income at or below the relevant state plan standard with special institutional rules including an exemption from spousal deeming; or 3) Children under age 21 using eligible using special institutional rules including exemption from parental deeming.)

**Table 1. CFSS groups and characteristics**

| CFSS 1915 recipients (State Plan) 1915-i group | CFSS 1915 recipients (State Plan) 1915-k group | CFSS 1115 recipients (Waiver)1915 i-like group | CFSS 1115 recipients (Waiver) 1915 k-like group |
|---|---|---|---|
| Have incomes under 150% of the federal poverty level | - | Have income above 150% of the federal poverty level | Have income above a Medicaid state plan standard<br><br>Meet all non-financial eligibility factors for eligibility for a home and community-based waiver |
| Enrolled in Medicaid | Enrolled in Medicaid | Are at or below the relevant state plan limit for categorical eligibility | Qualify for Medicaid using the rules of the special home and community-based waiver group under 42 CFR §435.217 |
| Do not have an assessed need for | Have an assessed need for an | Do not meet an institutional level of | Need an institutional level of care |

| CFSS 1915 recipients (State Plan) 1915-i group | CFSS 1915 recipients (State Plan) 1915-k group | CFSS 1115 recipients (Waiver)1915 i-like group | CFSS 1115 recipients (Waiver) 1915 k-like group |
|---|---|---|---|
| an institutional level of care | institutional level of care | care for a NF, ICF-ID or hospital | |
| - | - | Meet the personal care assistance criteria* | Meet the personal care assistance criteria |

* A person meets the personal assistance criteria if he/she: 1) Has an assessed need for assistance with at least one activity of daily living, or 2) Demonstrates physical aggression toward oneself or others, or 3) Destruction of property that requires immediate intervention by another person

**Program Goals**

The goals of the CFSS program under the Reform 2020 Waiver are to:

- Provide a comparable level of access to CFSS to the waiver populations as the other CFSS recipients in the state plan.
- Achieve comparable health outcomes after utilization of CFSS for the waiver populations as is achieved for the comparable state plan eligibility groups using CFSS.
- Achieve comparable consumer satisfaction and costs for consumers utilizing CFSS services under the waiver as compared to state plan CFSS participants.

**Evaluation Strategy for Consumer First Services and Supports**

The evaluation plan addresses both program processes and outcomes. It relies mainly on secondary data sources, such as Medicaid claims and administrative data gathered through the program. Primary data collection is proposed in areas not well covered by administrative systems, such as client quality of life or autonomy.

The goals and associated metrics identified in section 5.3 will be evaluated by DHS and University of Minnesota using MMIS claims and beneficiary assessment data. It is appropriate for DHS to conduct the descriptive component of the evaluation using readily available data sources, as part of its ongoing quality monitoring and management activities. External evaluation will include expanded data elements and more rigorous analysis methods.

The evaluation will focus on the transition period (first 24 months) from personal care and consumer support grants to CFSS, and the impacts on CFSS recipients and subgroups.

**Goals and Objectives**

Despite the need for multiple federal authorities to implement the reformed personal care benefit, access to CFSS services for waiver populations will be as good as access experienced by people receiving CFSS services who are eligible under the state plan (hereinafter "state plan eligibility groups.") We will determine if experiences of the 1115 subgroups ("i-like" and "k-like) is comparable to the CFSS state plan eligibility groups, in terms of health outcomes and program satisfaction, and their use of the flexible CFSS budget.

**Evaluation Populations for CFSS**

The waiver evaluation populations will consist of the following subgroups: CFSS 1915(i)-like group and CFSS 1915(k)-like group (Table 1).

The comparison groups will be people receiving CFSS under 1915(i) or 1915(k) state plan option, respectively. People in 1915(i) group are enrolled in Medicaid with incomes under 150% of the federal poverty level and do not have an assessed need for an institutional level of care. People in 1915(k) group are enrolled in Medicaid and have an assessed need for an institutional level of care.43

**Hypotheses**

In this evaluation, we want to understand experiences of the CFSS waiver beneficiaries compared to CFSS state plan eligibility groups, relative to health outcomes and program satisfaction, and use of the flexible CFSS budget.

CFSS waiver beneficiaries will experience comparable access to CFSS services, compared to CFSS beneficiaries under the state plan. Access will be evaluated using the following measures:

- Number and percent of recipients using CFSS services
- Percent of CFSS authorized units paid over time

CFSS waiver beneficiaries will experience similar health outcomes following use of CFSS services, compared to CFSS beneficiaries under the state plan. Health outcomes will be evaluated using the following measures:

- Percent of recipients admitted to nursing facilities or other long-term care institutions.
- Amount of nursing facility use.

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[43] This group will include a subgroup of people who are receiving HCBS waiver services in addition to CFSS and a subgroup of people who are not receiving HCBS waiver services in addition to CFSS. The experience of the subgroup of people who are not receiving HCBS waiver services in addition to CFSS are likely to be more similar to the CFSS 1915(k)-like waiver population.

- Number of people that move from nursing facility to CFSS program.
- Use of emergency departments and acute care use.
- Level of independence with activities of daily living.

CFSS waiver beneficiaries will experience comparable satisfaction with CFSS services, compared to CFSS beneficiaries under the state plan. Satisfaction will be evaluated using the following measures:

- Percent of CFSS recipients reporting that they are the primary decision makers regarding their service plans (or their child's plan).
- Percent of CFSS participants reporting that support workers arrive when they are supposed to and perform the tasks requested.
- Percent of CFSS participants reporting satisfaction with their service providers.

CFSS waiver beneficiaries will experience comparable average costs of CFSS services, as compared to CFSS beneficiaries under the state plan. Costs will be evaluated using the following measures:

- Average cost per recipient of LTC services, by geographic and demographic group.
- Percent of CFSS participants also using institutional services, by amount of use.
- Percent of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time.

**Data Sources**

*MMIS:*

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the county – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs. State Medicaid management information system contains extensive data related to Medicaid recipients' eligibility and enrollment, as well as detailed claims data encompassing both traditional fee for service and managed care encounter records. It also records assessments of needs and service plans.

- Claims - cost and utilization for FFS population, diagnoses.
- Encounter data - utilization for managed care population, diagnoses; only partial cost data.
- Eligibility files - program enrollment, waiver status, demographics, reasons for eligibility, dual eligible status.
- Assessment data - functional status, presence and extent of service needs.
- Service agreements - specific authorized levels and types of service.

*LTC Screening Document:*

This form is used to document pre-admission screening and long-term care consultation (LTC) activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. Variables include program type, entry and exit from waivered programs (including death) and exit reasons, case-mix, level of care, etc.

*MnCHOICES:*

MnCHOICES is a single, comprehensive assessment and support planning Web-based application for long-term services and supports in Minnesota. MnChoices uses one assessment process for people of all ages, abilities and financial statuses, promotes choice and integrated community living, and provides a common data collection tool; it uses a person-centered planning approach to help people make decisions about long-term services and supports. It replaced the following assessment tools:

- Developmental Disability Screening, Long-Term Care Consultation, Personal Care Assistance Assessment.
- Consumer assessments.
- Satisfaction surveys.
- Other programmatic data.

*Minimum Data Set (MDS):*

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. Variables include admission and discharge date, type of entry, and Medicare stay.

**Design Approaches**

The sections below provide information about the study design, the comparison group(s), metrics, and statistical methods.

*Pre-Post Analysis*

We will measure CFSS service access use, nursing facility use, satisfaction with CFSS service and providers, and average cost of service, before and after the PCA-to-CFSS transition. Authorized CFSS units will be available in MMIS. Program satisfaction and provider evaluation data will be extracted from MnChoices/MnSP questions.

Statistical Analysis: For all measures, we will report the denominator, number and percent of beneficiaries, and utilization rates, as appropriate. We will test the difference in means before and after, using t-tests. We will also compare the difference in means using ANOVA and post-hoc estimations. Covariates includes, but are not limited to, age, number of admissions to nursing facility in a given year, and case-mix.

*External Evaluation*

In addition to the designated activities to be conducted by DHS, DHS will contract with Center for Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management, to conduct an evaluation of the impact of the 1915 i-like and k-like waiver populations on access, quality and cost for eligible children, adults and low-income senior population in the state. Greg Arling, PhD, Katherine Birck Professor, School of Nursing, Purdue University, will assist in the analysis.

*Evaluation Objective:*

This component of the evaluation will include analysis of pre-waiver and post-waiver 1915(i)-like and 1915(k)-like program service use and payments, and the relationship to utilization of flexible benefits, medical care, nursing facility use and HCBS Waiver use.

*Analysis Plan:*

For this evaluation, the following data sources will be utilized: Medicaid Management Information Systems (MMIS), Medicaid files, Minimum Data Set (MDS v3), Medicare claims, MnChoices and MnSP data, and long-term care consultation (LTC) assessment data. The measures and comparison populations are listed in Table 2.

The planned analysis strategies will consist of multiple strategies involving descriptive statistics, cross-sectional comparisons at different time points, and longitudinal analysis of client level processes and outcomes. Comparisons will be made between the Budget and Agency Models and by client subgroups to determine differential use of services, costs, and program impacts.

*Baseline characteristics*: Descriptive statistics on the client population will be prepared during the 12-month period prior to CFSS implementation on client populations that are expected to transition into CFSS – PCA users, CS grant recipients, and CDCS recipients. Characteristics will include disability group, demographics, health and functional status, service use and expenditures.

*Repeated cross-sectional analysis*: To assess change in the program or its impact, descriptive statistics on characteristics of the CFSS population will be calculated for different time periods (quarterly or semi-annually). Characteristics will include disability group, demographics, health and functional status, service use and expenditures.

*Longitudinal client-level analysis:* In order to assess program processes and impact at the client level, clients will be tracked from baseline or program entry to program exit. Change will be analyzed in health and functional status, service use and expenditures, satisfaction with care, and independent living skills. The time points for the longitudinal analysis will vary from monthly (e.g. service use and costs) to semi-annual or annual (health and functioning or satisfaction with care).

**Table 2. Overview of Populations, Measures and Years**

| Waiver Populations | Comparison Populations | Measures | Data Source |
|---|---|---|---|
| CFSS i-like & k-like groups | CFSS i and k groups | # and % of recipients using each CFSS service, compared by eligibility group | MMIS Claims |
| CFSS i-like & k-like groups | CFSS i and k groups | % of CFSS authorized units paid over time by eligibility group | MMIS Claims;<br><br>MMIS Service Agreement; Screening Documents |
| CFSS i-like & k-like groups | CFSS i and k groups, all groups over time | % of participants admitted to nursing homes during the year by amount and frequency of use | Screening documents;<br><br>MDS |
| CFSS i-like & k-like groups | CFSS i and k groups, all groups over time | # of participants that moved from nursing homes onto the program | Screening documents;<br><br>MDS |
| CFSS i-like & k-like groups | CFSS i and k groups, all groups over time | % of CFSS participants also using institutional services by amount of use | MMIS Claims |
| CFSS i-like & k-like groups | CFSS i and k groups | % of CFSS participants reporting they are the primary deciders of what is in their service plan (or their child's plan), compared by eligibility group | MnChoices/MnSP |
| CFSS i-like & k-like groups | CFSS i and k groups | % of CFSS participants reporting that whose paid to help them come when they | MnChoices/MnSP |

| Waiver Populations | Comparison Populations | Measures | Data Source |
|---|---|---|---|
| | | are supposed to, compared by eligibility group | |
| CFSS i-like & k-like groups | CFSS i and k groups | % of CFSS participants reporting that whose paid to help them do the things you want them to | MnChoices/MnSP |
| CFSS i-like & k-like groups | CFSS i and k groups | % of CFSS participants reporting that they satisfied with their service provider | MnChoices/MnSP |
| CFSS i-like & k-like groups | CFSS i and k groups, all groups over time | Overall average cost per recipient of LTC services by eligibility group, lead agency, and demographic group, compared as well by eligibility group | MMIS Claims |
| CFSS i-like & k-like groups | CFSS i and k groups, all groups over time | % of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time | MMIS Claims |

*Evaluation Implementation Strategy*

**Coordination of the Alternative Care and CFSS Evaluations:**

The goals and associated metrics identified in sections 3.3 and 5.3 will be evaluated by DHS using MMIS claims and assessment data. DHS conducts descriptive evaluations using readily available data sources, as part of its ongoing quality monitoring and management activities.

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

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

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

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

The Department also monitors HCBS waiver and case management activities through quality assurance plans and MMIS subsystems. Counties and tribes are required to submit a quality assurance plan to the Department every one to two years. The plan is a self-assessment of

compliance with waiver policies and procedures, some of which directly apply to case management activities. Our MMIS design supports HCBS waiver policies and procedures, including those related to case management. DHS uses data from MMIS to monitor case management activities. DHS reports on the quality assurance plans and MMIS subsystems in accordance with the §1915(c) waiver requirements.

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

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

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

**Conclusion, Best Practices, and Recommendations:**

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

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

## Introduction

This is the Minnesota Department of Human Services' final report on the Minnesota Family Planning Program (MFPP) section 1115 demonstration waiver, and represents the results of the MFPP evaluation for the waiver period of July 2006 through December 2016, per the requirements under the MFPP waiver Special Terms and Conditions, paragraph 30. The MFPP is no longer a waiver and now operates under the Medicaid state plan.

## Overview of the Minnesota Family Planning Program

The Minnesota Department of Human Services (DHS) began implementation of the Minnesota Family Planning Program on July 1, 2006. This program was initially approved by the Centers for Medicare and Medicaid Services (CMS) for a 5-year period, ending June 30, 2011. An extension of the MFPP waiver was approved by CMS in December 2011 for the period July 1, 2011 through December 31, 2013. On December 31, 2012, DHS submitted a request to extend the waiver for an additional three years. In June of 2013, CMS approved a one-year extension of the MFPP waiver through December 31, 2014. Since this initial one-year extension a series of temporary extensions have been approved by CMS. The most recent temporary extension was approved by CMS through December 31, 2016. This temporary extension allowed the State to conduct necessary activities related to the phase-out of the demonstration during the transition of the MFPP to state plan authority. Effective January 1, 2017, the MFPP was converted to state plan authority under the Family Planning State Plan option.

The goal of the Minnesota Family Planning Program is to provide access to family planning services to individuals who do not have access to those services through other programs. Increased access to family planning services is expected to lead to decreased expenditures by public health care programs by reducing the number of births resulting from unintended pregnancies.

Participants in the Minnesota Family Planning Program must be Minnesota residents 15 to 49 years of age, have income at or below 200 percent of the federal poverty guideline, be US citizens or qualified non-citizens eligible for Medicaid with federal financial participation, not be enrolled in other Minnesota Health Care Programs (MHCP) administered by DHS, not be pregnant, and not reside in a medical institution.

MFPP benefits include family planning office visits, exams, counseling, and education; contraceptive medications and supplies; voluntary sterilization; diagnosis, testing, and treatment of sexually transmitted infections found during family planning visits, HIV testing and counseling, and pharmacy services and laboratory tests related to these benefits.

## Evaluation Plan

The demonstration objectives, and associated indicators for measurement of progress toward those objectives, are listed in the following table.

**Evaluation Objectives and Indicators**

| OBJECTIVES | INDICATORS |
|---|---|
| 1. Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs. | **a.** Annual unduplicated count of individuals aged 15 to 49 enrolled in MHCP offering family planning services (includes Medical Assistance, MinnesotaCare, General Assistance Medical Care, and MFPP; excludes programs that do not offer family planning services).<br>**b.** *Annual unduplicated count of individuals ever enrolled in MFPP from program implementation to present.*<br>**c.** *Percentage of MFPP enrollees who enroll in the program after the presumptive eligibility period.* |
| 2. Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services. | a. Annual proportion of MHCP enrollees with a family planning service or pharmacy claim.<br>b. Annual proportion of MHCP enrollees receiving contraceptive services and supplies.<br>c. Annual proportion of MHCP enrollees receiving testing for a sexually transmitted disease (STD). |
| 3. Increase the average age of mother at first birth among MHCP enrollees. | a. Maternal age distribution for MHCP-financed births.<br>b. Annual average maternal age among MHCP-financed births. |
| 4. Reduce the teen birth rate among MHCP enrollees. | Annual rate of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP. |

# Appendix G: Medicaid Tribal Consultation Policy

DHS will designate a staff person in the Medical Director's office to act as a liaison to the Tribes regarding consultation. Tribes will be provided contact information for that person.

The liaison will be informed about all contemplated state plan amendments and waiver requests, renewals, or amendments.

The liaison will send a written notification to Tribal Chairs, Tribal Health Directors, and Tribal Social Services Directors of all state plan amendments and waiver requests, renewals, or amendments.

Trial staff will keep the liaison updated regularly regarding any change in the Tribal Chair, Tribal Health Director, or Tribal Social Services Director, or their contact information.

The notice will include a brief description of the proposal, its likely impact on Indian people or Tribes, and a process and timelines for comment. At the request of a Tribe, the liaison will send more information about any proposal.

Whenever possible, the notice will be sent at least 30 days prior to the anticipated submission date. When a 30-day notice is not possible, the longest practical notice will be provided.

The liaison will arrange for appropriate DHS policy staff to attend the next Quarterly Tribal Health Directors meeting to receive input from Tribes and to answer questions.

When waiting for the next Tribal Health Directors meeting is inappropriate, or at the request of a Tribe, the liaison will arrange for consultation via a separate meeting, a conference call, or other mechanism.

The liaison will acknowledge all comments received from Tribes. Acknowledgement will be in the same format as the comment, e.g. email or regular mail.

The liaison will forward all comments receives from the Tribes to appropriate state policy staff for their response.

The liaison will be responsible for ensuring that all comments received responses from the State.

When a Tribe has requested changes to a proposed state plan amendment or waiver request, renewal, or amendment, the liaison will report whether the change is included in the submission, or why it was not included.

The liaison will inform Tribes when the State's waiver or state plan changes are approved or denied by CMS, and will include CMS' rationale for denials.

For each state plan or waiver change, the liaison will maintain a record of the notification process; the consultation process, including written correspondence from Tribes and notes of meetings or other discussions with Tribes; and the outcome of the process.

# Appendix H: State Public Notice Process

## Public Notice and Comment Period

The State must provide a 30-day public notice and comment period prior to submission of initial/extension application.

The Public Notice must include comprehensive descriptions of initial/extension application:

- Program description, goals, and objectives.
- Current/New beneficiaries to be impacted.
- Proposed healthcare delivery system.
- Eligibility requirements.
- Benefit coverage.
- Cost sharing (e.g. - premiums, co-pays, deductibles).
- Enrollment and expenditure data, historical and projected.
- Hypothesis and evaluation parameters.
- Waiver and expenditure authorities requested.
- Locations and Internet address where copies of application are available for public review and comment.
- Postal and Internet addresses where written public comments may be sent and reviewed, indicate the 30-day time period in which comments will be accepted.
- Location, date, and time of two public hearings convened by the State of Minnesota.

## Statement of Public Notice and Public Input Procedures

The State must publish the following on the main page of the DHS public website or on a demonstration-specific webpage linked to the main page of the DHS public website:

- Public notice process.
- Public input process.
- Planned hearings.
- Demonstration application/extension request.
- Link to the Medicaid demo page on CMS website.

The State must maintain and keep current the public website throughout the public comment and review process

The State must also publish abbreviated public notice (State Register Notice) 30 days prior to submission. The State Register notice must include:

- Summary description of demonstration.
- Location and times of two public hearings.
- A link to the full public notice document on the State's website.

The State must utilize additional mechanisms such as an email distribution list to notify interested parties of the demonstration application.

## Public Hearings

The State must conduct two public hearings, on separate dates, and separate locations at least 20 days prior to submission.

The State must use telephonic and/or web conference capabilities for at least one hearing to assure statewide accessibility.

The State must use at least two of the following forums:

- Medical Care Advisory Committee that operates in accordance with 431.12.
- Commission open to the public.
- State legislative process that affords public review and comment on demonstration content.
- Any other similar process that affords public review and comment on demonstration content.

## Tribal Consultation

The review must be conducted in accordance with consultation processes outlined in July 17, 2001 letter or the State's formal Tribal Consultation Process (Appendix G) as outlined in the State's approved Medicaid State Plan.

Documentation of Tribal consultation activities must be included in the demonstration/extension application, including:

- Description of notification process.
- Entities involved in consultation.
- Dates.
- Locations.
- Issues raised and potential resolution of issues.

# Appendix I: Ongoing DHS Performance Measurement

Calculated annually by DHS using claims data submitted to the State by MCOs

**Table 1: HEDIS Performance Measures**

| No. | Measure | HEDIS Identifier | ATR Measure | IHP 2.0 Measure |
|---|---|---|---|---|
| 1 | Adults' Access to Preventative/Ambulatory Health Services (20-44, 45-64, 65+ years & Total) | AAP | X | X |
| 2 | Follow-up Care for Children prescribed ADHD medication (6-12 years) | ADD | | |
| 3 | Annual Dental Visit (2-3, 4-6, 7-10, 11-14, 15-18, Total for children, 2-18, 19-21, 22-64, 65+, & Total for adults 19+) | ADV | | X |
| 4 | Antidepressant Medication Management (18-64, 65+ years, & Total)<br>• Acute Treatment<br>• Continuous Treatment | AMM | X | X |
| 5 | Asthma Medication Ratio (5-11, 12-18, 19-50, 51-64 years) | AMR | X | X |
| 7 | Adolescent Well-Care Visits (12-21 years) | AWC | X | X |
| 8 | Breast Cancer Screening (52-64 years, 65-74 years, & Total) | BCS | X | X |
| 9 | Children and Adolescents' Access to Primary Care Practitioners (12-24 months, 25 months-6 years, 7-11 years, 12-19 years, & Total) | CAP | X | X |
| 10 | Cervical Cancer Screening (CCS) (24-64 years) | CCS | X | X |
| 11 | Diabetes Screening (18-64, 65-75 years, & Total)<br>• HbA1c Testing | CDC | X | X |
| 12 | Chlamydia Screening (16-20 years, 21-24 years, and Total) | CHL | X | X |
| 13 | Childhood Immunizations (Total 2 year olds) all Combinations | CIS | X | X |
| 14 | Colorectal Cancer Screening (50-64, 65-75, & Total) | COL | | X |
| 15 | Follow-Up After Hospitalization for Mental Illness 7/30 Days (FUH) (6-17, 18-64, 65+ years) | FUH | | X |
| 16 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (13-64, 65+ years, & Total) | IET | | X |
| 17 | Immunizations for Adolescents (Total 13 years old) | IMA | | X |
| 21 | Plan All Cause Readmission (18 – 64, 65+years, & Total) | PCR | | X |

| No. | Measure | HEDIS Identifier | ATR Measure | IHP 2.0 Measure |
|---|---|---|---|---|
| 22 | Prenatal & Postpartum Care (all ages) | PPC | | |
| 23 | Adherence to Antipsychotic medications for individuals with schizophrenia (19-64 years) | SAA | | X |
| 26 | Well-Child Visits First 15 Months (zero, 1, 2, 3, 4, 5, 6 or more visits) | W15 | X | X |
| 27 | Well-Child Visits (3 – 6 years) | W34 | X | X |
| 28 | Adult Body Mass Index Assessment (18-74) | ABA | | |
| 29 | Ambulatory Care – Emergency Dept. Visits (<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, 85+, Unknown) | AMB | | X |
| 30 | Flu Vaccines for Adults (18-64) | FVA | | |
| 31 | Medical Assistance with Smoking and Tobacco Cessation (18+) | MSC | | |
| 32 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (3-11, 12-17, total) | WCC | | X |
| 33 | Metabolic Monitoring for Children and Adolescents on Antipsychotics (1-5, 6-11, 12-17, total) | APM | | |
| 34 | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence | FUA | X | |
| 35 | Follow Up after ED visit for Mental Illness | FUM | | X |
| 36 | Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications | SSD | | |
| 38 | Inpatient Utilization – General Hospital/Acute Care | IPU | | X |
| 40 | Opioids at High Doses | HDO | | |
| | Total | 32 | 14 | 25 |

# ATR measures must be calculated by August 1st or sooner of each year.

**Table 2: AHRQ Prevention Quality Indicators (PQI)**

| No. | Prevention Quality Indicator | CY 2017,-CY 2018, and CY 2019 |
|---|---|---|
| PQI 01 | Diabetes Short Term Complication Admission Rate | X |
| PQI 02 | Perforated Appendix Admission Rate | X |
| PQI 03 | Diabetes Long-term Complication Admission Rate | X |
| PQI 05 | Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate | X |
| PQI 07 | Hypertension Admission Rate | X |

| No. | Prevention Quality Indicator | CY 2017,-CY 2018, and CY 2019 |
|---|---|---|
| PQI 08 | Heart Failure Admission Rate | X |
| PQI 10 | Dehydration Admission Rate | X |
| PQI 11 | Bacterial Pneumonia Admission Rate | X |
| PQI 12 | Urinary Tract Infection Admission Rate | X |
| PQI 13 | Angina Without Procedure Admission Rate | X |
| PQI 14 | Uncontrolled Diabetes Admission Rate | X |
| PQI 15 | Asthma in Younger Adults Admission Rate | X |
| PQI 16 | Lower-Extremity Amputation among Patients with Diabetes Rate | X |
| PQI 90 | Prevention Quality Overall Composite (IHP Measure) | X |
| PQI 91 | Prevention Quality Acute Composite | X |
| PQI 92 | Prevention Quality Chronic Composite | X |
| | Total | 16 |

# Appendix J: Directed Payment Arrangements

DHS contracts with MCOs include provisions for directed payments in several categories: Integrated Health Partnerships, Behavioral Health Homes, and State Operated Dental Services. The following discusses these contract components and how they align with the goals of the Quality Strategy.

## 1. Integrated Health Partnerships

The Integrated Health Partnership is a Medicaid service delivery reform demonstration that is based on an integrated care model. The goal of the demonstration is to improve the health of the target population by delivering care of higher quality and lower cost through innovative approaches to both care and payment. In this effort, the state contracts with a consortium of health partnerships, each of whom works with an associated group of Medicaid providers. The providers work together to coordinate their efforts, and achieve a demonstrable level of savings when compared to targets developed by the state. Providers that demonstrate an overall savings across their population, while maintaining or improving quality of care, may receive a portion of the savings. Providers that cost more over time may be required to pay back a portion of the losses.

Providers in the Integrated Health Partnership program receive a base payment for services just like other Medicaid providers. In addition, the state calculates a target payment amount that is based past utilization and cost data for the population served. If a provider is able to deliver service at a lower cost than the calculated target, an incentive (directed) payment may be made to the provider. Lower costs may be the result of better coordination, greater efficiency, or reduced utilization of medical services.

The classes of providers participating in this arrangement include the following: Physician services; nurse midwife; nurse practitioner; Child & Teen Check-up (EPSDT); public health nurse; rural health clinic; federally qualified health center; laboratory; radiology; chiropractic; pharmacy; vision; podiatry; physical therapy; speech therapy; occupational therapy; audiology; mental health; chemical dependency; outpatient hospital; ambulatory surgical center; inpatient hospital; anesthesia; hospice; home health (excluding personal care assistant services); and private duty nursing.

The methods used to determine savings and quality are the same for all providers, except when a provider's patient population differs measurably from the average Medicaid population. In those instances, the state may apply quality measures that are more appropriate to the type of patients served by the provider. For example, a quality measurement related to the provision of cancer screening for adults may be substituted for child and teen checkups when evaluating quality for a provider of pediatric services.

Providers are given incentive to improve value and quality through a payment arrangement that is directly tied to the objectives of the Quality Strategy. Providers receive an incentive payment

when they can demonstrate savings beyond a threshold established by the state, and fifty percent (50%) of this payment is contingent on meeting or exceeding quality and utilization performance measures. Providers who show cost greater than the established threshold may owe the state money, which provides them with further incentive.

Performance is reviewed annually. Costs are evaluated relative to the estimated payment targets. Quality of service is measured under several categories: prevention and screening, care for at-risk populations, behavioral health, access to care, patient safety, outpatient care, and meaningful use of electronic health record technology.

All enrollees are eligible with the following exceptions: individuals dually eligible for Medicare and Medicaid; qualified Medicare beneficiaries who are not otherwise receiving Medical Assistance; non-citizens receiving only emergency Medical Assistance; individuals eligible for Medical Assistance on a spenddown basis; individuals enrolled in specialized Medical Assistance managed care programs; and individuals whose Medical Assistance is supplemented by a third party's liability.

The Integrated Health Partnership is a voluntary, direct-contract payment model that serves both managed care and fee-for-service Medicaid enrollees. Incentive (directed) payments are made under the same conditions for each provider, and all providers within a given class are subject to the same terms of performance and participation requirements.

The metrics and methodology used for measuring performance of providers participating in the IHP program are discussed in the body of the Quality strategy and Appendices I, J, and K. Measures listed may not apply to all IHPs, as some measures vary based on contract start date or population served.

## 2. Behavioral Health Home Services

Behavioral health home services provide a team-based model of integrated care for adults with serious mental illness, and children with emotional disturbance. In order to receive services, an individual must meet the criteria for serious mental illness or emotional disturbance and have a current diagnosis of serious mental illness or emotional disturbance from a qualified health professional. Individuals receive comprehensive care management through a collaborative process designed to more effectively manage medical, social, and behavioral health conditions. Providers draft a person-centered health action plan based on a template developed by the state Medicaid agency. The plan requires the team to maintain regular contact with the individual, coordinate services among other providers involved in the individual’s care, and monitor progress towards achieving the goals outlined in the plan. When the individual is a child, all activities must include the consent of the child’s parent or guardian. All behavioral health home Services providers are certified by the state.

These providers include: primary care clinics, rural health clinics, community mental health centers, community mental/behavioral health agencies and federally qualified health centers

(FQHCs). A behavioral health home services team includes the following: Integration specialists (which include registered nurses, and mental health professionals); Behavioral Health Home System Navigators (which include case managers and mental health professionals); Qualified Health Home Specialists (including community health workers, peer specialists, and certified health education specialists); and other specialists as necessary. Providers are paid a monthly bundled rate for each Medicaid enrollee receiving services through the behavioral health home. Payment for each behavioral health home services provider is determined using the same metrics and terms of performance.

Behavioral health home services providers must have the capacity to perform core services specified by Centers for Medicare and Medicaid Services (CMS) and meet state-specific requirements. The State developed BHH services certification standards to ensure that behavioral health home services providers meet the required state and federal standards.

In September 2019, an evaluation was completed on the implementation of the behavioral health home services delivery model in Minnesota. The goal was to evaluate the program implementation by assessing how sites were using the behavioral health home services model and documenting the successes, challenges and preliminary outcomes associated with it. In the next evaluation phase, the state will examine outcomes based on age, race, ethnicity, and mental health diagnosis, selected measures from the Medicaid Health Home Program Core Set, and the Healthcare Effectiveness Data and Information Set, and additional quality measures identified. The state will also conduct individual interviews and focus groups with enrollees receiving behavioral health home services. A Minimum Fee Schedule for Behavioral Health Home Services was approved by CMS on February 21, 2020.

## 3. Certified Community Behavioral Health Clinics (CCBHC)

| Goal(s) | Objectives(s) |
|---|---|
| Create a comprehensive continuum of care that provides more coordinated, cost effective, patient-centered care to those living with mental health and substance use challenges. | 1. Providers will provide the full scope of CCBHC services.<br>a) CCBHCs will provide services from the 9 required service categories (outpatient mental health and substance use disorder, crisis services, screening, assessment and diagnosis, treatment planning, targeted case management, peer family supports, psychiatric rehabilitative, community-based services for veterans and outpatient primary care screening & monitoring) serving as a "one-stop- |

| Goal(s) | Objectives(s) |
| --- | --- |
| | shop" to meet the needs of the population served.<br>b) CCBHCs ensures all 9 service categories, if not available directly through the CCBHC, are provided through a Designated Collaborating Organization (DCO).<br>c) Individuals will receive CCBHC services in a person-centered and family-centered manner.<br>d) Providers will consider the client's choice in care services provided, as well as the physical, behavioral health, and social service needs of each individual as these factors influence the well-being of the whole person.<br>2. Coordinated, integrated care provided by CCBHCs is cost effective since a client will receive an array of services at one location, potentially on the same day instead of accessing care at multiple locations and times.<br>3. CCBHCs will provide care coordination.<br>a) Care coordinators will coordinate care across settings and providers to ensure seamless transitions for clients across the full spectrum of health services, including acute, chronic, and behavioral health needs.<br>b) Care coordination activities are carried out in keeping with the client's preferences and needs for care and, to |

| Goal(s) | Objectives(s) |
|---|---|
| | the extent possible and in accordance with the client's expressed preferences. |
| Increase access to services and serve as a "one-stop-shop" to those who are currently underserved. | a) CCBHCs will provide services to all populations regardless of age, ability to pay, and place of residence.<br>b) CCBHCs will provide intensive community-based outpatient behavioral health care for members of the US Armed Forces and veterans. All individuals inquiring about services are asked whether they have ever served in the U.S. military.<br>c) CCBHC will hire peer and family supports to engage and support underserved communities, where individuals can be less able or willing to obtain services from "traditional" providers.<br>d) CCBHCs will increase the use of telemedicine to increase availability of services, especially in the rural and frontier counties in Minnesota. |
| Reduce behavioral health disparities for American Indian tribes, communities of color, and other cultural groups. | a) CCBHCs will increase access and availability of services to communities experiencing behavioral health disparities, especially American Indian tribes and communities of color.<br>b) Peer and family supports will serve as "cultural brokers" for underserved communities and to assist individuals to obtain behavioral health services from providers who are not from their culture and/or don't speak their language.<br>c) CCBHCs will provide outreach to engage and retain persons of |

| Goal(s) | Objectives(s) |
|---|---|
| | color and those whose primary language is not English in behavioral health services. |
| Develop Minnesota's behavioral health workforce. | CCBHC will expand providers' capacity to serve more people via an expanded workforce by:<br>a) Creating more staff positions increase access to services and serve more clients.<br>b) Paying more adequately and increase the ability to offer a living wage to CCBHC staff.<br>c) Hiring a more diverse population from different cultural backgrounds to reflect cultural backgrounds of the people they serve. |

## 4. Long Term Services and Supports

Certain providers are required to be paid by MCOs at or above the rates paid in the state's fee-for-service program (FFS). The Long Term Services and Supports (LTSS) providers in this group are nursing facility, home care, and Elderly Waiver services. Increases in the FFS program fee schedule are to be directly reflected in MCO payment.

The purpose of this directed payment is to support maintenance and growth of LTSS services, some of which are recognized by the state as shortages (for example, PCA services). Establishing reasonable minimum payment rates for MLTSS will help the state ensure that MLTSS services are as accessible to all managed care enrollees as compared to the FFS program and that the quality of service delivery is as high as FFS. When Minnesotans are able to access the MLTSS services they require, their overall quality of life improves.

Because the MCOs will be paying the same rates as the FFS system they will be paying for, as well as sharing in, the improved quality and efficiency expected from the projects and administrative processes promoted by the state. See, for example, the nursing facility quality improvement projects. In addition, uniform payment floors for all MLTSS supports DHS' overall efforts for consistency in providers' expectations, and results in administrative simplification which lowers costs for providers. Approval was granted by CMS on February 21, 2020 for a Minimum Fee Schedule.

## Appendix K: IHP Specific Measures

**Table 1. Additional IHP 2.0 Measures**

| Measure Category | Measure Name | Measure Specification Organization | Core Set or IHP specific |
|---|---|---|---|
| Care for At-Risk Populations | Optimal Diabetes Care Composite | MNCM | Core IHP 2.0 Set |
| Care for At-Risk Populations | Optimal Vascular Care Composite | MNCM | Core IHP 2.0 Set |
| Care for At-Risk Populations | Optimal Asthma Control – Adults and Children | MNCM | Core IHP 2.0 Set |
| Patient-centered Care | CG-CAHPS[44] Timely appointments, care and information | AHRQ | Core IHP 2.0 Set |
| Patient-centered Care | CG-CAHPS How well providers communicate with patients | AHRQ | Core IHP 2.0 Set |
| Patient-centered Care | CG-CAHPS Helpful, courteous and respectful office staff | AHRQ | Core IHP 2.0 Set |
| Patient-centered Care | CG-CAHPS Patient rating of provider as 9 or 10 | AHRQ | Core IHP 2.0 Set |
| Patient-centered Care | CG-CAHPS Providers' Use of Information to Coordinate Patient Care (Coordinate Care Composite) | AHRQ | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS[45] Communication with Nurses | CMS | Core IHP 2.0 Set |

[44] Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

[45] Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

| Measure Category | Measure Name | Measure Specification Organization | Core Set or IHP specific |
|---|---|---|---|
| Patient-centered Care | HCAHPS Communication with Physicians | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS Responsiveness of Hospital Staff | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS Communication about Medications | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS Cleanliness of Hospital Environment | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS Quietness of Hospital Environment | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS Discharge Education | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS Care Transitions | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS Overall Hospital Rating | CMS | Core IHP 2.0 Set |
| Patient-centered Care | HCAHPS recommend the Hospital as 9 or 10 | CMS | Core IHP 2.0 Set |
| Medicaid Meaningful Use of E.H.R Technology | Health Information Exchange | CMS, Medicaid EHR Incentive Program Stage 2, Objective 5 | Core IHP 2.0 Set |
| Medicaid Meaningful Use of E.H.R Technology | Patient Electronic Access | CMS, Medicaid EHR Incentive Program Stage 2, Objective 8 | Core IHP 2.0 Set |

| Measure Category | Measure Name | Measure Specification Organization | Core Set or IHP specific |
|---|---|---|---|
| Medicaid Meaningful Use of E.H.R Technology | Secure Electronic Messaging | CMS, Medicaid EHR Incentive Program Stage 2, Objective 9 | Core IHP 2.0 Set |
| Medicaid Meaningful Use of E.H.R Technology | Stage 3, Objective 6: Coordination of Care, Measures 1, 2, and 3 | CMS, Medicaid Promoting Interoperability (PI) Program Stage 3 | Core IHP 2.0 Set |
| Medicaid Meaningful Use of E.H.R Technology | Stage 3, Objective 7: Health Information Exchange, Measures 1, 2, and 3 | CMS, Medicaid Promoting Interoperability (PI) Program Stage 3 | Core IHP 2.0 Set |
| Care for at risk populations | Optimal asthma control: ACT 20+, < 2 admissions/ER/ | MNCM | IHP-specific |
| Behavioral Health | Adolescent Mental Health and/or Depression screening with use of a depression screening tool annually for patients 12yr and older | MNCM | IHP-specific |
| Behavioral Health | Depression Remission at 6 months | MNCM | IHP-specific |
| Patient-centered Care | Timely appointments, care, and information: Was your child seen by this provider in a timely manner? | AHRQ | IHP-specific |
| Patient-centered Care | How providers communicate with patients: Did this provider listen carefully to you? [No. Yes, somewhat. Yes, mostly. Yes, definitely] | AHRQ | IHP-specific |
| Patient-centered Care | Providers' use of information to coordinate patient care: Did this provider give you enough information about your child's health and | AHRQ | IHP-specific |

| Measure Category | Measure Name | Measure Specification Organization | Core Set or IHP specific |
|---|---|---|---|
| | treatment? [No. Yes, somewhat. Yes, mostly. Yes, definitely] | | |
| Patient-centered Care | Helpful, courteous, and respectful office staff: How often were the staff at the provider's office as helpful as you though they should be? [Never. Sometimes. Usually. Always] | AHRQ | IHP-specific |
| Patient-centered Care | Patients' rating of the provider: Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider? | AHRQ | IHP-specific |
| Patient-centered Care | Child HCAHPS: Willingness to Recommend | AHRQ | IHP-specific |
| Patient-centered Care | Child HCAHPS: Overall Positive Experience | AHRQ | IHP-specific |
| Pilot Measure, Patient Engagement | Well visits in years 7-11 yr | HEDIS | IHP-specific |
| Pilot Measure, Patient Engagement | Application of fluoride varnish at Well visits annually through age 5 yr | CDC | IHP-specific |

**Table 2. IHP Legacy Measures**

| Measure Category | Measure Name | Measure Specification Organization | Core Set or IHP specific |
|---|---|---|---|
| Clinical Quality | Optimal Diabetes Care Composite | MNCM | Core IHP Legacy Set |
| Clinical Quality | Optimal Vascular Care Composite | MNCM | Core IHP Legacy Set |
| Clinical Quality | Depression Remission at 6 Months | MNCM | Core IHP Legacy Set |
| Clinical Quality | Optimal Asthma Control (Adults and Children) | MNCM | Core IHP Legacy Set |
| Clinical Quality | Asthma Education and Self-Management - Adults and Children | MNCM | Core IHP Legacy Set |
| Clinical Quality | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), CMS138v5 | HRSA, UDS | IHP-specific |
| Clinical Quality | Asthma: Use of Appropriate Medications: (Line 16), CMS126v5 | HRSA, UDS | IHP-specific |
| Clinical Quality | CAD: Lipid Therapy: | HRSA, UDS | IHP-specific |
| Clinical Quality | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (Line 18), CMS164v5 | HRSA, UDS | IHP-specific |

| Measure Category | Measure Name | Measure Specification Organization | Core Set or IHP specific |
|---|---|---|---|
| Clinical Quality | Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v6 | HRSA, UDS | IHP-specific |
| Clinical Quality | Uncontrolled Diabetes | HRSA, UDS | IHP-specific |
| Clinical Quality | Hypertension Control | HRSA, UDS | IHP-specific |
| Clinical Patient Experience | HRSA Patient Satisfaction Survey | HRSA, UDS | IHP-specific |
| Clinical Patient Experience | Patient Experience (CG-CAHPS) | AHRQ | IHP-specific |
| Hospital Patient Experience | Patient Experience (HCAHPS) | CMS | IHP-specific |

# Appendix L: Initiatives under Development

To ensure compliance with recent changes to 42 CFR Section 438, DHS is actively developing additional reporting tools that will aid in monitoring the performance of partner MCOs and communicating MCO performance to public program enrollees. The State Monitoring Report is being developed by a cross-functional team in DHS and will include measurements and metrics that compliment and contribute to the Annual Technical Report and inform the State Quality Strategy. DHS' Quality Rating system is also in development and will provide a public-facing reporting tool, which will assist enrollees in making coverage decisions based on their needs. Summaries of these initiatives are provided below:

## 1. State Monitoring Report

Annually, the Minnesota Department of Human Services (DHS) assesses the quality and appropriateness of health care services delivered under managed care, monitors and evaluates MCO's compliance with state and federal Medicaid and Medicare managed care requirements. DHS also imposes corrective actions and sanctions if MCOs are not in compliance with these requirements and standards. DHS emphasizes compliance with the state and federal requirements, enrollee satisfaction, and improvements in the care and services provided to all enrollees.

The State Monitoring Report is pursuant to 42 C.F.R Part 438 Section 66, in accordance with Centers for Medicare and Medicaid Services Final Rule published on May 6th, 2016. In compliance with 42 CFR §438.66 (b), the purpose of the report is to provide an overview of Minnesota Department of Human Services (DHS) current monitoring efforts and performance for all managed care programs in the following areas:

- Administration and management.
- Appeal and grievance system.
- Claims management.
- Enrollee materials and customer services, including the activities of the beneficiary support system.
- Finance, including medical loss ratio reporting.
- Information systems, including encounter data reporting.
- Marketing.
- Medical management, including utilization management and case management.
- Program integrity.
- Provider network management, including provider directory standards.
- Availability and accessibility of services, including network adequacy standards.
- Quality improvement.
- Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program.
- All other provisions of the contract as appropriate.

An internal workgroup has been created to establish content editors among the Department Human Services Staff, to ensure that the appropriate department(s) and/or division(s) are involved to provide pertinent content. Internal and/or external stakeholders and the Medical Advisory Committee will be reviewing the document prior to posting the final version of the State Monitoring Report on the DHS Website.

## 2. State Quality Rating System

*Medicaid Managed Care: Star Quality Rating System (QRS) DRAFT Plan for MN-DHS*

**Background**

As per CMS's final rule on Medicaid Managed Care regulations (§438.334), states are required to develop and implement a Star Quality Rating System (QRS) over the next three years to measure Medicaid Managed Care (MMC) beneficiaries' health services as well as experience and satisfaction with their health plans.

According to the rule, states will be able to use an alternative methodology or adopt additional measures in the rating system, as long as it is "substantially comparable" to the CMS's recommended QRS and is approved by CMS. The rule also requires states to "prominently display" the health plan ratings on the website, in a manner that complies with the standards in §438.10(d), and ensure that beneficiaries have access to the quality ratings annually at the time of the enrollment so that they can use QRS to compare and choose a health plan.

The "stars" ratings will be implemented after CMS publishes CMS model of QRS or provides further guidance regarding framework and methodology (e.g. mandatory measures, along with their weightage points, within each Medicaid product, as well as the calculations methodology for all three domains: clinical care, experience of care, and plan administrations).

**Goal**

Enable beneficiaries on market based selection of MCOs based on quality and services provided

**Objectives**

- Develop a Medicaid Managed Care Star QRS to be published annually on MN-DHS webpage
- Publish summary Star QRS annually in open enrollment packet or MHCP Enrollee's Handbook

**Primary Audience**

MN-DHS Medicaid Managed Care Enrollees

**Stakeholders**

- External Stakeholders: CMS, MHCP Enrollees, and other Stakeholders (e.g. HSAG).
- Internal Stakeholders: MN DHS – Directors (Medical, Medicaid, HRQ Division), Managers (Healthcare Program, Contract, Federal Relations, HRQ).
- MCOs: Blue Plus, HealthPartners, IMCare, Medica, Hennepin Health, PrimeWest, SCHA, UCare.

**Timeline**

No later than three (3) years, after CMS publishes guidance on Federal Register.

**Vision and Scope**

The overall goal of the current project (e.g. HRQ Managed Care Regulation Compliance Work Plan) is to design and implement an alternative Medicaid Managed Care Star QRS, which is robust yet simple to understand; aligned with CMS's QRS yet specific to MN-DHS Medicaid Managed Care products. The objective of the QRS is to serve as an aid for meaningful health plan comparison by potential and current enrollees, similar to other star rating systems developed by CMS.

In Phase I of the QRS project, the HRQ Managed Care Regulation Compliance Work Group will focus on "Clinical Care" domain only. Subsequently, other domains will be evaluated (e.g. Member Experience and Satisfaction, Plan Administration).

As the first step of Phase 1 of the project, the Medicaid Marketplace QRS framework was reviewed as our first QRS methodology option for "Clinical Care" domain. DHS' QRS methodology uses the National Percentile Ranks for measures standardization and weight point assignment.

In the next step, the QRS methodologies used for Medicare Star Rating system were evaluated, as they use different methods for measures standardization and for determining star cut-off points. Then, the pros and cons of each methodology for the "Clinical Care" domain were considered, followed by the development of a proposed / draft version of a Medicaid QRS methodology.

In future phases, the "Member Experiences and Satisfaction" domain will be explored. The CAHPS survey follows a different methodology for standardizing and scoring of these measures. If it is decided to include a third domain ("Plan Administration"), the components from the State Monitoring Report may be used to rate the plan administration.

**QRS Hierarchy and Methodology (draft)**

The Star QRS program is a hierarchical model composed of the following: four Summary Indicators / Population (e.g. Children, Adults, Senior, SNBC); three Domains (e.g. Clinical Care, Member Satisfaction or Experience of Care, and Plan Administrations); and six Composite Scores (e.g. five composites in Clinical Care domain and one composite in Member Satisfaction domain). The Plan Administration domain may rely some or all components of the State Monitoring Report to demonstrate performance in this domain.

**Summary Indicators**

Population: DHS expects that it will have various Medicaid Managed Care products offered at MN-DHS. For example, CHILDREN and ADULTS population will have enrollees from "Families and Children MA", as well as

“MinnesotaCare” products; the Senior population will have enrollees enrolled in MSHO and MSC+ products; and the SNBC population will have enrollees enrolled in SNBC product.
Clinical Care domain will have various CMS’s Adult and Child Core Set performance measures, grouped into five composites (e.g. Preventive and Well Care Composite, Maternal and Perinatal Health Composite, Acute and Chronic Care Composite, Behavioral Health and Substance Use Composite, Dental / Oral Health Composite).

Member Satisfaction or Experience of Care domain will have one composite, called “Member Satisfaction Composite” which has the following six components (e.g. Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Cultural Competence, and Plan Administration). The survey questions in the QRS measure set will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

**Overview of example QRS Hierarchy**

- Population: Children (Age 0-17); Adults (Age 18-64); seniors (Age 65+); SNBC (Age 18-64).
- Products: F&C MA + MinnesotaCare; MSHO; MSC+; SNBC.
- Domains: A. Clinical Care, B. Member Satisfaction, C. Plan Administration.
- Clinical Care Composite.
- Preventive and Well Care Composite.
- Maternal and Perinatal Health Composite.
- Acute and Chronic Care Composite.
- Behavioral Health and Substance Use Composite.
- Dental / Oral Health Composite.
- Member Satisfaction / Experience of Care Composite.
- Plan Administration Composite.