DHS-4538E-ENG 6-21

DEPARTMENT OF HUMAN SERVICES

Minnesota Medicaid Managed Care Comprehensive Quality Strategy

June 2021

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TABLE OF CONTENTS

Executive Summary

Over 1 million Minnesotans are insured through the Minnesota Health Care Programs, administered by the Minnesota Department of Human Services (DHS), the state Medicaid agency. DHS's mission is to help people meet their basic needs so they can live in dignity and achieve their highest potential.

Health care disparities uncovered by the COVID-19 public health emergency and the civil unrest after the death of George Floyd triggered changes to state's organizational priorities. Together with its stakeholders, DHS revised its comprehensive quality strategy to renew its focus on equity and improve the quality of health care for all Minnesotans enrolled in the Medicaid program.

This revised quality strategy delineates DHS's goals and objectives for continuous quality improvement. Continuous quality improvement is a cyclical process that requires planning, implementing the strategy, studying the results, and then improving the design based on lessons learned.

While DHS's goals describe where we want to be, the quality improvement initiatives explain how we want to get there. DHS currently oversees a number of programs that include well-structured quality improvement components. These initiatives range from quality measurement and reporting efforts to performance improvement programs and innovative payment arrangements.

This comprehensive quality strategy was developed in accordance with federal regulations governing managed care at 42 CFR §438.340 titled "Managed Care State Quality Strategy."

Table 1. DHS goals and objectives for continuous quality improvement.

Goals	**Objectives**
Goal 1. Increase Accountability and Transparency	DHS's objective is to increase public transparency about Medicaid's administration and outcomes.
Goal 2. High Value Care	DHS's objective is to assure that the delivery system provides 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.
Goal 3. Patient-centered Care	DHS's objective is to empower Medicaid enrollees to become active participants in their care.
Goal 4. Improve Quality of Care and Achieve Better Health Outcomes	DHS's objective is to evaluate performance on quality metrics and engage health plans, providers, and enrollees in continuous quality improvement.

Goals	Objectives
Goal 5. Increase Independence and Community Integration	DHS's objective is to ensure that seniors and Minnesotans with disabilities have the opportunity to live close to their families, to live more independently, to engage in productive employment, and to participate in community life.
Goal 6. Integrate Mental Health and Increase Recovery from Substance Use Disorders	DHS's objective is to integrate behavioral health services with primary care services and substance use services.
Goal 7. Achieve Racial Equity and Close Disparities	DHS's objective is to procure high quality health care services for all Medicaid enrollees regardless of race, ethnicity, age, sex, and disability status. DHS's objective is to be an anti-racist organization.

Introduction

The Department of Human Services oversees the administration of the Medicaid program and is one of the largest purchasers of health care services in the state, purchasing health care coverage for over 1 million Minnesotans.

Medicaid plays a critical role in ensuring access to quality care for under-resourced communities including children, persons with disabilities, seniors, and communities that have been systematically marginalized.

As the state Medicaid agency, our goal is to procure high quality health care services for all Medicaid enrollees. DHS's mission is to work with others to help "people meet their basic needs so they can live in dignity and achieve their highest potential."[1]

This document articulates our strategy for quality improvement. Chapters I and II provide an overview of the Minnesota Health Care Programs and the current state of health care quality. Chapter III describes where we want to be by clearly stating DHS's goals and objectives for continuous quality improvement. Then, chapter IV explains how we use our assets – payment arrangements, improvement programs, quality measurement and reporting – to improve the quality of health care services for Medicaid enrollees. Finally, chapter V walks us through the requirements under the federal regulation (42 CFR §438.340) that calls for the states to develop a comprehensive managed care quality strategy.

This quality strategy is comprehensive not only because it describes quality improvement activities under all types of payment arrangements - managed care, fee for service, and value

[1] MN DHS, Mission and Vision. Available at: https://mn.gov/dhs/general-public/about-dhs/who-we-are/#:~:text=Mission,and%20achieve%20their%20highest%20potential. Accessed on April 9, 2021.

based payments – but also because this document includes a wealth of practical information about state's and MCOs' duties with regards to federal managed care regulations (see appendix A), the role of quality in demonstration waivers (see appendices D and E), lists of quality measures (see appendix F), and other helpful information.

DHS' staff can use this comprehensive quality strategy as they engage and coordinate work across DHS and with other state agencies as well as with enrollees, managed care organizations, providers and with the community.

Chapter I. Minnesota Health Care Programs

Minnesota Health Care Programs have a long history of helping Minnesotans meet their health care needs.[2]

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. Currently, MN DHS contracts with eight managed care organizations (MCOs) across five subprograms: Medical Assistance, MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC).

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 2019, about 256,811 people were enrolled in the state's fee-for-service system with 934,415 people enrolled in managed care.

Both managed care and fee-for-service enrollees can participate in payment and care delivery innovations. Approximately 35 percent of all Medicaid enrollees are part of a value-based payment initiative, called Integrated Health Partnerships (IHP), where the State contracts directly with providers and rewards high quality of care.

Enrollees can also participate in care delivery innovations focused on behavioral health and care for substance use disorders. Our Behavioral Health Homes (BHHs) integrate behavioral and primary care services, while the Certified Community Behavioral Health Clinics (CCBHCs) integrate substance use disorder, mental health and primary care services.

The State has also applied for federal waivers to test additional ways to deliver and pay for health care services. A waiver program allows the state to waive some requirements of the

[2] MN DHS. Medicaid Matters. The Impact of the Minnesota's Medicaid Program. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7659-ENG. Accessed on April 8, 2021. Medicaid Milestones can be found on page 50.

Medicaid State Plan – the agreement between the state and the federal government - to better meet the needs of the enrollees.

Some of the current waivers include the Substance User Disorder waiver that addresses the opioid crisis, the Reform 2020 waiver that supports seniors at risk of nursing home placement, the Indian Health Board of Minneapolis waiver that improves access to care for Indian Health Board patients, the Long Term Services and Supports (LTSS) waiver that supports the growth of LTSS services, and five community-based waivers: the Developmental Disabilities Waiver, the Elderly Waiver, the Community Access for Disability Inclusion waiver, the Brain Injury wavier, and the Community Alternative Care waiver.

To support providers who participate in payment and care delivery innovations, the State may direct managed care plans to make payments to these providers in line with federal regulations. Current contracts with managed care plans include provisions for directed payments to providers participating in Integrated Health Partnerships, Behavioral Health Homes, Certified Community Behavioral Health Clinics, Long Term Services and Supports, and Substance Use Disorder waiver.

This complex system of waivers, care delivery and payment reforms, fee-for-service and managed care programs has one common underlying objective: all of these policies are design to help people access services they need and support providers in the provision of these services. Through this complex system of payments and policies, the Department of Humans Services aims to make sure that Minnesotans enrolled in Medicaid have access to the right care at the right time.

Chapter II. Quality of Health Care in the Minnesota Health Care Programs

Surveys of patients' experience of care show that Minnesotans enrolled in Medicaid are overall satisfied with their personal doctors and with care coordination. Enrollees also feel that they get needed care quickly. However, when DHS compared our enrollees' ratings with the national benchmark, we observed that Medicaid enrollees in Minnesota rated their health plans and health care overall below the national median.[3]

The Minnesota Medicaid program performs comparably to other States on access to preventive care services like cancer screenings. Almost 60 percent of adult women in the Minnesota

[3] MN DHS. 2020 Consumer Experience Survey. Public Summary Report. July 2020. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5541L-ENG Accessed on April 8, 2021.

Medicaid program were screened for breast cancer, cervical cancer, and chlamydia which is close to the median rate calculated among the states that reported the measures.[4]

Indicators of potentially preventable complications show that chronic conditions like diabetes, asthma, and heart failure are being well managed compared to other states. Blood pressure is well controlled among adult Minnesotans diagnosed with hypertension. Also, compared to other states, the ratio of asthma controller medication to total asthma medication among children and adults is indicative of good asthma control.[5]

Children in the Minnesota's Medicaid program, however, are not accessing recommended well-child visits during the first years of life at the same rate as children in other states. In fact, Minnesota's well-child visit rates are below the 25th percentile of the states' median. [6] Moreover, although only a small percent of newborn weigh less than 2,500 grams[7], a disproportional percentage of low birthweight babies are Black and Native American.

When we compared the quality of care provided to Medicaid enrollees with the quality of care provided to the commercially insured populations, we saw that Medicaid enrollees are not receiving preventive care services at the same rate as their commercially insured counterparts. Also, Medicaid enrollees do not achieve optimal control of chronic conditions at the same rate as commercially insured patients.[8]

The Medicaid population in Minnesota not only receives lower quality of care compared to commercially insured patients, but Black Americans and Native Americans receive the lowest quality of care among Medicaid enrollees.[9]

Due to the COVID-19 pandemic, rates for vaccinations, primary, and preventive services have declined during the 2020 calendar year. Going forward, the decline in utilization of services may have significant impacts on long-term health outcomes for children and under-resourced

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[4] Medicaid.gov. Medicaid & CHIP in Minnesota. Quality of Care in Minnesota. **Adult** Quality Measures Data. **Primary Care Access and Preventive Care.** Available at: https://www.medicaid.gov/state-overviews/stateprofile.html?state=minnesota Accessed on March 19, 2021.
[5] Medicaid.gov. Medicaid & CHIP in Minnesota. Quality of Care in Minnesota. Adult Quality Measures Data. **Care for Acute and Chronic Conditions**. Available at: https://www.medicaid.gov/state-overviews/stateprofile.html?state=minnesota Accessed on March 19, 2021.
[6] Medicaid.gov. Medicaid & CHIP in Minnesota. Quality of Care in Minnesota. **Child** Quality Measures Data. **Primary Care Access and Preventive Care.** Available at: https://www.medicaid.gov/state-overviews/stateprofile.html?state=minnesota Accessed on March 19, 2021.
[7]Medicaid.gov. Medicaid & CHIP in Minnesota. Quality of Care in Minnesota. Child Quality Measures Data. **Maternal and Perinatal Health**. Available at: https://www.medicaid.gov/state-overviews/stateprofile.html?state=minnesota Accessed on March 19, 2021.
[8] MNCM. Minnesota Disparities by Insurance Type. Available at: https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20Insurance%20Type/2019%20Disparities%20by%20Insurance%20Type.pdf Accessed on March 19, 2021.
[9] Ditto.

populations. DHS is closely monitoring and initiating activities to ensure that Medicaid enrollees do not fall further behind.

Continuous improvement in the areas listed previously – i.e. preventive care, care for chronic and acute conditions, early screening and treatment for kids as well as health care disparities and patients' experience of care - requires continuous work and collaboration with our partners.

The State has taken actions to understand and address racial disparities and systemic racism that contributes to poor health outcomes for Black American and Native American people. In chapter 4, we explain actions that have been taken to mitigate poor outcomes, but first, the next chapter clarifies the State's goals and objectives for continuous quality improvement.

Chapter III. Goals and Objectives for Continuous Quality Improvement

DHS's goals and objective are subject to continuous quality improvement. Continuous quality improvement is a cyclical process that starts with identifying the underlying problem, then implementing a specific quality improvement intervention, evaluating the effectiveness of the intervention, and finally modifying it based on the findings from the evaluation in order to achieve the desired goal. DHS's goals and objectives are described in more detail here.

Goal 1: Increase Accountability and Transparency

As stewards of public funds, DHS must hold its contracted managed care organizations (MCOs) accountable for the quality of the health care services MCOs provide to Medicaid enrollees. The MCO procurement process – the process of selecting an MCO - gives DHS the opportunity to reset the state's expectations of MCOs performance and replace poorly performing contractors.[10] DHS evaluates MCOs' performance through the use of consistent quality and performance measures. DHS also aims to increase public transparency about Medicaid's

[10] Georgetown University Health Policy Institute. Medicaid Managed Care Procurement: Opportunity for Transparency? Available at https://ccf.georgetown.edu/2020/11/18/medicaid-managed-care-procurement-opportunity-for-transparency/ Accessed on March 19, 2021.

administration and outcomes through managed care reporting webpages (including monthly enrollment data)[11], public dashboards[12, 13, 14] and Medicaid Matters reports[15].

Goal 2: High Value Care

DHS aims to provide high value health care to Medicaid enrollees. Value is understood here as a ratio of quality over cost: the better the quality and the lower costs, the higher the value of provided services. The value of services provided is determined in relation to long-term health care outcomes and satisfaction of principal consumers. DHS's objective is to assure that the delivery system provides 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.

Goal 3: Patient-centered Care

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 have access to the prerequisite health care information. Medicaid patients are surveyed about their experiences with health plans and health care providers. Information about enrollees' experiences is also gathered through community and stakeholder engagement activities. DHS's objective is to empower Medicaid enrollees to become active participants in their care.

Goal 4: Improve Quality of Care and Achieve Better Health Outcomes

DHS continues to design programs, benefits, and payment structures to improve care and health outcomes for Medicaid enrollees. Minnesota's Medicaid program includes a comprehensive array of services for Medicaid enrollees at different stages of life and across different health care settings. We also leverage research about social drivers of health to improve quality and access to services for all enrollees who need them. For example, the recent report on deep poverty documents how living in deep poverty leads to poor health and provides recommendations on how to improve the health of people living in deep poverty.[16] DHS's

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[11] MN DHS. Managed Care Reporting. Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/ Accessed on March 19, 2021.
[12] MN DHS. Investments in Health Care Available at: https://mn.gov/dhs/medicaid-matters/investments-in-health-care/ Accessed on March 19, 2021.
[13] MN DHS. Who Medicaid and MinnesotaCare Serve. Available at: https://mn.gov/dhs/medicaid-matters/who-medicaid-and-minnesotacare-serves/ Accessed on March 19, 2021.
[14] MN DHS. Oral Health. Available at: https://mn.gov/dhs/medicaid-matters/oral-health/ Assessed on March 19, 2021.
[15] MN DHS. Medicaid Matters. Available at: https://mn.gov/dhs/medicaid-matters/ Accessed March 19, 2021.
[16] DHS. Deep Poverty and Health Report. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8061-ENG

objective is to effectively evaluate performance on quality metrics and engage health plans, providers, and enrollees in continuous quality improvement.

Goal 5: Increase Independence and Community Integration

DHS's objective is to ensure that seniors and Minnesotans with disabilities have the opportunity to live close to their families, to live more independently, to engage in productive employment, and to participate in community life. In addition to home and community-based services, DHS works to improve the integration of Minnesotans with disabilities into the community under the Olmstead Plan, and helps seniors stay in their homes under the Reform 2020 waiver. Seniors and people with disabilities who are engaged in their communities have a better quality of life.

Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders

DHS aims to integrate behavioral health services with primary care services and substance use services. This is done via programs like Behavioral Health Homes, Certified Community Behavioral Health Clinics, as well as substance use disorder system reform waiver. The success of the integration is measured by better health outcomes for people who live with mental illness and substance use disorders.

Goal 7: Achieve Racial Equity and Close Disparities

DHS's goal is to procure high quality health care services for all Medicaid enrollees regardless of race, ethnicity, age, sex, and disability status. However for years there have been disparities in health care outcomes identified by race and ethnicity, largely due to structural racism and inequity. The department has implemented specific policies to help close racial disparities. Equity analysis is incorporated into new legislative proposals and each DHS project is evaluated from the perspective of how it will positively or negatively impact the underrepresented groups. Quality measures are stratified by race, ethnicity, age, sex, as well as payer type to identify any health care disparities. Managed care organizations and Integrated Health Partnerships (IHPs) receive financial incentive for improving equity in health care. DHS's objective is to be an anti-racist organization.

The previously described goals and objectives guide DHS's quality improvement efforts. DHS currently oversees a number of programs that include well-structured quality improvement components. These quality improvement initiatives and interventions are described in the next Chapter.

Chapter IV. Quality Improvement Initiatives

In this chapter, we discuss the numerous quality improvement efforts occurring throughout the department where DHS collaborates with our partners to support the needs of communities we serve. Quality improvement requires collaboration. This comprehensive quality improvement

strategy provides an opportunity to coordinate all of the initiatives. The following initiatives are assets and tools that we use to improve the quality of health care for Medicaid enrollees.

COVID-19 Response

Supports DHS's Goals 3, 4, 5, 6 and 7

During the COVID-19 public health emergency, MN DHS issued extensive modifications to public program requirements to ensure access and continuity of enrollee care. Among other flexibilities, current Medicaid enrollees retained benefits without the need to reapply. The prescription drug limits on maintenance medications for certain therapeutic drug classes have been increased from 34 days to 90 days. Quarterly reassessments of services for older adults and people with disabilities were conducted by phone instead of in-person. Telemedicine was also broadened in primary care as well as in mental health and substance use disorder (SUD) treatments.[17, 18]

Medicaid Core Set Measures

Supports DHS's Goals 1, 4 and 7

DHS measures quality of care in the Minnesota Medicaid program using CMS's Medicaid core set measures: the child core set and the adult core set.

MN DHS has participated in the reporting of child and adult core sets since their inception. The child core set was established in 2009 by the CHIP Reauthorization Act, and the first child core set was released in 2010. The adult core set was established by the Affordable Care Act, and the first adult core set was released in 2012.

For now, reporting to CMS is voluntary. Starting in 2024 states will have to report child core set measures (the Bipartisan Budget Act of 2018, P.L. 115-123) and behavioral core set measures including the adult core set (the SUPPORT for Patients and Communities Act, P.L. 115-271). The state is prepared to report measures that use the administrative method of data collection, i.e. information that is collected through claims. Some quality measures require clinical information – e.g. blood sugar level or blood pressure rate – that DHS cannot access directly.

The child core set includes quality measures organized into six categories:

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[17] MN DHS. Bridge to Benefits Covid-19 Response. Available at: http://www.bridgetobenefits.org/COVID-19%20Resources Accessed on March 30, 2021

[18] A summary of COVID-19-related regulatory flexibilities is available at https://mn.gov/dhs/waivers-and-modifications. Accessed on April 14, 2021.

1. Primary care access and preventive care,
2. Maternal and perinatal care,
3. Care of acute and chronic conditions,
4. Behavioral health care,
5. Experience of care
6. Dental health services.

The adult core set includes quality measures organized into six categories:

1. Primary care access and preventive care,
2. Maternal and perinatal care,
3. Care of acute and chronic conditions,
4. Behavioral health care,
5. Experience of care,
6. Long-term services and supports.

The Medicaid Core Set quality measures are incorporated into various reporting requirements throughout DHS' programs, including Integrated Health Partnerships, the MCO annual technical report, behavioral health homes (BHHs), and Certified Community Behavioral Health Clinics (CCBHCs). DHS systematically evaluates performance on these measures for each population of patients and across the entire Medicaid program. A high level summary of DHS's performance on core set measures is included in Chapter 2. The list of Medicaid Core Set measures monitored by DHS is included in Appendix F.

Annual External Independent Reviews

Supports DHS's Goals 1 and 4

Medicaid Managed Care External Quality Review

Each year, in compliance with *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review,* the External Quality Review Organization– i.e. IPRO of New York State - performs an independent review of the quality outcomes, timeliness of and access to the services included in the contract between Minnesota Health Care Programs (MHCP) and each health plan. The review focuses on federally mandated quality review activities.

The External Quality Review Organization (EQRO) is charged with assessing the strengths and weaknesses of the health plans and reporting on their:

- Quality, access and timeliness of health care services provided under managed care,
- Compliance with federal and state Medicaid managed care regulations,
- Validation of performance measures and performance improvement projects,
- Enrollee satisfaction measured from Quality of Care Surveys.

For the purpose of the external quality review, DHS collects contractually required reports directly from the MCOs, including the annual MCO Quality Work Plans and the Quality

Assessment and Performance Improvement Program Evaluations. The external quality review also includes DHS initiatives such as the annual Minnesota Health Care Disparities Report and Minnesota's response to the opioid crisis.

Findings from the external quality review are summarized by EQRO in the Annual Technical Report. In the report, EQRO evaluates, compares, and contrasts the MCO performance as well as statewide performance on a number of quality measures. For the list of measures please see Appendix F.

The Annual Technical Report also includes recommendations for MCOs on improvement in areas of weakness and assesses the degree to which each MCO addressed previously identified problems. The External Quality Review Organization offers technical support to the MCOs which deliver services through DHS contracts.

Triennial Compliance Assessments

To determine MCO compliance with DHS and CMS requirements, the External Quality Review Organization (EQRO) uses information from the Quality Assurance Exam, Triennial Compliance Assessment report and follow-up deficiency audits. The Quality Assurance Exam and Triennial Compliance Assessment are conducted by the Minnesota Department of Health (MDH) because MDH licenses all health maintenance organizations (HMOs) and regulates county-based purchasing entities doing business in Minnesota.

To monitor and assess compliance with state HMO licensing regulations, MDH conducts a quality assurance examination of all MCOs every three years. While the primary purpose of the exam is to monitor compliance with Minnesota's HMO licensing regulations, since 2007, MDH has started collecting additional compliance information for DHS public programs. For more information about the Triennial Compliance Assessment please see Appendix B.

DHS and MDH work collaboratively to assure that information collected for the MDH Quality Assurance Examination and the Triennial Compliance Assessment is consistent with federal Medicaid external quality review requirements and to avoid the duplication of mandatory data collection. For more information about non-duplication and reduction of data collection burden, see Appendix C.

If MDH discovers an MCO deficiency, a corrective action and mid-cycle follow-up review is required to ensure all deficiencies are resolved. DHS also imposes corrective actions and appropriate sanctions if MCOs are out of compliance with requirements and standards.

Managed Care Organizations' Performance Improvement Projects

Supports DHS's Goals: 1, 2, 3, and 4

Minnesota MCOs are contractually required to conduct performance improvement projects (PIPs) that meet federal standards and DHS contract requirements. The PIPs must address clinical and non-clinical areas, and are expected to improve both enrollee health outcomes as well as enrollee satisfaction with their care and MCO. The performance targets are established by the MCOs in their PIP proposals and represent improvement over previous annual performance rates.

Starting in 2016, the DHS PIP reporting requirements were modified (from 1-year cycle) to resemble the Medicare format. PIPs run for three (3) years and follow the Balanced Budget Act (BBA) guidelines for PIP protocols. DHS and MCOs collaboratively select PIP topics. MCOs submit PIP proposals to DHS for review and approval. Thereafter, MCOs provide annual progress reports to DHS and a final report upon the completion of the PIP cycle.

The 2018-2020 PIPs focused on Reducing New Chronic Opioid Users. Collaboratively, the MCO PIPs aimed to prevent patients who receive a new opioid prescription from staying on opioid drugs for long periods, especially if more effective pain management options are available and appropriate for the patient. DHS published the summary reports online.[19]

The 2021-2023 PIPs focus on two topics: 1) Healthy Start for Mothers and Their Children (for Families and Children contracts) and 2) Improving Comprehensive Diabetes Care (for Seniors and SNBC contracts).

Risk Corridors

Supports DHS's Goals: 1, 2, 4, and 7

The COVID-19 pandemic has had a disproportionate impact among Black and African Americans, Hispanics, and American Indians, in terms of prevalence, hospitalization, and mortality. Additionally, there have been steep declines in the utilization of primary and preventive care amongst Medicaid and CHIP program beneficiaries. Federal, state, and local response to the pandemic has stressed the need to address the impact of the pandemic on racial and ethnic minority communities.

In keeping with these goals, DHS introduced quality incentives tied to the 2021 MCO risk corridor arrangements to improve racial equity among MCO enrollees. Under these quality incentives, MCOs can retain additional payment through the risk corridors arrangements if they

[19] MN DHS. Managed care: quality, outcome, and performance measures. MCO performance improvement projects. Available at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp Accessed on May 24th, 2021.

are able to achieve improved outcomes on specific measures, such as well child visits, vaccinations, and cancer screenings.

Overall, DHS selected 12 quality measures for which disparities exist in the statewide community. Each measure stratified by race and ethnicity groups (Asian/Pacific Islander, Black, Hispanic, Native American, and Non-Hispanic White) will be assessed against a baseline disparity gap with the Non-Hispanic White population.

The majority of measures are in alignment with the Medicaid core sets. The specifications for the measures are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) 2020 technical specifications. For the list of measures please see Appendix F.

Self-reported MCO Quality Improvement Initiatives

Supports DHS's Goals: 1, 2, and 4

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.[20]

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

[20] MN DHS. Managed care: quality, outcome, and performance measures. HEDIS and quality assurance reports. Available at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp Accessed on May 24th, 2021.

Managed Care Withholds

Supports DHS's Goals: 1, 2, and 4

The overall purpose of the financial withhold is to emphasize and focus MCO and health care provider improvement efforts in the areas of prevention or early detection and screening of essential health care services. Specifically, the DHS-MCO contract allows DHS to withhold a percentage of the capitation payments due to the MCO, only to be returned if the MCO meets performance targets determined by the state. The performance targets are based on improvement over previous annual performance rates. The calendar year 2019 performance measures addressed the following:

- Annual dental visits for certain age stratifications;
- Dental network equity;
- Dental service utilization;
- Senior health risk assessment;
- Emergency department utilization rates;
- Hospital admission rates;
- 30-day hospital readmission rates; and
- Deficiencies on quality assurance examinations administered by the Minnesota Department of Health.

The MCO withhold scores are detailed in the Annual Technical Report.

Managed Care Grievances

Supports DHS's Goals: 1, 2, 3, 4, and 7

The Managed Care Ombudsman office collects grievance data from all managed care organizations (MCOs) on a quarterly basis. Data reported to the Managed Care Ombudsman office are reviewed to identify trends and analysis to ensure quality of care and contract compliance for managed care members.[21, 22]

A grievance or complaint is defined as a member's expression of dissatisfaction about the quality of care or service(s) provided by the MCO or a contracted provider. Managed care members can file a grievance with their health plan orally or in writing. Oral grievances are required to be resolved within (10) days and results are communicated verbally to members.

[21] Minnesota Statues 2020. M.S. § 62Q.68 – 62Q.73 Available at: https://www.revisor.mn.gov/statutes/cite/62Q/pdf Accessed on May 19, 2021

[22] Minnesota Statues 2020 M.S. § 256B.69, subd. 20. Available at: https://www.revisor.mn.gov/statutes/cite/256B.69 Accessed on May 19, 2021

Written grievances are required to be resolved within (30) days with a written resolution mailed to the member.

MCOs collect and report to the Managed Care Ombudsman office grievances on all managed care programs. Grievances are reported under the following categories: access, MCO administration, communication and behavior, coordination of care, facilities and environment and technical competence.

DHS compiles an annual report summarizing data on enrollee grievances and appeals filed with MCOs; notices of MCO denials, terminations or reductions; and managed care state fair hearings filed with DHS. The five (5) most common grievances reported across all MCOs for the years 2018-2020 were:

1. Transportation (i.e., unassisted non-emergency medical transportation)
2. Other – Not related to a service (i.e., provider's office, health plan)
3. Profession Medical Services (i.e., specialty care, primary care, other)
4. Pharmacy (i.e., formulary, other, non-formulary)
5. Dental (i.e., preventative care, dentures, crowns and fillings)

All grievances have an outcome that is provided to the enrollee and reported to the Managed Care Ombudsman's office. The outcomes are: grievance acknowledged, grievance substantiated/action taken, grievance unsubstantiated, referred to quality review, or withdrawn. Only the enrollee can withdraw a grievance.

The Managed Care Ombudsman office may bring grievance concerns and questions directly to the MCO, discuss trends at the quarterly MCO Workgroup meeting or use the MDH Audit review to address concerns and ask questions. If the data suggests there may be an MCO contract issue or a coverage concern, the Ombudsman office brings concerns to DHS management.

Consumer Experience

Supports DHS's Goals: 1, 2, 3, 4, and 7

Understanding patients' experiences with health care is an essential component of health care quality. DHS measures patients' experience of care using Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS is a program spearheaded by the Agency for Healthcare Research and Quality (AHRQ). Different CAHPS surveys are designed to assess patients' experience in different health care settings: at a hospital, in a clinic, with home and community-

based services, or with health plans. All CAHPS surveys are standardized and tested for validity to allow comparisons.[23]

DHS uses CAHPS surveys to understand Minnesota Medicaid enrollees' experience with health care; to provide enrollees with tools to better inform their decisions; and to facilitate quality improvement among health plans and health care providers. CAHPS surveys are also used in value-based purchasing, public reporting, and to fulfill regulatory requirements of a State Medicaid Agency. CAHPS surveys currently used by DHS are described in more detail here.

- The *Adult Health Plans CAHPS* survey assesses enrollees' experience with their health plan and health care providers. DHS administers this survey to our managed care and fee-for-service enrollees. The survey consists of standardized questions, standardized supplemental questions as well as other supplemental questions that have not been standardized but are of interest to DHS. The most recent survey includes supplemental questions developed by DHS to assess racial equity. The Adult Health Plans CAHPS survey goes hand in hand with the evaluation of enrollees' grievances and with community and stakeholder engagement activities. The survey results are submitted to the AHRQ Data Warehouse for the purpose of Medicaid Adult Core Set reporting. The results are included in the Annual Technical Report (ATR) compiled by the External Quality Review Organization (EQRO) and in open enrollment materials for new members. The survey results are also published on the DHS website in a form of an annual summary report.[24]

- The *Minnesota Senior Health Options (MSHO) CAHPS* survey assesses experiences of senior enrollees enrolled in the Medicare-integrated Minnesota Senior Health Options (MSHO) program. DHS and CMS collaborate to send MSHO enrollees a single, annual CAHPS survey. The survey is design to assess patients' experiences with the Medicare Advantage and Medicare Advantage Prescription Drug plans and DHS adds questions on topics of special interest to the state Medicaid agency. DHS contracts with a vendor to collect the results from CMS and to write a report summarizing experiences of MSHO enrollees. The annual report is available on the DHS website.[25]

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[23] Agency for Healthcare Research and Quality. *About CAHPS*. Available at: https://www.ahrq.gov/cahps/about-cahps/index.html Accessed on May 20th, 2021

[24] MN DHS. Managed care: Quality, outcome and performance measures. Enrollee Surveys and Grievances. Consumer satisfaction survey results 2020, (DHS-5541L). Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5541L-ENG Accessed on May 20th, 2021

[25] MN DHS. Managed care: Quality, outcome and performance measures. Enrollee Surveys and Grievances. *MSHO consumer satisfaction survey results 2019, (DHS-7396C).* Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7396C-ENG Accessed on May 20th, 2021

- The *Clinician & Group CAHPS (CG-CAHPS)* survey assesses patients' experience of care in a clinic. DHS has administered this survey since 2018 to our Integrated Health Partnerships (IHP) attributed patients. Before 2018, DHS did not administer the survey but rather collected the survey results from the Minnesota Department of Health. 2017 state legislation, however, removed the CG-CAHPS survey requirement form the Statewide Quality Reporting and Measurement System (SQRMS). Since then, DHS started administering the survey to IHP attributed patients every other year. The results are shared with our IHP partners and used in their value based payment arrangements.

- The *Hospital CAHPS (HCAHPS)* survey assesses patients' experience in a hospital. Hospitals are required to administer the survey and submit the results to CMS. DHS collects the results from the Hospital Compare website. The results are used in value based payment arrangements with our IHP partners.

In addition to CAHPS surveys, DHS has also utilized community engagement activities to collect information about enrollees' experiences. Community engagement provides an opportunity to gather information directly from enrollees as well as providers about the barriers standing in the way of accessing primary care, dental care, behavioral health care, and specialty care services.

Integrated Care System Partnerships

Supports DHS's Goals: 2, 3, 4, 5, and 6

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. ICSP's 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. Provider 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.

Value-Based Payment Program

Supports DHS's Goals: 1, 2, 3, 4, and 7

The MN DHS value-based payment initiative is called the Integrated Health Partnership (IHP) program. The IHP program uses direct contracts with providers to enhance accountability through the potential for shared savings or losses, and creating incentives for quality improvement. The goal of the demonstration is to improve the health of the Medicaid population by delivering high-quality, lower cost care.

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, with the goal of achieving 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. Performance is reviewed annually.

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 measure 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. IHP quality measures are listed in Attachment I.

The IHP model has evolved since its start in 2013. The initial legacy model ended in 2019 and was replaced by the 2.0 model. In the IHP legacy model, a portion of an IHP's potential shared savings was contingent on their overall quality score. This remains an important part of risk bearing contracts under the 2.0 model, which began in 2018. However, IHPs may now participate in a Track 1 or Track 2 contract, as described in more detail below.

IHP 2.0 Track 1 – Population Based Payment

IHP 2.0 includes a population-based payment (PBP). For the purpose of the population-based payment, IHPs are evaluated on health equity, quality, and utilization measures. Each IHP is required to design an intervention to address specific health care disparities observed among the IHP's population. The role of the health equity measures is to gauge the effectiveness of each intervention as the State reviews both qualitative and quantitative information. For the qualitative aspect, the IHP must complete an annual assessment of the intervention, reporting on predetermined metrics and providing narrative detail on the intervention's progress. Utilization and clinical quality measures make up the quantitative aspect and these measures are based on the goals of the equity intervention. 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 – Population-Based Payments and Total Cost of Care

While all IHP 2.0 participants receive population-based payments only some enter into a shared risk arrangement that requires a calculation of the total cost of care (TCOC). For the purpose of the total cost of care model, IHPs are evaluated on a core set of measures to determine the share of any savings an IHP will receive. In each demonstration year, fifty percent of an IHP's portion of potential 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; Care for at Risk Populations, Behavioral Health; Access to Care; Patient-centered Care; Quality of Outpatient Care);
- Health Information Technology (Meaningful Use of Electronic Health Record (EHR): Coordination Care objective and Health Information Exchange objective); and
- (optional) Pilot Measures (e.g., patient engagement, care coordination, opioid use or specialty measures).

All IHP providers are incentivized to improve value and quality through a payment arrangement that is directly tied to the goals of the State Quality Strategy.

Table 2: DHS Goals and IHP Objectives

DHS Goals	**IHP Objectives**
DHS Goal 1: Increase Accountability and Transparency	The IHP program continues to evolve the quality scoring methodology to reward higher performance, shifting point assignment to more significantly reward performance that is above the IHP benchmark, thus increasing accountability for higher performance. This scoring change has a direct impact on shared savings as 50% of the shared savings are reducible based on the quality score.
DHS Goal 2: High Value Care	The IHP program addresses this in a couple of ways: 1) At its core the IHP program aims to drive high value care and reinforce this goal. It includes a variety of performance areas such as clinical performance, utilization, patient experience, and cost of care, assessing IHP performance in each of these areas. During each RFP cycle, the value levers are assessed and refined so we are constantly evaluating how the program best drives value. 2) Ensuring that IHPs have the data they need to look at the individual factors (i.e., utilization, cost, etc.) and measure improvement or focus on particular areas for improvement. IHPs receive robust data as a part of their involvement in the program.
DHS Goal 3: Patient-centered care	The IHP program addresses this in a couple of ways: 1) Driving improvement of patient clinical quality of care by significantly rewarding performance that is above the IHP average. This has a direct impact on shared savings as 50% of the shared savings are reducible by the quality score and patient experience of care accounts for part of the score. 2) Monitoring health information technology use and how successfully the IHP uses it for patient care. This includes how well patients are able to access their information, which also allows them to better engage in their care.

DHS Goals	IHP Objectives
DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes	The IHP program addresses this in several ways: 1) Incenting focus on the particular needs of the IHP population and developing an intervention to address those needs through the PBP. This focuses efforts on a concrete population need, while constantly evaluating progress from both a qualitative and quantitative perspective. 2) Continuing the evolution of the IHP quality scoring methodology to more significantly reward performance improvement, thus increasing the incentive to improve quality performance across years. This scoring change has a direct impact on shared savings as 50% of the shared savings are reducible by the quality score. 3) Increasing the number of tools available to IHPs for performance comparison to other IHPs, as well as performance improvement. These new tools will enhance the ability of an IHP system to be successful with their improvement efforts.
DHS Goal 7: Achieve Racial Equity and Close Disparities Gaps	The IHP program is increasing transparency regarding disparate performance across racial and ethnic groups by providing quality performance data stratified by racial and ethnic groups, as well as payer type (when available). The program will also utilize this data to inform conversations with IHPs about closing performance gaps.

Behavioral Health Homes Model

Supports DHS's Goals: 3, 4, and 6

Behavioral Health Home (BHH) services model provides person-centered care for adults and children with serious mental illness. DHS implemented the BHH services model in response to the known barriers to health care access, co-occurrence of chronic health conditions and early mortality that individuals with serious mental illness disproportionately experience. The BHH model aims to deliver better health outcomes for adults and children with serious mental illness.

The BHH services launched in 2016 as Minnesota's version of the "Health Home" benefit under the Affordable Care Act. The model was planned and designed with input from over 26 stakeholder and community member groups. Since then, the model has been continuously improved and refined based on an ongoing feedback from engaged stakeholders. In 2019, 35 Health Home providers provided behavioral health home services to 2,786 adults and 389 children.

In order to receive BHH 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 effectively manage medical, social, and behavioral health conditions.

BHH providers draft a person-centered health action plan based on guidance developed by the state Medicaid agency. The person-centered 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.

BHH services providers include: primary care clinics, rural health clinics, community mental health centers, community mental/behavioral health agencies and federally qualified health centers (FQHCs). The model is intended to bring an integrated approach to service delivery and practice transformation by utilizing a multidisciplinary team including, but not limited to, mental health professionals, registered nurses, mental health practitioners, community health workers, and peer support specialists. Providers are paid a per member per month rate for each Medicaid enrollee receiving BHH services. Payment for each BHH services provider is determined using the same metrics and terms of performance.

BHH providers are certified by the State and must have the capacity to perform core services specified by Centers for Medicare and Medicaid Services (CMS) and meet state-specific requirements. DHS is currently evolving its BHH certification process to support a further integration of primary care and behavioral health services.

BHH Services Model Evaluation

Since the inception of the BHH model in 2016, DHS has evaluated the quality of care provided to enrollees who receive BHH services. Each year, we review BHH's performance on measures in the Medicaid Health Homes core set, which includes an evaluation of quality and cost savings. In addition to the health home quality measures, we also evaluate BHHs on quality measures related to prevention, screening, and chronic care conditions. This way, DHS monitors the effectiveness of the BHH model with regards to the coordination of care across primary care services, behavioral health services, and, when possible, long term services and supports. The rates calculated for the population of enrollees who receive BHH services are compared to rates calculated for a comparison group (i.e. enrollees who live with serious mental illness but do not participate in the BHH services model) and also to the entire Medicaid population. BHH quality measures are listed in Attachment I.

In addition to the Medicaid Health Homes core set, DHS also evaluates the implementation of the overall BHH model. The initial program evaluation of the BHH services delivery model was completed in September 2019. The goal was to evaluate the program implementation by

assessing how sites were using the BHH services model and documenting the successes, challenges and preliminary outcomes associated with it. The state also conducted individual interviews and focus groups with enrollees receiving BHH services.

From the initial evaluation, DHS learned that BHH services teams make thousands of referrals to community organizations. People who received BHH services reported a collaborative and supportive approach to creating and fulfilling health goals.

DHS continues to evaluate BHH services to better understand key outcomes and identify trends in cost and quality of care. As part of this process, DHS surveyed BHH providers to help identify key outcomes for BHH services. In the second evaluation phase, completed in May 2021, the state examined 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 (HEDIS), and additional quality measures.

In the future, the results of the provider survey, along with cost, quality, and utilization data and information from the 2019 (phase I) and 2021 (phase II) evaluations, will be used to:

- Understand the extent of which the BHH services program is meeting its goals and expected outcomes
- Identify opportunities for future quality improvement initiatives and technical assistance needs
- Inform recommendations for process, outcome, and quality standards for use in tracking BHH services performance and that can be used in ongoing certification processes
- Identify measures that should be stratified by race, ethnicity, and geographic location to learn more about the disparities facing specific communities and target interventions

Overall, the BHH services model aims to better manage population health by providing comprehensive care management, care coordination, health and wellness promotion, referrals, and individual and family support. The desired outcomes are articulated by the Minnesota legislature in Minnesota Statute Chapter 256B and include improved utilization, experience, quality of life, and wellness, as well as slowed down growth in health care costs for Medicaid patients.

BHH objectives in relation to DHS's goals for continuous quality improvement are describe in the table below.

Table 3: Goals and BHH Objectives

DHS Goal	**BHH Objectives**
DHS Goal 3: Patient-centered care	All persons receiving BHH services will work with their BHH services team to collaboratively develop a Health Action Plan within six months of enrollment.

DHS Goal	BHH Objectives
	All persons receiving BHH services have a completed BHH services consent form indicating informed consent and individual choice to participate.
DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes	Increase the number of BHH patients receiving follow up care after ED visit for alcohol and other drug abuse (FUA-HH Core Measure set). Increase the number of BHH patients receiving follow up care within 7 days after hospitalization for mental illness (FUH-HH Core Measure set) Reduce the number of hospital admissions for complications that could have been potentially prevented by good outpatient care for chronic conditions (PQI-HH Core Measure set)
DHS Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders	The BHH providers have multidisciplinary teams that 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 Health Action Plan. Measure and evaluate BHH patients' access to preventive care (e.g. cancer screenings, child and adolescent care visits) and appropriate care for chronic conditions. Improve coordination of care after hospital discharge to reduce the number of unplanned hospital readmissions (PCR-HH Core Measure set). Increase the number of BHH patients who initiated and stayed engaged in treatment for alcohol and other drug dependence (IET- HH Core Measure set). Increase the number of BHH patients receiving follow up care for mental illness after an ED visit with a principal diagnosis of mental illness or intentional self-harm (FUM, NCQA).

Certified Community Behavioral Health Clinics (CCBHC)

Supports DHS's Goals: 1, 2, 3, 4, 6, and 7

CCBHC service delivery model aims to integrate mental health and substance use disorder services. Certified clinics coordinate care across settings and providers to ensure seamless transitions for Medicaid enrollees across the full spectrum of health and social services, increase consistent use of evidence-based practices, and increase access to high-quality care.

The eight Certified Community Behavioral Health Clinics (CCBHCs) and the Minnesota Department of Human Services (DHS) are required to collect and report on quality, client perception of care, and impact data as a condition of participation in the CCBHC Section 223 federal demonstration program and the concurrent federal authority of the State Plan (pending CMS approval). The data reporting requirements are designed to evaluate whether the priorities of the CCBHC program are met: to improve access to care and high-quality services.

Currently, CCBHC federal reporting requirements include 22 quality measures: nine measures calculated by CCBHCs from clinical data collected in their electronic health records; ten measures calculated by DHS from claims data; one measure calculated based on client level data from the CCBHCs; and two client experience of care surveys (one for adults and one for families and children). Beyond the 22 federally required quality measures, the CCBHC program is also evaluated on eight Minnesota impact measures.

Under the current CCBHC Section 223 federal demonstration payment policy and concurrent SPA policy, six of the federally required measures – Suicide Risk Assessment for adults and children, Adherence to Antipsychotics for Individuals with Schizophrenia, Follow up after Hospitalization for Mental Illness for adults and children, and the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – are tied to financial incentives.

Specifically, a quality bonus payment (QBP) is paid annually as a lump sum in addition to the basic prospective payment system (PPS) rate to any CCBHC that meets the minimum performance targets set forth for all six measures. Beginning in demonstration year two (DY2) a portion of the QBP is available to CCBHCs who meet two additional optional measures – Plan All Cause Readmission and Screening for Clinical Depression and Follow-up Plan. See Appendix F for a list of the current CCBHC quality measures.

Recently, the MN State legislature required the DHS Commissioner to develop recommendations for a Minnesota-specific quality incentive program for CCBHC. Recommendations were developed in consultation with DHS quality staff and stakeholders.

Table 4: DHS Goals and CCBHC Objectives

DHS Goals	CCBHC Objectives
DHS Goal 1: Increase Accountability and Transparency	DHS will establish and maintain a process for periodically reviewing and revisiting the CCBHC quality measures by: a) Eliciting partner/stakeholder input. b) Engaging quality measurement subject matter experts.
DHS Goal 2: High Value Care	CCBHC will integrate mental health and substance use disorder services as well as coordinate care with primary care providers by: a) Administering identified primary care screenings and preventive services: • Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF) • Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) • Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) b) Making referrals to primary care providers: • Schedule an appointment, and close the loop by following up with the provider and the client. c) Ensuring that a primary care provider is identified and contact information is in the client file. d) Continuously monitor progress on the quality measures to ensure improvements are being made and identify areas for continuous quality improvement.
DHS Goal 3: Patient-centered care	CCBHC will offer person and family centered care by: a) Using Culturally and Linguistically Appropriate Services (CLAS) standards to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. b)
DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes	CCBHC will expand providers' capacity to serve more people via an expanded workforce by: a) Creating more staff positions that reflect the cultures, languages and ethnicity of communities served to increase access to services and serve more underserved clients. b) Paying more adequately and increase the ability to offer a living wage to CCBHC staff.

DHS Goals	CCBHC Objectives
	Hiring a more diverse population from different cultural backgrounds to reflect cultural backgrounds of the people they serve.
DHS Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders	1. Providers will provide the full scope of CCBHC services. 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-shop" to meet the needs of the population served. b) CCBHCs ensures all 9 service categories, if not available directly through the CCBHC, are provided through a Designated Collaborating Organization (DCO). c) Individuals will receive CCBHC services in a person-centered and family-centered manner. 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. 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. 3. CCBHCs will provide care coordination. 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. Care coordination activities are carried out in keeping with the client's preferences and needs for care and, to the extent possible and in accordance with the client's expressed preferences.

DHS Goals	CCBHC Objectives
Goal 7. Achieve Racial Equity and Close Disparities	a) CCBHCs will increase access and availability of services to communities experiencing behavioral health disparities, especially American Indian tribes and communities of color. 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. CCBHCs will provide outreach to engage and retain persons of color and those whose primary language is not English in behavioral health services.

Substance Use Disorder (SUD) System Reform Waiver

Supports DHS's Goals: 3, 4, and 6

The 1115 SUD System Reform Demonstration is a statewide SUD modernization project aimed at creating an evidence-based and person-centered, coordinated system of care using nationally recognized criteria for the treatment of SUD for Medical Assistance recipients. The Department of Human Services is creating this system through two components:

- Increasing the use of evidence-based placement criteria to match a client's individual risk with the appropriate American Society of Addiction Medicine's Criteria (ASAM) level of care
- Expanding Medical Assistance coverage to Institutions for Mental Disease (IMDs), defined as residential facilities with 17 or more beds

Minnesota is working to achieve federal and state-level goals through improved provider coordination between different levels of care, integrating primary and mental health care into the SUD treatment planning process, and improving access to medication-assisted treatment. ASAM's levels of care allow clinicians to assess a client's individual risks, needs, skills, and strengths to create a personalized treatment plan based on a biopsychosocial assessment. Under ASAM guidelines, Minnesotans will receive the right level of care at the right time. This effort will also move SUD treatment toward a long-term chronic disease management model that uses evidence-based treatment methods.

Through implementation, Minnesota will establish a comprehensive and coordinated network of providers who offer ASAM levels of care to Medical Assistance recipients with SUD. Participating SUD providers have patient referral agreements with facilities providing the levels of care they do not offer, allowing recipients access to the services and resources they need. Additionally, residential programs must provide medication-assisted treatment for opioid use disorder on-site

or facilitate access to the service off-site. A person seeking SUD treatment in an 1115 Demonstration facility will be recommended to receive treatment in the level of care that best meets their needs, even if that requires a referral to a different facility. Providers will use ASAM's six dimensions criteria for their assessments and level of care recommendations. An individualized treatment plan will be written for each person and include transition planning in preparation for the client's next phase of treatment. The treatment plan must consider cultural and socioeconomic factors that may affect that person's access to services.

Outcome and trend data are reported to CMS quarterly in addition to an external evaluator performing a mid-point assessment, evaluation, and provider capacity assessment. The focus will be on CMS's six goals and objectives: increase rates of identification and engagement in treatment for SUD; increase retention in treatment; reduce use of emergency department or hospital inpatient settings for SUD; reduce preventable readmissions; reduction in overdose deaths, particularly those due to opioids; and improve access to other health care services. The 1115 Demonstration is designed to use data to inform the next steps in Minnesota's evidence-based and data-driven SUD system innovation. An external utilization management process will assure Medical Assistance recipients who are receiving SUD treatment receive the proper care based on their diagnoses. Health outcomes, system usage data, utilization management data, external partnerships, and continuing community engagement will guide the next steps in Minnesota's SUD treatment system innovation

Table 5: DHS Goals and SUD Waiver Objectives

DHS Goals	**SUD Objectives**
DHS Goal 3: Patient-centered care	• Increase the utilization of ASAM's evidence-based assessment and placement criteria through payment incentives for participation in the demonstration. • Implement a utilization management program focused on matching clients with the right level of care at the right time.
DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes	• Increase the utilization of ASAM Criteria through payment incentives for participation in the demonstration. • Providers must offer Medication Assisted Treatment (MAT) services and maintain formal referral arrangements with other demonstration providers offering step up, and step down levels of care. • Eligible providers must have medical, psychological, laboratory, toxicology, and pharmacological services available through consultation and referral • Tracking of health outcomes through trend predictions as a component of the required monitoring reports and through an independent evaluation of the demonstration

DHS Goals	SUD Objectives
DHS Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders	• Providers must offer Medication Assisted Treatment (MAT) services and maintain formal referral arrangements with other demonstration providers offering step up, and step down levels of care. • Eligible providers must have medical, psychological, laboratory, toxicology, and pharmacological services available through consultation and referral. • Requirements for participation focused on increased treatment coordination and interdisciplinary treatment planning that incorporate the consultation and referral requirements outlined previously.

Opioid Prescribing Improvement Program

Supports DHS's Goals: 1, 2, 3 and 4

The Opioid Prescribing Improvement Program (OPIP) is a unique, community supported effort to improve prescriber practice via a community wide improvement process tied to Medicaid provider enrollment. The OPIP aims to balance the evidence for the use of opioids to treat certain types of pain with the inherent risks these medications posed to individuals and communities. The project was authorized during the 2015 legislative session, and is led by DHS with support from the Minnesota Department of Health (MDH).

The goal of this program is to build a safer opioid prescribing culture and reduce opioid dependency and use disorders due to or related to the prescribing of opioid analgesics by health care providers. The project includes 4 main components:

1. Statewide opioid prescribing protocols for acute, post-acute and chronic pain;
2. Provider education resources;
3. Annual opioid prescribing reports that compare a provider's rate to their specialty average; and
4. A quality improvement program for those provider's whose prescribing rates are outside the community standard(s).

The Opioid Prescribing Work Group (OPWG) is the expert advisory body charged with developing recommendations for all of the program components. The OPWG members include physicians and mid-level providers who treat pain and opioid use disorder; pharmacists, a pain psychologist, a dentist, a medical examiner, health plan representatives, a law enforcement representative, and consumer/patient members who experience chronic pain and/or have been impacted by opioid use disorder. Non-voting OPWG members include representatives from MDH, DHS and the Minnesota Department of Labor and Industry (DLI).

Patient populations excluded from this work include patients with cancer and patients receiving hospice services. The program does not apply to opioid therapy used to treat opioid use disorder, including methadone and buprenorphine formulations.

Quality improvement (QI) program

DHS and the OPWG identified significant variation in opioid prescribing practices within specialty groups in 2016. Variation in opioid prescribing within specialty groups can indicate problematic behaviors, unless it is explained by factors such as distinct differences in patient populations and severity of disease. These data were used to support development of the OPIP sentinel measures and QI program.

The OPIP uses the term "sentinel measure" to signal the need for a consistent and robust response to opioid prescribing patterns that exceed community-agreed upon standards. A brief description of the 7 OPIP sentinel measures is provided below:

1. Index opioid prescription prescribing rate
2. Index opioid prescription: prescribing rate over recommended dose (100 morphine milligram equivalents (MME) for medical specialties or 200 MME for surgical specialties)
3. Rate of prescribing 700 cumulative MME or more during an initial opioid prescribing episode
4. Chronic opioid analgesic therapy (COAT) prescribing rate
5. Rate of prescribing high-dose COAT
6. Rate of prescribing concomitant COAT and benzodiazepine therapy
7. Rate of prescribing COAT to patients with multiple opioid prescribers

On an annual basis, DHS collects and reports to enrolled providers the data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers. DHS and the OPWG identified QI threshold for 5 of the 7 measures (measures 4 and 7 are excluded from the QI work). Individual providers whose prescribing rate exceeds the threshold for a given measure may be required to participate in the QI program.

DHS mailed nearly 16,000 individual opioid prescribing reports to providers in 2019, 2020 and spring 2021. Beginning in 2021, individual providers whose prescribing rate exceeds a QI threshold are required to engage in with DHS. The QI work will begin in two phases in year one:

- Prescribers whose acute pain practice is flagged for QI will be asked to review their data to better understand the opportunities for improving their prescribing, the barriers that might limit their success in improvement, and the assets available to them. This group will submit a quality improvement attestation form to DHS for review and approval.
- Prescribers who chronic pain practice is flagged for QI will engage with DHS in other ways. DHS and the Institute for Clinical Systems Improvement – ICSI – will work with

chronic pain providers refine the QI work for patients with High Impact Chronic Pain (HICP) in 2021.

Year two of the QI program will expand the project to include the other sentinel measures, continue to work with providers who require assistance, and begin the quality improvement program for providers who treat chronic pain.

Improvement in prescribing practices

DHS and the Minnesota health care community work closely together on opioid prescribing initiatives. Specific to the OPIP, DHS recently supported the development of Minnesota Hospital Association's opioid stewardship roadmap, in order to align the two organizations' efforts. DHS also supported the development of ICSI's Opioid Prescribing Improvement Framework – a resource available statewide to assist with opioid QI efforts.

Close collaboration with the health care community has led to decreases in opioid prescribing overall within the state. Notable highlights from 2016-2019 include:

- A 17% decrease in the overall number of opioid prescriptions in Minnesota Medicaid and MinnesotaCare from 2018-2019. In 2019, there were 565,877 opioid prescriptions filled for enrollees.
- An 11% decrease in the total number of index opioid prescriptions ("first prescriptions") filled by enrollees from 2018 to 2019.
- In 2019, there were 16,252 long-term opioid recipients, marking a 26% decrease from 2018.
- There was a 35% decrease in the number of enrollees who went from being opioid naïve to over 45 days of continued use in the measurement year. This means that fewer patients who received an opioid for acute pain went on to develop longer-term use.

Managed Long Term Services and Supports (MLTSS)

Supports DHS's Goals: 3, 4, and 5

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, Personal Care Assistant (PCA) services.

Establishing reasonable minimum payment rates for Managed Long Term Services and Supports (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.

Home and Community-based Services (HCBS)

Supports DHS's Goals: 3, 4, 5, and 7

Home and community-based services support people living in the community who would otherwise live in an institution, like a nursing home, a hospital, an institution for mental disease, or an intermediate care facility for persons with developmental disabilities. Home and community based services allow seniors and Minnesotans with disabilities to live, work, and socialize in the community.

DHS currently oversees five HCBS waivers: the *Community Access for Disability Inclusion waiver*, the *Community Alternative Care waiver*, the *Brain Injury waiver*, the *Elderly waiver*, and the *Developmental Disability waiver*

DHS reaches out to seniors and people with disabilities to assess their experience of care using the following consumer assessment tools:

- National Core Indicators - Aging and Disability (NCI-AD): DHS uses NCI-AD to survey Elderly Waiver (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, with a focus on identifying and closing racial disparities where they exist. 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.

- 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. Elderly

Waiver 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.

- 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 percent 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 supported by a family survey and regulatory data from DHS and the Minnesota Department of Health. The first round of state wide resident and family survey data will be collected in the fall of 2021.

Reform 2020 Waiver

Supports DHS's Goal: 3, 4, and 5

The Reform 2020 waiver demonstration provides federal support for the Alternative Care program, which provides supports to help seniors at risk of nursing home placement to stay in their homes. The Reform 2020 demonstration assists the state in its goals to achieve better health outcomes; increase and support independence and recovery; and increase community integration. The demonstration also simplifies the administration of the program and improves its sustainability. To see how the success of the Reform 2020 waiver is evaluated, please see Appendix E.

Olmstead Plan

Supports DHS Goals: 3 and 5

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 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.

Nursing Home Quality

Supports DHS's Goals: 1, 2, 3, and 4

Minnesota administers four coordinated strategies to improve the quality of care in nursing homes: the nursing home report card, value based reimbursement, the performance-based incentive payment program, and the quality improvement incentive payment program. All four efforts are managed by the Nursing Facility Rates and Policy Division of the Department of Human Services (DHS). Each effort is described below.

1. Minnesota Nursing Home Report Card

In 2006, the Minnesota Department of Health (MDH) and DHS collaborated with the University of Minnesota to introduce 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.[26]

The Report Card has multiple features to help users:

- Separate short and long stay search paths.
- Search by location or facility name and 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.

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

- 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, mailed, telephone and online user surveys each year. The use of multiple quality measures requires considerable attention to data integrity, necessitating audit and quality assurance processes on a scheduled basis and as issues arise.

2. 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 percent of the Twin Cities seven-county median ($105.40/resident day for VBR's first rate-year). If their quality score = 100, the facility can spend

145.625 percent 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 percent 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.

3. 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 358 projects, including but not limited to:

- Clinical Quality (147 projects): Fall reduction, strength training, sleep, pain management, osteoporosis, antibiotic stewardship, skin care, congestive heart failure, wound care, pressure sore prevention, incontinence, and targeted therapy.
- Psychosocial (81 projects): Dance program, music therapy, art therapy, healing touch, end of life planning, behavior management, cognitive care, and hearing loss.
- Organizational Change (78 projects): Person-centered care, culture change, community outreach, and staff mentoring.

- Transitions (27 projects): Community transition skills, rehabilitation, and Alzheimer's-related community caregiver support.
- Technology (25 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.

4. 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 25th / 75th percentile, whichever goal represents more improvement. This cycle is repeated annually.

To date:

- Almost 100 percent of providers participate annually.

- About 90 percent of facilities choose clinical outcomes while 10 percent work on quality of life.
- Almost 75 percent of providers earn a full or partial payment (average QIIP for providers with any improvement is $2.63).

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.

Health Care Disparities by Insurance Type

Supports DHS's Goals: 1, 4, and 7

Health care disparities are differences in health care between groups that cannot be explained by health needs, treatment recommendations, or performance. They can be explained, however, by social and economic disadvantages.[27] Health care disparities affect under-resourced communities and are a result of underlying structural problems.

DHS has partnered with the Minnesota Community Measurement (MNCM) to monitor health care disparities between Medicaid enrollees and patients insured through Medicare and commercial insurance. For over a decade, MNCM has analyzed data submitted to MNCM by health care providers across the State of Minnesota and summarized the findings in an annual Minnesota Health Care Disparities by Insurance Type report.[28]

According to the findings, the Medicaid population has consistently received lower quality of care compared to commercially-insured populations in Minnesota. Moreover, among the Medicaid enrollees, the percentage of African Americans and Native Americans who receive appropriate health care is consistently lower than the Minnesota Medicaid average.

DHS recognizes its unique position to work with our partners to prevent health care disparities by designing equitable programs and policies. To that effect, since 2018, our IHP partners have been required to propose at least one equity intervention intended to reduce health care disparities among their population of patients. More recently, the MCO risk corridor

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[27] Kaiser Family Foundation. *Disparities in Health and Health Care: 5 Key Questions and Answers.* Available at: https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/ Accessed on May 20th, 2021.

[28] Minnesota Community Measurement. *2020 Minnesota Health Care Disparities by Insurance Type*. Available at https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20Insurance%20Type/2020%20RY%20Disparities%20by%20Insurance%20Type.pdf Accessed on May 20th, 2021.

arrangements have been tied to quality incentives to improve racial equity and health outcomes.

In an effort to understand the drivers of health care disparities, DHS has prioritized efforts to improve the quality of demographic data about the people we serve and supported MNCM in further research which includes stratifications of the results by race, ethnicity, sex, and primary language. DHS also plans to join forces with clinics, providers, and health plans to reduce disparities and reach out to patients to better understand what is important to our enrollees. Reducing health care disparities contributes to improved long-term health of individuals and communities and to better health outcomes across our state.

Prepaid Medical Assistance Project Plus (PMAP+) Waiver

Supports DHS's Goals: 1, 3, and 4

The PMAP+ Section 1115 Waiver has been in place for over 30 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care coverage through Medicaid funding for people with incomes in excess of the standards in the Medical Assistance program.

On January 1, 2015, MinnesotaCare was converted to a basic health plan, under section 1331 of the Affordable Care Act. As a basic health plan, MinnesotaCare is no longer funded through Medicaid. Instead, the state receives federal payments based on the premium tax credits and cost-sharing subsidies that would have been available through the health insurance exchange.

The PMAP+ waiver continues to be necessary to continue certain elements of Minnesota's Medical Assistance program. The current waiver provides continued federal authority to:

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

In June 2020 a request to renew the PMAP+ waiver for an additional five year period was submitted to CMS. The waiver is currently operating under a temporary extension issued by CMS through December 2021. A copy of the proposed evaluation plan for the renewal period is found at Appendix D.

Integrated Care for High Risk Pregnant Women

Supports DHS's Goals: 3, 4, 5, 6 and 7

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. This program targets 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 eight-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 are connected to existing maternal health and substance abuse services through community and public health programs. The program works 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 can 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.

If the project is expanded to where its services can be offered to most pregnant women in the targeted communities, 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 currently in a limited capacity pilot phase, demonstrating that pregnant women at high risk of adverse perinatal outcomes can be successfully engaged by care collaboratives, assessed for unmet needs, and connected to appropriate supports and services by paraprofessional navigators. Legislation was approved in 2015 and funding continues at the pilot level.[29]

[29] Minn. Statutes § 256B.79

Chapter V. Managed Care Regulations

DHS' quality strategy has been developed to incorporate federal regulation governing managed care at 42 CFR §438.340 titled "Managed Care State Quality Strategy." This chapter summarizes elements of DHS's state quality strategy per federal managed care requirements.

Elements of the State Quality Strategy

According to 42 CFR §438.340, each state contracting with an MCO must implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO. As per federal regulations, this State quality strategy includes the following:

- The State-defined network adequacy and availability of services standards for MCOs required by §§ 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with § 438.236.
    - 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. For more information see Appendix A: *42 CFR §438.68* and *42 CFR§438.206*.
    - The agency requires MCOs to adopt guidelines based upon valid and reliable clinical evidence, or a consensus of Health Care Professionals in the particular field. The MCOs are required to publish these guidelines to providers and to use them in utilization management, coverage of services, and enrollee education. For examples of evidence-based clinical practice guidelines see Appendix A: *42 CFR §438.236.*
- The State's goals and objectives for continuous quality improvement.
    - The state's goals and objectives for continuous quality improvement are described in Chapter 3. Also, see Chapter 4: *Quality Improvement Initiatives* for objectives pertinent to specific quality initiatives and defined in terms of measurable steps toward meeting the state's goals.
- A description of quality metrics and performance targets to be used in measuring the performance of each MCO.
    - Overall, DHS evaluates the quality of health care using quality metrics organized into the following categories: primary care access and preventive care, maternal and perinatal care, care of acute and chronic conditions, behavioral health care, experience of care, dental health services, and long-term services & supports.

Quality measures are used across various improvement initiatives. For the list of quality metrics used in measuring MCOs performance, see Appendix F ('Annual Technical Report' and 'MCO Risk Corridors').

  - Performance targets are population-specific and described per each applicable quality improvement initiative in Chapter 4.

- A description of quality improvement projects, including a description of any interventions the State proposed to improve access, quality, or timeliness of care for enrollees.

  - Quality improvement projects and interventions are described in Chapter 4. Also, see Appendix A: *42 CFR §438.330* for information specific to MCO's quality improvement projects.

- Information about arrangements for annual external independent reviews.

  - The External Quality Review Organization performs an annual independent review of the quality outcomes, timeliness of and access to the services included in the contract between Minnesota Health Care Programs (MHCP) and each health plan. For more information see Chapter 4: *Annual External Independent Reviews*.

- A description of the State's transition of care policy.

  - The state agency requires by contract that MCOs assist enrollees in transition of care, both when the enrollee is new to their plan and in transition from one setting to another. State law governs transition procedures. For more information see Appendix A: *42 CFR §438.62(b)(3)*.

- The State's plan to identify, evaluate and reduce health disparities based on age, race, ethnicity, sex, primary language, disability status, and also payer type.

  - The State's plan to achieve racial equity and close disparities is described in Chapter 3 (see Goal 7). Also, see the following quality improvement initiatives in Chapter 4: *MCO Risk Corridors, Value-based Payments, Consumer Experience, Health Care Disparities by Insurance Type, and Integrated Care for High Risk Pregnant Women*.

- Appropriate use of intermediate sanction.

  - 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. For more information see Appendix A: *42 CFR §438.700, 42 CFR § 438.702, and § 438.704*.

- Mechanisms to comply with 438.208 (c)(1), identification of persons who need long-term services and supports or persons with special needs.

    - The State uses the Long Term Care Consultation (LTCC) assessment and the Personal Care Assistance (PCA) assessment as mechanisms to identify persons who need LTSS or persons with special health care needs. For more information see Appendix A: *42 CFR §438.208*.

- If the state utilizes the non-duplication option in 42 CFR 438.360 for EQR, it must explain the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities.

    - DHS contracts with the Minnesota's regulatory agency for HMOs, the Minnesota Department of Health (MDH), for review of network, quality, and other HMO licensure activities. MDH determines whether the MCO's quality activities meet the contractual guidelines provided by DHS, including whether activities performed for another accreditation meet the requirements of the Triennial Quality examination. For more information see in Chapter 4: Annual External Independent Reviews: *Triennial Compliance Assessment* and Appendix C: *Data Collection Burden Reduction*.

- The State's definition of "significant change" for the purposes of revising the quality strategy per 42 CFR 438.340(c)(3)(ii).

    - DHS defines "significant change" as a change in the state's organizational priorities triggered by circumstances outlined in Chapter 5: *Development, Evaluation, Revision, and Availability of the State Quality Strategy*.

Development, Evaluation, Revision, and Availability of the State Quality Strategy

DHS developed and published its initial written quality strategy in the State Register for public comment in June 2003. This current version from July 2021 is a revision of the last version published in July of 2020.

The External Quality Review Organization (EQRO) reviews the state's comprehensive quality strategy and comments on it in its Annual Technical Report. According to the most recent EQRO review, "(t)he DHS quality strategy aligns with CMS's requirements and provides a framework

for MCOs to follow while aiming to achieve improvements in the quality of, timeliness of and access to care."[30]

The quality strategy is regularly reviewed and revised. When the quality strategy document is being updated, DHS solicits feedback from multiple internal and external stakeholders through workgroups and posting a draft of the comprehensive quality strategy on DHS's website for public review and comment. The feedback provided by stakeholders, including the MCO Quality Workgroup, External Quality Review Organization, Tribal Leadership, Medicaid Services Advisory Committee, Medicaid enrollees and their representatives, is taken into consideration and incorporated into the comprehensive quality strategy updates.

For the purposes of revising the quality strategy, DHS defines "significant change" as a change in the state's organizational priorities triggered by:

- input received from stakeholders (e.g. EQRO) and senior leadership;
- a pervasive pattern of quality deficiencies identified through analysis of the annual data;
- changes to quality standards resulting from regulatory authorities or legislation at the state or federal level; and
- a change in membership demographics or the provider network of 50 percent or greater within one year.

DHS posts its quality strategy[31], EQR technical report[32], and managed care plan accreditation information[33] on its website.

[30] IPRO. Minnesota Department of Human Services. 2019 External Quality Review Annual Technical Report. Issued April 29, 2021. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6888G-ENG Accessed on June 2, 2021.
[31] MN DHS. Managed care: Quality, outcome and performance measures. Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp Accessed on June 2, 2021
[32] MN DHS. Managed care: Quality, outcome and performance measures. Annual technical reports. Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp Accessed on June 2, 2021
[33] MN DHS. Managed care reporting. Reports and audits. Accreditation Status (PDF). Available at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/ Accessed on June 2, 2021

List of Appendices

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

- Appendix A: Managed Care Core Quality Strategy Components
- Appendix B: Triennial Compliance Assessment
- Appendix C: Data Collection Burden Reduction
- Appendix D: Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver
- Appendix E: Reform 2020 Section 1115 Demonstration Waiver
- Appendix F: DHS Performance Measurement

Appendix A: Managed Care Core Quality Strategy Components

Title 42 Part 438 of the Code of Federal Regulations (CFR) includes a set of rules issued by the Centers of Medicare and Medicaid Services governing managed care. In 42 CFR §438, Subparts A through K include standards and rules around availability of services, coordination and continuity of care, coverage and authorization, provider selection, confidentiality, grievance systems, sub-contractual relationships, health information systems etc.[34] Standards and rules relevant to this State Quality Strategy are described in the following.

42 CFR § 438.206 Availability of services

MCO Duties

In a managed care delivery system, the MCO agrees to provide specified services to enrollees through its contract with the State. The comprehensive risk contracts include physical and behavioral health and in appropriate population also include long term services and supports. 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 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. 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.

[34] Cornell Law School. Legal Information Institute (LII). 42 CFR Part 438. Managed Care. Available at: https://www.law.cornell.edu/cfr/text/42/part-438 Accessed on April 8th, 2021.

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. 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 here:

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) home and community-based 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 five Medicare Advantage Special Needs Plans to provide SNBC. SNBC offers all medically necessary Medicaid State Plan Services with the exception of HCBS waivers, Personal Care Assistants, and private duty nursing (PDN). HCBS waiver services, PCA, and PDN services are paid by the MA fee-for-service program. If an enrollee is Medicare eligible, the MCO covers all Medicare services, including prescription

drugs covered by Part D and any alternative services the MCO may choose to offer. The MCO pays for the first 100 days of nursing facility care for community enrollees who enter a nursing facility after enrollment. 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 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), provider directories, and other enrollee-directed materials. 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. DHS Managed Care Ombudsman's Office staff assists enrollees with access, care or provider complaints, and resolving issues. 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 of MCOs every three years. This includes a review of each MCO's policy and procedure for Grievance and Appeals and second opinions. The results of the MDH review are turned over to the External Quality Review Organization (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. A standard report is submitted to CMS as the

regulator for this program, and CMS may make comments to improve the program. 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. 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. DHS transfers race or ethnicity and language information to MCOs in the MCO's enrollment file, to the extent that the enrollee is willing to provide such information.

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.[35] 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 the MCO has sufficient capacity to meet community standards.

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

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 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 may have 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 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. 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 grievances 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 of enrollees, or the MCO service area in a particular county may be terminated. A referral may be made to MDH to evaluate whether the MCO meets state standards.

Reports and evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's compliance with this standard. The EQRO will 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 §438.62(b)(3) State's transition of care policy

State and MCO duties

The state agency requires by contract that MCOs assist enrollees in transition of care, both when the enrollee is new to their plan and in transition from one setting to another. The State's transition of care policy governs MCOs responsibilities and transition procedures when a provider network changes (e.g. due to termination of a provider), an enrollee is new to the MCO, and in special cases when an enrollee is transitioning to a new provider. In addition to MCOs, providers such as hospitals and home health providers are also required by law to provide discharge planning and transition of care.

If a provider is terminated or leaves the MCO's network, the MCO must notify affected enrollees and assist with transition to an in-network provider. The MCO must assist in the transfer of records and data required to facilitate the transition of care.

If an enrollee is new to an MCO and has an established source of care that is not in-network , the enrollee may continue to use their existing provider for a period of up to 120 days for treatment of acute or life-threatening conditions, pregnancy, disability, certain culturally or language-appropriate services. For terminal conditions the period is longer. The MCO must authorize services out of network upon notice by the provider or enrollee, then the enrollee and provider must be included in any transition plan to in-network providers if the care is to be ongoing after the initial 120 days.

Services already authorized by another MCO or the FFS system are to be continued by the enrollee's new MCO. Specific guidelines are in state law for orthodontia care, mental health services, at-risk pregnancy services, and substance use disorder services. All medication authorizations existing when the enrollee changes MCOs are to be continued for 90 days or until a transition plan to another medication is established.

Oversight activities by the state agency

The state agency tracks transition issues through its complaint and appeal processes by the state Managed Care Ombudsman's office. The Ombudsman requires submission of all appeal and grievance data from the MCOs and also receives complaints directly.

Reports and evaluation (if applicable)

The Ombudsman tracks and analyzes appeals and grievance data, which are included in the quarterly reports to CMS regarding continuation of the 1115 PMAP and other waivers.

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 and payment.

Oversight

DHS reviews the Evidence of Coverage materials 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.

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[36] 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 enrollee's rights with respect to MCO appeals and State Fair Hearing process. Decisions to deny or reduce services must be made by an appropriate health care professional.

[36] 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)).

Oversight activities

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

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

Every three years, MDH conducts an on-site Quality Assurance Examination 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.

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.[37] 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 42 CFR § 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.

[37] 42 CFR § 438.602(b),

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 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 previously described requirements – 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 assesses 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. The contracted MCOs are "Fully Integrated" or "Highly Integrated" special needs plans under the Medicare Advantage regulations. 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.[38] 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.

The agency requires MCOs to adopt guidelines based upon valid and reliable clinical evidence, or a consensus of Health Care Professionals in the particular field. The MCOs are required to publish these guidelines to providers and to use them in utilization management, coverage of services, and enrollee education. This contract requirement (in section 7.1.6 of the Families and

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

Children contract, 2021) is consistent with the requirements of 42 CFR § 438.236, which does not require the state to mandate use of any particular set of guidelines.

Examples of guidelines used by current MCOs are:

- Medica: https://www.medica.com/providers/policies-and-guidelines/clinical-guidelines
- Health Partners: https://www.icsi.org/guidelines/
- PrimeWest Health: https://www.primewest.org/practice-guidelines
- UCare: https://home.ucare.org/en-us/providers/clinical-practice-guidelines/
- Blue Plus: https://provider.publicprograms.bluecrossmn.com/minnesota-provider/medical-policies-and-clinical-guidelines-full-list

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.

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

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

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

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

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

Oversight activities

Each year the MCO selects a project topic and submits to DHS a project proposal describing the project to be undertaken beginning in the next calendar year. The project usually spans a three to four year period with an annual interim report, due upon request, leading to a final project report. DHS reviews and recommends changes as appropriate and submits the final reports to the EQRO for evaluation to determine if significant improvement has been achieved and if it will be sustained over time. The 2018 – 2020 PIP focused on Preventing Chronic Opioid Use. The 2021-2024 PIPs will focus on Healthy Start for Mothers and their Children for the programs that have children enrolled, and Comprehensive Diabetes Care for the seniors program.

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

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

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. 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 encounter data 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.

42 CFR §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, § 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.

42 CFR § 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 B: Triennial Compliance Assessment

SUMMARY

Federal statutes require the Department of Human Services (DHS) to conduct assessments of each contracted Managed Care Organization (MCO) to ensure they meet minimum contractual standards. Beginning in calendar year 2007, during the Minnesota Department of Health's (MDH's) managed care licensing examination (MDH QA Examination) MDH began collecting (on-behalf of DHS) on-site supplemental compliance information. This information is needed to meet the federal Balanced Budget Act's external quality review regulations and is used by the External Quality Review Organization (EQRO) along with information from other sources to generate a detailed annual technical report (ATR). The ATR is an evaluation of MCO compliance with federal and state quality, timeliness and access to care requirements. The integration of the MDH QA Examination findings along with supplemental information collected by MDH (triennial compliance assessment- TCA) meets the DHS federal requirement.

TRIENNIAL COMPLIANCE ASSESSMENT (TCA) ELEMENTS

1. **QI Program Structure:** The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D (access, structure and operations, and measurement and improvement) as stated in contract section 7 of DHS/MCO Contracts.
2. **Information System:** The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs as stated in contract section 7 of DHS/MCO Contracts.
3. **Review of Utilization Management:** The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."[40] 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 as stated in contract section 7 of DHS/MCO Contracts.
4. **Special Health Care Needs:** The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.
5. **Practice Guidelines:** The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans,*" QI 7 Clinical Practice Guidelines as stated in contract section 7 of DHS/MCO Contracts.
6. **Annual Quality Assurance Work Plan (QA Work Plan):** 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 current NCQA

[40] 2021 *Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2021

"*Standards and Guidelines for the Accreditation of Health Plans*", as stated in contract section 7 of DHS/MCO Contracts.

7. **Annual Quality Assessment and Performance Improvement Program Evaluation (QAPI):** The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."
8. **Performance Improvement Projects (PIPs):** 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 § 438.30(b)(1) and (d) and CMS protocol entitled "CMS External Quality Review (EQR) Protocols October 2019." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.
9. **Population Health Management (PHM) Program**. The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment 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 plan MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The plan must be updated within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.3, Service Delivery Plan, as stated in contract section 7 of DHS/MCO Contracts.
10. **Advance Directives Compliance**: The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the Elements stated in contract section 14 of DHS/MCO Contracts.
11. **Validation of MSHO and MSC Care Plan Audits:** MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MSC+ Contract.
12. **Subcontractors (Including Pharmacy Benefit Managers):** 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 elements stated in contract section 9 of DHS/MCO Contracts.
13. **EW Care Plan Audit:** Since July 1 2009, MDH has been collecting information on Elderly Waiver Care Planning Audit, required by the DHS/MCO Minnesota Senior Health Options (MSHO) / Minnesota Senior Care Plus (MSC+) Contract. A Care Plan Audit Protocol is developed each year for use by the MCOs. The seventeen elements included in the Care Plan Audit Protocol are as follows:
    1. Enrollee Assessment
    2. Comprehensive Care Plan
    3. Comprehensive Care Plan – Assessed Needs Addressed
    4. Comprehensive Care Plan – Goals
    5. Comprehensive Care Plan – Choice
    6. Comprehensive Care Plan – Safety/Person Risk Management
    7. Comprehensive Care Plan – Informal and Formal Services
    8. Comprehensive Care Plan – Caregiver Support

9. Comprehensive Care Plan – Housing and Transition
10. Communication of Care Plan/Summary – Physician
11. Communication of Care Plan/Summary – Enrollee and Providers
12. Comprehensive Care Plan – Enrollee Request for Updates
13. Care Coordinator Follow-up Plan
14. Annual Preventive Health Exam
15. Advance Directive
16. Appeal Rights
17. Data Privacy

Appendix C: Data Collection Burden Reduction

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, and 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 the requirements of 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.

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 §438.330 (b)(3)	UM 1-4, UM 10-11, UM 13
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 (2021 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 is 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 D: Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver

Evaluation Plan 2021 to 2025

Introduction

The PMAP+ Section 1115 Waiver has been in place for over 30 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 (MA) Program. On January 1, 2015, the MinnesotaCare program converted to a Basic Health Plan. Even though the PMAP+ waiver is no longer necessary to continue the MinnesotaCare program, several aspects of the PMAP+ waiver continue to be necessary.

PMAP+ Section 1115 Waiver Extension January 1, 2021 through December 31, 2025

In June 2020, DHS submitted a request to renew the PMAP+ waiver for the time period beginning January 1, 2021, and ending December 31, 2025. The proposed waiver extension seeks to continue federal authority for the following:

- Preserving eligibility methods currently in use for children ages 12 through 23 months;
- Waiving the federal requirement to predetermine the basis of MA eligibility for caretaker adults with incomes at or below 133 percent of the FPL who live with a child(ren) age 18 who are not full-time secondary school students;
- Providing full MA benefits for pregnant women during the period of presumptive eligibility; and
- Payments for graduate medical education costs through the MERC fund.

Waiver Populations and Expenditure Authorities for PMAP+ 2021-2025 Evaluation

MA One-Year-Olds

The PMAP+ waiver provides 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.

Research Question(s)	**Comparison Population(s)**	**Measures**	**Comparison Years**	**Data Source(s)**
1. Did the MA one-year-old child population experience comparable utilization of preventative and chronic disease services, when compared to national Medicaid averages?	Children 12-24 months who are enrolled in Medicaid in the United States.	a) Childhood immunization status (2 yr) (CIS)* b) Well-child visits (first 15 months) (W15)* c) Child access to primary care practitioners (ages 12-24 mo.s) (CAP)*	Measurement Years (MY) 2021-2025 Reference Years (RY) RY 2019-2020	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data
2. Do childhood immunization status, well-child visits, or access to primary care	Comparisons by race will be made within the population of MA enrollees who are	a) Childhood immunization status (2 yr) (CIS)*	MY 2021-2025 RY 2019-2020	MMIS claims data

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
practitioners vary by race within the one-year-old child population?	between 12 and 24 months of age.	b) Well-child visits (first 15 months) (W15)* c) Child access to primary care practitioners (ages 12-24 mo.s) (CAP)*		

*NCQA HEDIS Measures

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

- 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)?
- 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.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
1. Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota?	a) MA parents in Minnesota b) MA adults without children in Minnesota	For both comparison populations, the following measures will be used: a) Annual dental visit b) Cervical cancer screening c) Comprehensive diabetes care	MY 2021-2025 RY 2019-2020	MMIS claims data

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
		d) Follow-up after hospitalization for mental illness e) Medication management for people with asthma f) Access preventative/ambulatory health services		
2. Did the MA caretaker adult waiver population 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	a) Other adults enrolled in MA in the United States	a) Cervical cancer screening b) Comprehensive diabetes care c) Follow-up after hospitalization for mental illness d) Medication management for people with asthma e) Access preventative/ambulatory health services	MY 2021-2025 RY 2019-2020	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
asthma, and access preventative/ambulatory health services)?				

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 A

Research Question(s)	**Comparison Population(s)**	**Measures**	**Comparison Years**[41]	**Data Source(s)**
1. Were the number of students and residents at training sites maintained or increased during this waiver period compared to the previous waiver period for rural and	a. **Rural:** Number of students and residents at training sites in rural areas of the state for Demonstration	a. **Rural**: Compare the number of students and residents at training sites in rural Minnesota for years 2021 through 2025 to the number of	MY 2021-2025 RY 2019- 2020	MERC Program data

[41] Comparison Years are based on State Fiscal Years.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years[41]	Data Source(s)
urban areas of the state?[42]	Year (DY) 24[43] and DY 25[44]. b. **Urban:** Number of students or residents at training sites in urban areas of the state for DY 24 and DY 25.	students and residents at training sites in rural Minnesota for DY 24 and DY 25. b. **Urban**: Compare the number of students and residents at training sites in urban areas of the state for the current waiver period to the number of students and residents at training sites in urban areas of the state in DY 24 and DY 25.		
2. How did the MERC-funded	N/A	Of the total grant distribution for years 2021 through 2025,	MY 2021-2025	MERC Program Data

[42] Urban areas of the state include the seven-county metro area which includes the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Washington and Scott. The rural areas of the state include the remaining 80 counties in Minnesota.

[43] PMAP demonstration year 24 covers the period of July 1, 2018 through June 30, 2019.

[44] PMAP demonstration year 25 covers the period of July 1, 2019 through June 30, 2020.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years[41]	Data Source(s)
grantees use the payments?		identify the percentage of funds that were used to support training in the following health professions: a. Medical training (physicians) b. Dental providers (including dental therapists) c. Psychologists d. Pharmacists e. Community Paramedics f. Other health professionals		

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 Question

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?

Hypothesis B

Research Question(s)	**Comparison Population(s)**	**Measures**	**Comparison Years[1]**	**Data Source(s)**
1. Was the ratio of rural, primary care providers to urban primary care providers maintained or improved during this waiver period compared to the previous waiver period?	Primary care providers in rural areas of the state in DY 24 and DY 25 who were enrolled in Medical Assistance. Primary care providers in urban areas of the state in DY 24 and DY 25 who were enrolled in Medical Assistance	For Medicaid enrolled providers only, compare the ratio of rural primary care providers to urban primary care providers for years 2021 through 2025 to the ratio of rural primary care providers to urban primary care providers for DY 24 and DY 25	MY 2021-2025 RY 2019- 2020	Medicaid Provider Enrollment Data for primary care providers.
2. Was the ratio of rural primary care providers per 10,000 rural beneficiaries maintained or improved during this waiver period compared to the	Primary care providers per 10,000 beneficiaries in rural areas of the state in DY 24 and DY 25 who were enrolled in	For Medicaid enrolled providers only, compare the ratio of rural primary care providers per 10,000 rural beneficiaries for	MY 2021-2025 RY 2019- 2020	Medicaid Provider Enrollment Data for primary care providers.

Research Question(s)	Comparison Population(s)	Measures	Comparison Years[1]	Data Source(s)
previous waiver period?	Medical Assistance.	the years 2021 through 2025 to the ratio of rural primary care providers per 10,000 rural beneficiaries for DY 24 and DY 25		
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?	Primary care providers per 10,000 beneficiaries in urban areas of the state in DY 24 and DY 25 who were enrolled in Medical Assistance.	For Medicaid enrolled providers only, compare the ratio of urban primary care providers per 10,000 urban beneficiaries for the years 2021 through 2025 to the ratio of urban primary care per 10,000 urban beneficiaries for DY 24 and DY 25	MY 2021-2025 RY 2019- 2020	Medicaid Provider Enrollment Data for primary care providers.

[1] 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. The comparison 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. The 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.

5.4 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

- 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)?

Research Question(s)	Comparison Population(s)	Measures	Comparison Years	Data Source(s)
1. Did the MA pregnant women waiver population experience comparable utilization of prenatal and postpartum care when compared to national Medicaid averages?	Pregnant women who are enrolled in Medicaid in the United States.	a) Prenatal visit within first trimester b) Postpartum visit between 21 and 56 days after delivery	MY 2021-2025 RY 2019-2020	MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data

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.

Evaluation Implementation Strategy and Timeline

Waiver Populations under Sections 5.1, 5.2, and 5.4

Beginning in 2026, 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 2019 and 2020) will be calculated for the targeted populations and compared to CY 2021, 2022, 2023, 2024, and 2025. 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 2026 with the draft final report submitted to CMS in December 2026.

Here is an overview of evaluation activities and timelines:

August 2025: DHS will calculate measurement rates for baseline goals.

September-October 2025: DHS will calculate and stratify HEDIS 2020-2024 performance measures.

October 2026: HEDIS results will be reviewed and evaluated.

November-December 2026: Draft final waiver report is written, reviewed and submitted to CMS.

March 2027: CMS submits feedback to DHS.

May 2027: 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 24 and DY 25) will be compiled and compared to state fiscal year 2021, 2022, 2023, 2024, and 2025. Medicaid provider enrollment data for state fiscal year 2021 through 2025 will be extracted and analyzed. The results will be incorporated into the draft final report.

Appendix E: Reform 2020 Section 1115 Demonstration Waiver

This is a proposed evaluation plan for the Alternative Care program under Minnesota's demonstration waiver entitled Reform 2020: Pathways to Independence. The waiver was originally approved in October 2013 and was extended in February 2020.

Minnesota's Medicaid program, known as Medical Assistance (MA), offers an array of home and community–based 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 older adults (74% in 2018) and people with disabilities (95% in 2018) who are enrolled in MA and need long term care services are living in the community rather than in institutional settings.

Minnesota has five home and community-based services waivers: Developmental Disability (DD)[45], Community Alternatives for Disabled Individuals (CADI)[46], Community Alternative Care (CAC)[47], Brain Injury (BI)[48] and Elderly Waiver (EW)[49]. Similar services to support individuals living in the community 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.

In addition, 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.

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 by enabling the state to provide preventive services to seniors who are likely to become eligible for Medicaid and who need an institutional level of care. The demonstration goals align with those of Medicaid and assist the state in promoting title XIX program objectives in the following ways:

- Achieving better health outcomes;
- Ensuring that the demonstration increases the participants' level of support for independence and recovery;
- Increasing community integration;

[45] DD: 2019 unduplicated enrollment was 21,120
[46] CADI: 2019 unduplicated enrollment was 31,715
[47] CAC: 2019 unduplicated enrollment was 649
[48] BI: 2019 unduplicated enrollment was 1,242
[49] EW: 2019 unduplicated enrollment was 36,680 (managed care and fee-for-service)

- Reducing the reliance on institutional care;
- Simplifying the administration of the program; and
- Ensuring access to the program's offered services.

Background on the Reform 2020 Section 1115 Waiver for Alternative Care

The Alternative Care or AC program was implemented under Reform 2020 beginning November 1, 2013.Formerly a state-funded program, 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.

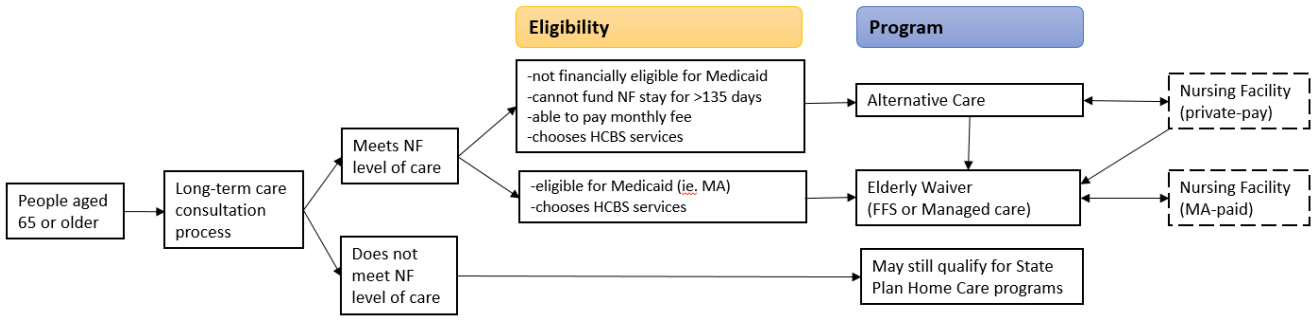
Acute and primary care services are not covered under the program. However, connecting seniors with community services earlier may divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established. Minnesota has a home and community-based waiver for people over age 65 that need nursing facility care called the Elderly Waiver. Although Alternative Care covers fewer services, 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.

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

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 participant is admitted to a nursing facility, his/her stay is either paid by Medicare (if eligible), other long-term care insurance, or out-of-pocket. Continued facility stays can result in

spenddown to MA. A person may also spend-down and become eligible for Medicaid while enrolled I Alternative Care. In that case, he or she can also transition to the Elderly Waiver. 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 participant. 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 services available under Alternative Care are the same as the services covered under the federally approved Elderly Waiver, *except:*

- Alternative Care **does not cover** transitional support services, assisted living (customized living) services, adult foster care services, or services that meet primary and acute health care needs
- Alternative Care **additionally covers** nutrition services and discretionary services

The comprehensive list of Alternative Care services follows.

- 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 agency 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.

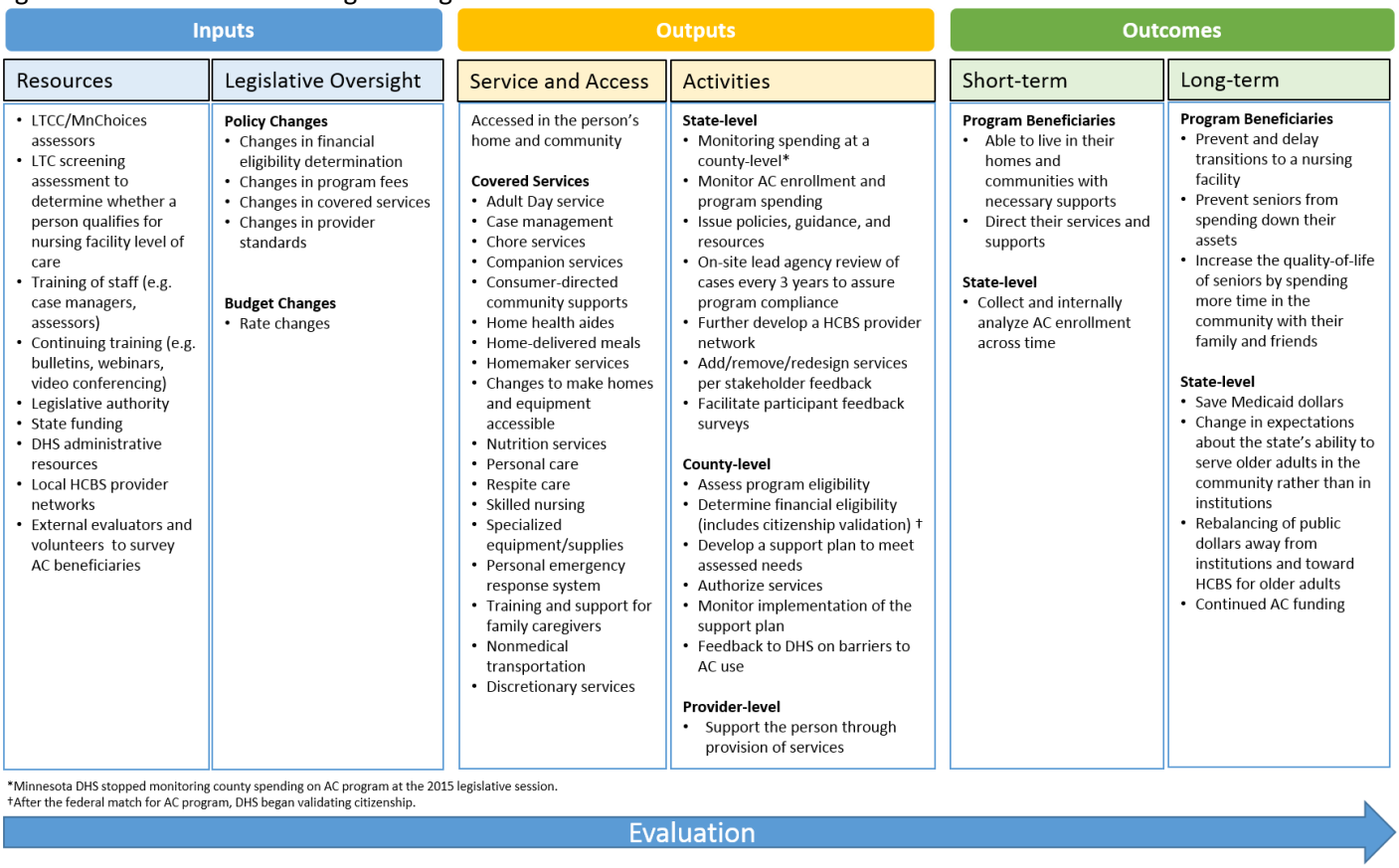
Program Goals

The goals of the Alternative Care program are to:

- 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.

- 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.
- 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



Evaluation Questions and Hypotheses

The Reform 2020 demonstration waiver extension is approved for the period October 18, 2013February 1, 2020 through January 31, 2025. This extension does not include substantial changes to the Alternative Care program, so we propose to continue the existing evaluation plan implemented during the first five years of the waiver. Since the federal waiver authorization has not resulted in any changes to the Alternative Care program structure, we propose continuing to evaluate the following hypotheses:

1. the waiver will not change the fundamentals of the program: size and characteristics of the population with AC;
2. 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;
3. the waiver will not change outcomes as indicated by use of acute and primary care services.

To test these hypotheses, we will evaluate the AC program over time (i.e., 2020-2025) in order to examine changes in any in program behavior, particularly any unintended negative consequences and the expected services 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 aging population or their use of services. AC and Comparison Population

The populations included in the evaluation consist of Alternative Care (AC) program enrollees and Elderly Waiver (EW) 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 EW participants will use residential services (i.e., customized living, adult foster care). We will identify EW participants in non-residential settings by excluding participants with any claims for residential services. For this evaluation, we will focus on these comparison populations: 1) EW participants in total, and 2) EW participants without residential services use, who are most directly comparable to the AC participants. As a sub-analysis we will also draw comparisons with EW participants who have residential use to see how they might differ from the primary comparison group. We will select a comparison group of EW participants according to propensity score matching in order to ensure that the matched EW comparison group is as similar as possible to the AC participants in demographics, health, and functioning.

Internal program monitoring and evaluation show that in the state fiscal year (July 2018-June 2019), there were approximately 3,600 unique participants in the AC program and 31,694 unique participants in the Elderly Waiver program (of which about 59% did not use any

residential services). The number of AC enrollees has been declining slightly, while the number of EW 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 participants has changed before and after the introduction of the AC waiver. We also will draw comparisons over time to Elderly Waiver participants 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 participants change before and after federal match? and 2) How do care and outcomes for Alternative Care participants compare to Elderly Waiver participants? We will evaluate changes over time (2020 to 2025) 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 participants will not change over time, neither alone nor in comparison to Elderly Waiver participants in non-residential settings. This will be evaluated using the following measures:

- Case mix status (low-need vs. high-need)[50]
- ADL dependencies and health functions
- Acuity rate differences between AC and Elderly Waiver non-residential participants
- Use of home and community-based services
- Acute and primary care services and emergency department visits where available for AC participants and when there is comparability between AC and Elderly Waiver participants

Alternative Care participants will experience equal or better access to consumer-directed service (CDS) options[51] over time, when examined alone and in comparison to Elderly Waiver participants in non-residential settings. This will be evaluated using the following measures:

- Authorized consumer-directed community supports
- Difference in CDCS use between AC and Elderly Waiver non-residential participants

[50] See section 2.42 for details on case mix is determined and level of need is defined.

[51] 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.

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

- Proportion of participant 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 or new use of AC or Elderly Waiver programs after discharge from nursing facility

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

- Remaining enrolled in AC
- Transition from AC to Elderly Waiver
- Transition to Essential Community Supports[52]
- Days alive in the community and not on Medicaid
- Use of Medicare services

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

[52] 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.

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 reassessment
- 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 and primary care or community) and discharge destination (e.g. acute and primary 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 participants or for periods when a participant 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 use of home health agency services
- 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. A copy of the Case Mix Classification Worksheet describing the factors used to determine a case mix classification for all AC and EW participants is at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG. 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, and
- 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.[53]

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

Analytic Methods

We propose the following methods to address the hypotheses within this evaluation. The following sections provide information about each approach, including the comparison group(s), metrics, and statistical methods. To compare efficiently across years (2020 through 2025), we will also report our measures as rates (e.g. per 1000 participants).

Cross-Sectional Analysis

To test hypothesis 2.31 and 2.32, 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 participants using LTC screening assessment data (also available in MMIS). We will further identify Elderly Waiver participants in non-residential settings by excluding participants with any claims for procedure codes denoting residential services (i.e.,

[53] EW also has a case mix V for people who are vent dependent

customized living, adult foster care, and residential care services). While living in the community, if an AC participant 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 participants by acuity type.

To test hypotheses 2.33 and 2.34, 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 participant 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 participants.

To test hypothesis 2.34, 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 participants, 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 a nursing facility in a given year, acuity groupings or RUGs 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.

Evaluation Strategy

Evaluation Objective and Comparison Population

This component of the evaluation will examine the hypotheses at a granular participant 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 and primary care services. Propensity score matching will be used to ensure that the EW comparison group is as similar as possible to the AC participants in demographics, health, and functioning.

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, and long-term care consultation (LTC) assessment data.

Analysis Plan

In addition to the research questions listed previously and in section 3.2, descriptive statistics will be used to analyze characteristics of AC participant during the period that waivers are in place. We will also compare waiver participants with other Medicaid services users (e.g., Elderly Waiver). Changes in service use and costs will be examined with a time series trend analysis, either multilevel models of change or differencing models. We also will use regression models to test whether amount of services at one point in time (T_0) predict future outcomes for service use (HCBS, Title III), medical use, nursing home use, and functional status at a subsequent point in time (T_1).

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

1. **Repeated cross-sectional participant-level analysis.** Descriptive statistics will be prepared on the participant population each year during the time period (2020-2025). 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 and primary care use (Medicare and Medicaid), and other variables. Multivariable logistic regression models will be applied in comparing AC and Elderly Waiver participants. 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.

2. **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 and primary 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 participants will

be modeled as a function of time, AC waiver period (before or after), and covariates (fixed or time-varying).

T**able 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		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		MDS and MMIS
NH use	Days, dollars	MDS and MMIS
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.

Methodological Limitations

Establishing a Baseline

Prior Alternative Care Evaluation reports have chosen the period prior to the introduction of the waiver (2010-2013) as the pre-waiver baseline, while 2014-2017 served as the implementation period after the waiver. As would be expected over such a long time period, the AC program underwent significant changes, as did the Elderly Waiver program. We found no evidence that these changes occurred because of the waiver. There were other external events, such as policy, programmatic, and demographic changes) that affected the program. The new evaluation will extend the period through 2025, making it increasingly difficult to determine if the AC program has changed as a result of a waiver introduced up to 10 years before, or because of external events or secular changes in the population and long-term service and support system over that span of time.

In order to address this limitation, the evaluation report will concentrate on findings for the prior three to five year data period. Furthermore, most of the analysis will be based on repeated cross-sections. A limited cohort analysis will be conducted, but only within the five year data period.

3.2 Comparison Population. The Elderly Waiver population serves as a comparator for Alternative Care in most of the analysis. EW participants differ significantly from AC participants

in some respects. Controlling statistically for these differences would strengthen the evaluation design.

Propensity score matching will be used in order that the EW comparison group is as similar as possible to the AC participants in demographics, health, and functioning.

Attachments

Independent Evaluator

DHS plans to continue contracting with Center for Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management to conduct the 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, Professor, School of Nursing, Purdue University, will assist in the analysis. Dr. Arling and his colleagues at University of Minnesota designed the current evaluation plan for the initial five year waiver period, and have been reporting on these measures on an annual basis.

The University of Minnesota will conduct all analysis using the methods described in this plan. DHS will provide access to administrative data, including MMIS claims, Minimum Data Set (MDS v3), and LTC assessment data. In addition, DHS staff will provide expertise on policy and program operations that may influence data trends.

Evaluation Budget

The total budget available for the independent evaluation over the five year waiver period is estimated to be $735,000. This about will cover evaluation expenses, including purchasing Medicare data as made available to the University by CMS, analysis and interim reports, and travel associated with presentations and in-person meetings. In addition, DHS staff time is necessary to provide the administrative data and consult on the evaluation findings.

Timeline and Major Milestones

Deliverable	**Responsible Party (from to)**	**Date**
Draft Evaluation Design Plan	State to CMS	Within 120 days after the approval of the demonstration extension (July 30, 2020)
Final Evaluation Plan	State to CMS	Within 60 days following receipt of CMS comments on Draft Evaluation Design Plan
Annual internal report to DHS from independent evaluator	Independent Evaluator to DHS	June of each year during demonstration
Final evaluation report	Independent Evaluator to DHS	Within 12 months following the end of the demonstration extension period

Deliverable	Responsible Party (from to)	Date
Draft Summative Evaluation Report	State to CMS	Within 18 months following the end of the demonstration extension period
Final Summative Report	State to CMS	Within 60 days of receipt of CMS comments

Appendix F: DHS Quality Metrics

This table lists quality measures used by DHS to evaluate the quality of health care in the Medicaid program. Following the example of the Medicaid Core Sets, DHS quality measures are organized into the following categories: primary care access and preventive care, maternal and perinatal care, care of acute and chronic conditions, behavioral health care, experience of care, dental health services, and long-term services & supports. Measures' rates are calculated annually by DHS using claims data.

Measure Steward	Measure Name	Medicaid Core Sets: Adults and Children	Annual Technical Report	MCO Risk Corridors	Integrated Heath Partnerships	Behavioral Health Homes	CCBHC	Disparities by Payer Type
Primary Care Access and Preventive Care								
NCQA	Cervical Cancer Screening (CCS)	X	X		X	X		
NCQA	Chlamydia Screening in Women Ages 16-20 and 21–24 (CHL)	X	X		X			
NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA)	X						
NCQA	Breast Cancer Screening (BCS)	X	X	X	X	X		X
NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				X			
NCQA	Childhood Immunization Status (CIS)	X	X	X	X			X
NCQA	Immunizations for Adolescents (IMA)	X			X			
OHSU	Developmental Screening in the First Three Years of Life (DEV)	X						
NCQA	Well-Child Visits in the First 15 Months of Life (W15) NEW W30	X	X	X	X			
NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) NEW WCV	X	X	X	X	X		

Measure Steward	Measure Name	Medicaid Core Sets: Adults and Children	Annual Technical Report	MCO Risk Corridors	Integrated Heath Partnerships	Behavioral Health Homes	CCBHC	Disparities by Payer Type
NCQA	Adolescent Well-Care Visits (AWC) NEW WCV	X	X	X	X	X		
NCQA	Adults' Access to Preventive/Ambulatory Health Services (AAP)				X	X		
NCQA	Colorectal Cancer Screening (COL)			X	X	X		
MNCM	Colorectal Cancer Screening (CCS)				X			X
Maternal and Perinatal Health								
NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC)	X						
CDC	Live Births Weighing Less Than 2,500 Grams (LBW)	X						
NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)	X						
OPA	Contraceptive Care – Postpartum Women Ages 15–20 and 21–44 (CCP)	X						
OPA	Contraceptive Care – All Women Ages 15–20 and 21–44 (CCW)	X						
Care of Acute and Chronic Conditions								
NCQA	Controlling High Blood Pressure (CBP)	X						X
NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	Retired	X	X	X			
AHRQ	Prevention Quality Indicators (PQI)	X			X	X		

Measure Steward	Measure Name	Medicaid Core Sets: Adults and Children	Annual Technical Report	MCO Risk Corridors	Integrated Heath Partnerships	Behavioral Health Homes	CCBHC	Disparities by Payer Type
NCQA	Plan All-Cause Readmissions (PCR)	X		X	X	X	X	
NCQA	Asthma Medication Ratio: Ages 5–18 and 19–64 (AMR)**	X			X	X		
NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB)	X		X	X	X		
MNCM	Optimal Vascular Care (OVC)				X			X
MNCM	Optimal Diabetes Care (ODC)				X			X
MNCM	Optimal Asthma Control (OAC) Children, Adults				X			X
MNCM	Depression Remission at 6 Months Adolescent, Adults				X			X
Behavioral Health Care								
NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	X		X	X	X	X	
NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	X						
NCQA	Antidepressant Medication Management (AMM)	X		X	X	X	X	
NCQA	Follow-Up After Hospitalization for Mental Illness: Age 6–20 and 18 and Older (FUH)	X		X	X	X	X	
NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who	X					X	

Measure Steward	Measure Name	Medicaid Core Sets: Adults and Children	Annual Technical Report	MCO Risk Corridors	Integrated Heath Partnerships	Behavioral Health Homes	CCBHC	Disparities by Payer Type
	Are Using Antipsychotic Medications (SSD)							
NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	X				X	X	
NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	X				X	X	
PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	X						
NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	X			X		X	
PQA	Concurrent Use of Opioids and Benzodiazepines (COB)	X						
CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	X				X		
NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	X					X	
NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	X						
NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	X						

Measure Steward	Measure Name	Medicaid Core Sets: Adults and Children	Annual Technical Report	MCO Risk Corridors	Integrated Heath Partnerships	Behavioral Health Homes	CCBHC	Disparities by Payer Type
Experience of Care								
NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)	X	X					
AHRQ	CG CAHPS				X			
CMS	Hospital CAHPS				X			
MN DHS	Patient Experience of Care Survey; Youth/Family Experience of Care Survey						X	
Dental and Oral Health Services								
NCQA	Annual Dental Visits		X		X	X		
ADA	Sealant Receipt on Permanent 1st Molars	X						
CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	Form CMS-416						
Long-Term Services & Supports								
NASDDDS/HSRI	National Core Indicators Survey (NCIDDS)	X						

CCBHC = Certified Community Behavioral Health Clinics. In the CCBHC program, some measures are reported by the clinics to DHS. In addition, DHS also calculates the Housing Status (HOU) for CCBHCs. The HOU and clinic-lead measures are not included in the table.

NCQA = National Committee for Quality Assurance

OHSU = Oregon Health and Science University

CMS = Centers for Medicare and Medicaid Services

MNCM = Minnesota Community Measurement

CDC = Center for Disease Control and Prevention

OPA = the U.S. Office of Population Affairs

AHRQ = Agency for Healthcare Research & Quality

PQA = Pharmacy Quality Alliance

DQA (ADA) = Dental Quality Alliance (American Dental Association)

NASDDDS = National Association of State Directors of Developmental Disabilities Services

HSRI = Human Services Research Institute