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

DRAFT
Waiver Extension Request
# Table of Contents

### Section One - Background and History

1.1 Minnesota’s Health Care Reform Waivers .................................................. 5
   1.11 Introduction .............................................................................................. 5
   1.12 History ....................................................................................................... 5
   1.13 Medical Assistance Program ...................................................................... 6
   1.14 MinnesotaCare Program .......................................................................... 6
1.2 Components of the Current MinnesotaCare Health Care Reform Waiver ...... 7
   1.21 Managed Care Provisions .......................................................................... 7
      1.211 Managed Care Less Than State-Wide ...................................................... 8
      1.212 Mandating Enrollment in MCOs with Restricted Networks .................... 8
      1.213 Medical Education ................................................................................. 9
      1.214 County-Based Purchasing .................................................................... 9
   1.22 Eligibility and Coverage Provisions ....................................................... 9
      1.221 Expansion populations in MinnesotaCare ............................................ 9
      1.222 MA Eligibility and Coverage ............................................................... 10
   1.23 Medicaid Eligibility Quality Control Program (MEQC) ......................... 10
   1.24 Administrative simplification ................................................................... 10
      1.241 Different Definition of “Family” ............................................................ 11
      1.242 Different Income Methodology .......................................................... 11
      1.243 Four-Month Penalty for Voluntary Terminations ............................... 11
      1.244 Continuous Eligibility ......................................................................... 12
   1.25 Benefit and Cost-Sharing Provisions ...................................................... 12
      1.251 Benefit Sets ......................................................................................... 12
      1.252 Different Cost-Sharing ......................................................................... 13
      1.253 Higher Premium Structure ................................................................. 13
      1.254 Crowd-Out Provisions ......................................................................... 14
1.3 Background of the MinnesotaCare Health Care Reform Waiver Extension Request .... 14
1.4 Plans for Medicaid Eligible Seniors Currently in PMAP ................................ 15

### Section Two - Demonstration Design and Overview

2.1 Rationale and Focus of Demonstration Design .......................................... 16
2.2 Managed Care Provisions .......................................................................... 16
   2.21 Mandatory Enrollment for Certain Populations ....................................... 16
      2.211 American Indians ............................................................................... 16
   2.22 Medical Education ................................................................................... 17
   2.23 County-Based Purchasing ....................................................................... 19
      2.231 Requirements for Participation ............................................................ 19
      2.232 Current CBP Projects ......................................................................... 20
      2.233 MSA Status ....................................................................................... 20
2.3 Eligibility and Coverage Provisions ......................................................... 21
   2.31 MinnesotaCare Expansion Populations ................................................... 21
   2.32 Coverage for Pregnant Women ............................................................... 22
Table of Contents

2.33 Children Under Age Two ................................................................. 22
2.4 Medicaid Eligibility Quality Control Program ........................................ 22
2.5 Administrative Simplification .............................................................. 22
  2.51 Different Definition of “Family” ...................................................... 23
  2.52 Different Income Methodology ....................................................... 24
  2.53 Four-Month Penalty for Voluntary Terminations ............................... 24
  2.54 Continuous Eligibility ................................................................. 24
2.6 Benefit and Cost-Sharing Provisions .................................................... 25
  2.61 Differing Benefit Sets ................................................................. 25
    2.611 Covered Access Services ......................................................... 26
  2.62 Different Cost-Sharing and Premiums ............................................. 26
    2.621 Different Cost Sharing ............................................................ 26
    2.622 Premium Payments ............................................................... 26
  2.63 Crowd-Out Provisions ............................................................... 27
2.7 MinnesotaCare Single Adults and Adults without Children .................... 27
  2.71 Benefit Set and Cost Sharing ......................................................... 27
  2.72 Potential Additional Expansion ..................................................... 28

Section Three - Organization and Administration ..................................... 29
3.1 Organizational Structure of Minnesota Department of Human Services .... 29
3.2 Key Personnel of the Demonstration .................................................. 29
  3.21 DHS Commissioner ...................................................................... 29
  3.22 DHS Health Care Administration .................................................. 29
  3.23 Administration of the Demonstration ............................................. 30
    3.231 MA Eligibility ......................................................................... 30
    3.232 MinnesotaCare Eligibility ....................................................... 30
    3.233 PMAP Purchasing ................................................................... 30
    3.234 MinnesotaCare Purchasing ..................................................... 31
  3.24 Public & Stakeholder Involvement ................................................ 31
3.3 Managed Care Contract Development and Management ....................... 32
  3.31 MCO Services Areas .................................................................. 32
  3.32 Contract Development ............................................................... 32
  3.33 Contract Management ............................................................... 33
3.4 Managed Care Quality Improvement .................................................... 33
3.5 Consumer Education and Enrollment ................................................ 35
  3.51 Health Match ........................................................................... 36
  3.52 Implications of Health Match on PMAP Enrollment ....................... 37
3.6 Advocacy and Ombudsman Activities ................................................ 38
  3.61 Grievance and Appeal Procedures .............................................. 38
  3.62 MCO Grievance and Appeal Procedures ...................................... 38
  3.63 Grievance, Appeal and State Fair Hearing .................................... 39
  3.64 County Advocates .................................................................... 41
  3.65 Ombudsman Activities ............................................................ 41
## Table of Contents

**Section Four - Evaluation**

4.1 Historical Evaluation of PMAP ................................................................. 42
   4.11 Federal Evaluation ........................................................................... 42
      4.111 Research Triangle Institute Study .......................................... 42
      4.112 Urban Institute Studies ......................................................... 42
   4.12 Health Plan Study ......................................................................... 42
   4.13 Minnesota Department of Human Services Studies ...................... 43
      4.131 Grievance panel survey ......................................................... 43
      4.132 Satisfaction surveys of providers ......................................... 43
      4.133 Inpatient utilization reporting (Utilization Data Definitions Committee) 43
      4.134 Public health nursing study .................................................. 43
   4.14 Managed Care Focus Groups ....................................................... 44
   4.15 Minnesota Health Data Institute Surveys ....................................... 44

4.2 Continuing Studies ............................................................................. 44
   4.21 Consumer Satisfaction ............................................................... 44
   4.22 Quality Improvement ................................................................. 45
   4.23 Quality Strategy .......................................................................... 45
   4.24 Plan Switching (Disenrollment) Survey ......................................... 45
   4.25 Health Plan Quality Improvement Systems ................................... 45
   4.26 External Review Process ............................................................. 45
   4.27 Data Warehouse and Executive Information System (EIS) ............ 46

**Section Five - Case Load and Cost Estimates** ........................................ 47

5.1 Case Load and Cost Estimates ............................................................ 47

**Section Six - Waivers Requested** .......................................................... 48

6.1 Waivers Granted to Implement Phase 1 ................................................ 48
   6.11 Waivers Granted under §1115(a)(1) ........................................... 48
   6.12 Expenditures Allowed under §1115(a)(2) .................................... 49
6.2 Waivers Granted Under Phase 2 ........................................................ 49
   6.21 Expenditures Allowed under §1115(a)(2) .................................... 50
6.3 Waivers Requested to Implement PMAP+ Extension .......................... 51
   6.31 Waivers Requested Under §1115(a)(1) ....................................... 52
   6.32 Expenditures Requested Under §1115(a)(2) ............................... 52
1.1 Minnesota’s Health Care Reform Waivers

1.11 Introduction

Minnesota was one of the early states to use health care reform waivers to cover its uninsured population. We received one of the first health care reform waivers (at the time called the MinnesotaCare Health Care Reform Waiver; currently known as PMAP+ Waiver), which allowed Minnesota to use managed care savings from the Medicaid population to finance the coverage of, first pregnant women and children in our MinnesotaCare program, and later also caretaker adults. By the time S-CHIP financing was available for other states, there were so few children in Minnesota possible to cover under the program (only children from 275% to 280% of Federal Poverty Guidelines are covered by S-CHIP funding in MinnesotaCare), that Minnesota had to use other populations to expend its S-CHIP allotment. In the past, this has put us in good stead – Minnesota is still one of the states with the lowest uninsurance rates in the nation.

1.12 History

For almost twenty years, Minnesota's Medicaid Program (Medical Assistance or MA) has administered a § 1115 waiver, allowing for the purchase of coverage from managed care organizations (MCOs) on a prepaid capitated basis. This purchasing project, known as the Prepaid Medical Assistance Program (PMAP), was originally limited to a few Minnesota counties. The project required that nondisabled MA recipients be enrolled with an MCO, and remain enrolled with that MCO for a 12-month period.

On April 27, 1995, the Centers for Medicare and Medicaid Services (CMS, then called HCFA) approved a statewide health reform amendment to the PMAP waiver. With subsequent extensions and the Phase 2 amendment, the waiver is effective through June 30, 2005. Generally, Phase 1 allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the federal poverty guidelines (FPG) into the Medicaid Program.

In March 1997, the State proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that CMS authorize a second phase of provisions that had been enacted by the Minnesota Legislature.

An amendment approved on February 22, 1999, expanded coverage to include parents enrolled in MinnesotaCare.
On August 22, 2000, CMS approved most aspects of Minnesota's Phase 2 amendment request. The waiver was titled the Prepaid Medical Assistance Project Plus (PMA+) waiver.

In June 2001, Minnesota requested an extension of its PMA+ waiver. In October 2001, CMS approved the extension. Minnesota also requested and received an amendment to the budget neutrality terms and conditions of the waiver. That amendment was effective July 1, 2003. The current waiver extension expires on June 30, 2005.

### 1.13 Medical Assistance Program

Minnesota, through its Department of Human Services (DHS), administers the MA Program under title XIX of the Social Security Act. The program covers health care services that address acute, chronic and long-term care needs for approximately 470,000 residents. Eligibility requirements for the program are set forth in the State’s Medicaid plan, in home-and community-based services waivers, the MinnesotaCare Health Care Reform/PMA+ §1115 Waiver, and the Minnesota Senior Health Options (MSHO)/Minnesota Disability Health Options (MnDHO) §1915(a/c) Waiver.

**Prepaid Medical Assistance Program.** Approximately 270,000 MA recipients receive services through prepaid managed care plans under the State's current §1115 waiver for the Prepaid Medical Assistance Program (PMA). The remaining recipients receive services from enrolled providers who are paid on a fee-for-service basis.

**Minnesota Senior Health Options.** The MSHO Waiver, formerly known as the Long-Term Care Options Project, is designed to test the efficiency and effectiveness of financing and delivery systems that integrate long-term care and acute care services under combined Medicare and Medicaid capitation payments for Medicare elderly recipients who are on Medicaid. Enrollment in MSHO began in March 1997.

**Minnesota Disability Health Options.** This is part of the MSHO waiver, and serves individuals who have a physical disability. Enrollment began in September 2001.

**Other waivers.** In addition, the State currently operates its Medicaid Program with six §1915(c) home-and community-based services waivers, one §1915(b) freedom-of-choice waiver, and one additional §1115 waiver. The state also recently received approval for a family planning waiver, which is in the pre-implementation phase.

### 1.14 MinnesotaCare Program

MinnesotaCare is a state-and federally-funded program that primarily covers acute care services for approximately 140,000 uninsured Minnesotans. This includes approximately 109,000 individuals in families with children whose family income does not exceed 275 percent of the
Section One – Background and History

federal poverty guideline (FPG) and approximately 33,000 adults without dependent children whose income does not exceed 175 percent of the FPG.

Minnesota receives federal financial participation (FFP) for infants, children, and pregnant women enrolled in the MinnesotaCare Program for Families with Children as part of the MinnesotaCare Health Care Reform/PMAP+ §1115 Waiver. Coverage for this population is equivalent to MA coverage under Minnesota’s Medicaid state plan.

Minnesota also receives FFP for parents and caretaker adults enrolled in MinnesotaCare. Coverage for this group differs from state plan coverage.

Minnesota covers adults without children in MinnesotaCare, but receives no FFP for these individuals. Coverage for this group differs from state plan coverage.

To be eligible for MinnesotaCare, individuals may not otherwise be insured for 4 months prior to application and may not have had access to employer-subsidized insurance coverage from a current employer for 18 months prior to application. Enrollees pay a premium for MinnesotaCare coverage based on a sliding scale related to family income and family size.

MinnesotaCare enrollees receive coverage through prepaid MCOs.

1.2 Components of the Current MinnesotaCare Health Care Reform Waiver

1.21 Managed Care Provisions

Comprehensive managed care under the Prepaid Medical Assistance Program (PMAP) provides coverage of almost all MA state plan services through a managed care organization to most nondisabled MA recipients in the counties where it is implemented. The following services are not delivered through the MCO: home and community-based waiver services, nursing facility (NF) services beyond the first 90 days, intermediate care facility for people with mentally retardation (ICFs/MR) services, abortion services, certain school-based services, adult mental health rehabilitation services, Rule 5 facility services, and targeted case management services. Additionally, in five counties, dental services are excluded and delivered on a fee-for-service basis.

In general, PMAP provides service delivery through a health plan to non-disabled MA recipients in the counties where it is implemented, although some additional populations are exempt from enrollment in PMAP.

Comprehensive purchasing of covered services through MCOs is implemented statewide on a prepaid, capitated basis for MinnesotaCare enrollees under Prepaid MinnesotaCare.
Under PMAP and Prepaid MinnesotaCare, prepaid dental, children’s mental health collaboratives, and other managed care entities may provide services to MA recipients in addition to those covered under the state plan.

The following sections describe briefly the components of Minnesota’s §1115 PMAP+ Health Care reform waiver, and how those components are applied to the PMAP and MinnesotaCare programs. A more complete description of waiver components and program operation may be found in the waiver MinnesotaCare Health Care Reform Waiver PMAP+ Operational Protocol.

1.211 Managed Care Less Than State-Wide

Under the current waiver, the State was authorized to provide MA services through pre-paid capitated MCOs, on a county-by-county basis. This authority allowed the State to introduce managed Medical Assistance incrementally, so that processes could be improved as the State and counties gained experience, and also allowed PMAP to be introduced into counties as they were prepared for its administration. PMAP is currently established in 81 of Minnesota’s 87 counties with an additional 2 counties implementing in January 2005.

1.212 Mandating Enrollment in MCOs with Restricted Networks

The current waiver provision allowing certain populations to be mandatorily enrolled in MCOs has allowed the State to provide the benefits of managed care to most Medical Assistance and MinnesotaCare enrollees. The populations that may be mandatorily enrolled in PMAP, in addition to families and children, include:

- Recipients in Itasca County who live near the county border and who use providers in a neighboring county
- Children in foster care placements.
- Individuals who have private health maintenance organization (HMO) coverage.
- American Indians living on a reservation.
- Persons eligible for Medical Assistance who are also eligible for Medicare (Dual Eligibles)

The population that may voluntarily enroll in PMAP has been expanded to include:

- Adults with serious and persistent mental illness.
- Children with severe emotional disturbance.
Section One – Background and History

Detailed information about programs designed to improve access to services for American Indians and the elderly is included in the Operational Protocol.

1.213 Medical Education

Under the current waiver, MA payments for the costs of medical education are removed from capitation payments to health plans under PMAP and are directed to a medical education trust fund for direct distribution to teaching entities. MA FFP is claimed for the costs paid into the trust fund. The State has established this medical education and research trust fund through the Minnesota Department of Health. Distribution is based on recommendations from a medical education and research committee of health care professionals and institutions appointed in accordance with state law. Through this process, the historical medical education funds are guaranteed to remain in the medical education field. Additional information about the trust fund and distribution is included in Section 2.22.

1.214 County-Based Purchasing

In 1997 the Minnesota Legislature authorized the development of county-based purchasing of MA services. County boards or groups of county boards may elect to contract with DHS to purchase or provide health care services for MA recipients who would otherwise be required or permitted to participate in PMAP. Counties that elect to implement county-based purchasing must do so for all services included in PMAP and in accordance with PMAP requirements except as otherwise specified. The county-based purchasing (CBP) entity must satisfy the Commissioner of Health that the CBP entity meets state licensing requirements for an HMO or a community integrated services network, but is not required to obtain a certificate of authority.

In January 1999, DHS submitted a request to CMS to amend PMAP+ to permit implementation of county-based purchasing. In response to CMS’s questions about the submission, an amended waiver request was submitted. The first CBP project was approved in 2001. Currently, two groups of counties (South Country Health Alliance and PrimeWest Health System), and a single county (Itasca), are operating as county-based purchasing plans. DHS continues to work with counties to ensure that county-based purchasing projects are responsive to CMS’s concerns. Additional information is included in Section 2.23.

1.22 Eligibility and Coverage Provisions

1.221 Expansion populations in MinnesotaCare

FFP is claimed under the current waiver for uninsured pregnant women, infants, and children eligible for the MinnesotaCare Program with an income standard of 275 percent of FPG, with no asset test. Services covered for this population are the same as those of the MA Program.
Section One – Background and History

FFP is also claimed for uninsured parents and caretaker adults with income up to the lesser of 275 percent of FPG or $50,000, and with assets up to $20,000. Services for this group are less comprehensive.

1.222 MA Eligibility and Coverage

Coverage for all pregnant women, including poverty related pregnant women, consists of the full MA benefit set for a qualified pregnant woman in accordance with §1902(a)(10)(A)(I)(iii).

MA eligibility for children age one and under age two is determined using an income standard of 275 percent of FPG with no asset test.

1.23 Medicaid Eligibility Quality Control Program (MEQC)

A waiver of 1902(a)(4)(A) of the Act was approved under Phase I and Phase 2 of the MinnesotaCare Health Care Reform Waiver. Under this waiver Minnesota has replaced traditional MEQC reviews with the Pilot Project to Redesign Quality Control in Minnesota. The pilot has been central to the state effort to improve service to recipients, to improve access to eligibility for publicly funded health care programs, and to assure the integrity of the programs.

1.24 Administrative simplification

Six-Month Income Reviews: Unvarying Unearned Income, Excluded Income The State eliminated 6-month income reviews and projects income for a 12-month period for the following medically needy MA recipients:

- Recipient households who have only unvarying unearned income, which is defined as income from a source other than employment or self-employment that can reasonably be anticipated to be the same amount every month and for which changes, such as periodic cost-of-living increases, can be anticipated.

- Recipient households whose sole income is from a source excluded from consideration by law.

For these two groups, income reported at the time of application or annual review is projected for 12 months. The amount of income reported is assumed to be the same unless the recipient notifies the local agency of a change.

Transitional MA Reporting and Income Requirements for Second Six Months The quarterly income review requirement was eliminated. Because information on recipients' earnings is no longer collected, the 185 percent of FPG income limit during the second six months was also eliminated. DHS has not instituted this change but would like to retain the authority to do so.
Section One – Background and History

Exclusion of Gift Income Under $100 Per Month  Gifts of money that do not exceed $100 per month are not required to be reported and are excluded from countable income when determining eligibility. DHS has not instituted this change but would like to retain the authority to do so.

Elimination of Post-Partum Review for Certain Pregnant Women  Women who were eligible under another basis before the pregnancy or who live with other eligible household members subject to the same basis and income limits are not required to reapply or have their eligibility reviewed until the household's next regularly scheduled review date after the end of the post-partum period.

1.241 Different Definition of “Family”

Under the MinnesotaCare waiver, “family” is defined differently than for MA. For MinnesotaCare eligibility, "family" means a parent or parents and their children; or guardians and their wards who are children; and grandparents, foster parents and relative caretakers residing in the same household; and includes children temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. "Family" also means an emancipated minor and an emancipated minor's spouse.

In general, families cannot choose to enroll only certain uninsured members in MinnesotaCare. Parents who enroll in MinnesotaCare must enroll any eligible children in MinnesotaCare or Medical Assistance, unless other insurance is available. If one child in a family is enrolled, all uninsured children must be enrolled. Children may be enrolled in MinnesotaCare even if their parents do not enroll. In families that include a grandparent, relative caretaker, foster parent or legal guardian, the grandparent, relative caretaker, foster parent or legal guardian may apply as a family or may apply separately for the children.

1.242 Different Income Methodology

Under the MinnesotaCare waiver, income is determined using a different methodology than that used for MA eligibility. A complete description of the MinnesotaCare income methodology is found at Section 5.3.3 of the Operational Protocol.

1.243 Four-Month Penalty for Voluntary Terminations

An enrollee who voluntarily terminates coverage from the program or who is disenrolled for failure to pay the required premium is not eligible to reenroll until four calendar months after the date coverage terminates unless the person demonstrates good cause for voluntary termination or nonpayment and pays the unpaid premium for any month in which coverage was provided. The four-month penalty is not applicable to children under age 2 or pregnant women.
Section One – Background and History

1.244 Continuous Eligibility

An enrollee remains eligible for MinnesotaCare regardless of the age or the presence or absence of children in the household as long as the enrollee:

- Maintains residency in Minnesota;
- Has annual income that is equal to or less than 275 percent of FPG and, for non-pregnant adults, is less than $50,000. Children in families whose income exceeds 275 percent of FPG may remain enrolled if 10 percent of their annual income is less than the annual premium for a policy with a $500 deductible through the Minnesota Comprehensive Health Association (MCHA). Children who are no longer eligible under this exception must be given a 12-month notice prior to disenrollment. Children in these families must pay full premium;
- Meets all other eligibility criteria; and
- Is continuously enrolled in MinnesotaCare or Medical Assistance.


1.251 Benefit Sets

Children and Pregnant Women For children under age 21, MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients and, for pregnant women, MinnesotaCare covers the same benefit set as the state plan authorizes for qualified pregnant woman MA recipients.

Caretaker Adults For caretaker adults, MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients, except that the following services are not covered:

- Services included in an individualized education plan.
- Private duty nursing services.
- Dental care services other than:
  - diagnostic and preventive services;
  - basic restorative services; and
  - emergency services.
Section One – Background and History

These dental services are subject to a $500 annual benefit limit. Emergency services, dentures, and extractions related to dentures are not included in the $500 benefit limit.

- Orthodontic services.
- Nonemergency medical transportation services.
- Personal care services.
- Targeted case management services.
- Nursing facility services.
- ICF/MR services.
- Outpatient mental health services other than diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

1.252 Different Cost-Sharing

The MinnesotaCare waiver permits greater cost-sharing than is permissible under Medicaid, including the following:

- For non-pregnant adult caretaker enrollees with family income less than or equal to 175 percent of FPG, MinnesotaCare applies a copayment of 50 percent of the fee-for-service MA payment rate for nonpreventive dental services, $3 per prescription, and $25 per pair of eyeglasses.
- For non-pregnant caretaker adult enrollees with family income greater than 175 percent of FPG but less than or equal to 275 percent of FPG, MinnesotaCare applies a copayment of $3 per prescription, $25 per pair of eyeglasses and coinsurance of ten percent of the charges for inpatient hospital services, subject to an annual out-of-pocket maximum of $1,000 per adult.

Copayments totaling $30 or more, paid by a pregnant woman after the date the pregnancy is diagnosed, are refunded.

1.253 Higher Premium Structure

The MinnesotaCare waiver permits premiums that are higher than would be permissible under Medicaid to be charged to MinnesotaCare applicants and enrollees.
Section One – Background and History

Applicants and enrollees must pay a premium to enroll and to continue enrollment in MinnesotaCare. The amount of premium is based on the family's gross annual family income. The amount of the premium is:

A. $4 per month for each child in a family whose income does not exceed 150 percent of FPG; plus

B. For any family member not included under Item A, the amount determined in accordance with premium tables; premium tables are updated annually in response to changes in federal poverty guidelines.

1.254 Crowd-Out Provisions

In order to avoid “crowding out” of private health insurance, the MinnesotaCare waiver permits provisions including:

Applicants may not currently have other health coverage nor have had other health coverage during the four months immediately preceding the date coverage begins. Applicants who were recipients of Medical Assistance and had cost-effective health insurance that was paid by Medical Assistance are exempt from the four month requirement.

Applicants also may not have current access to employer-subsidized health coverage, and employer-subsidized health coverage must not have been lost due to:

- the employer terminating coverage during the 18 months immediately preceding the date coverage begins, except that this provision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit, or
- the employee failing to take up coverage offered by the employer during an open enrollment period within the preceding 18 months.

1.3 Background of the MinnesotaCare Health Care Reform Waiver Extension Request

With implementation of BBA Managed Care regulations in 2003, states can implement through their State Plans many of the provisions that were previously only permitted under a §1115 waiver. Nevertheless, Minnesota requires waivers to continue several important provisions of our current waiver, including:

- Mandatory enrollment in PMAP for certain populations:
Section One – Background and History

- Dual eligibles,
- Children with special needs,
- American Indians

- Providing Medical Assistance services with federal financial participation to expansion populations
- Allowing for some current CBP counties that were determined to be MSAs in the most recent census to continue as the sole choice of MCO in those counties.

1.4 Plans for Medicaid Eligible Seniors Currently in PMAP

State legislation passed in 2003 requires the State to seek federal authority necessary to integrate home and community-based §1915(c) Elderly Waiver (EW) services and additional nursing facility (NF) services into Minnesota’s Prepaid Medical Assistance §1115(a) Waiver Project Plus (PMAP+). NF services covered under the managed care program will be increased from the current 90 days to 180 days for community enrollees.

Most seniors are required to enroll in managed care under Minnesota’s current PMAP+ §1115 waiver. Approximately 40,000 of the State’s 52,000 Medicaid eligible seniors are currently enrolled in PMAP+ each month. Current PMAP+ §1115 waiver authority expires in July 2005. Between now and the end of the current PMAP §1115 waiver period, Minnesota intends to move all PMAP+ seniors to a §1915(b) waiver.
2.1 Rationale and Focus of Demonstration Design

Minnesota has purchased Medical Assistance services for most eligibles through pre-paid, capitated health plans for more than 15 years, under its MinnesotaCare Health Care Reform §1115 waiver. With passage of the Balanced Budget Act of 1997, and subsequent promulgation of related regulations in 2002, most aspects of Minnesota’s pre-paid managed health care programs can be operated under the State Plan.

Nevertheless, several important components of the State’s programs continue to require waivers under §1115 of the Social Security Act (the Act) in order to remain in operation. This section of the waiver request explains which provisions of the Act the State is requesting to be waived, and describes how these waivers affect operation of the programs and how they are implemented.

2.2 Managed Care Provisions

2.21 Mandatory Enrollment for Certain Populations

The populations that may be mandatorily enrolled in PMAP include:

- Recipients in Itasca County who live near the county border and who use providers in a neighboring county
- Children in foster care placements.
- Individuals who have private HMO coverage.
- American Indians living on a reservation.
- Persons eligible for Medical Assistance who are also eligible for Medicare (Dual Eligibles)

The population that may voluntarily enroll in PMAP has been expanded to include:

- Adults with serious and persistent mental illness.
- Children with severe emotional disturbance.

2.211 American Indians

Out-of-network services. DHS has consulted with tribal governments to develop an approach to MA purchasing for American Indian recipients that is different from the remainder of the MA program, in order to address issues related to tribal sovereignty, the application of federal provisions that prevent Indian Health Services (IHS) facilities from entering into contracts with
MCOs, and other issues that have posed obstacles to enrolling American Indian/Alaska Native MA recipients living on reservations into PMAP.

American Indian MA recipients will be required to participate in PMAP and, whether residing on or off a reservation, will have direct access to out-of-network services at IHS or 93-638 (IHS/638) facilities. DHS will reimburse these IHS/638 services on a FFS basis using payment rates negotiated between IHS and CMS, except where a 638 facility elects to receive the MA rate applicable to non-tribal providers.

**Marketing, education, and enrollment.** The State will consult with tribal governments before approving marketing materials that target American Indian recipients. Certificates of Coverage will include a description of how American Indian enrollees may directly access IHS/638 providers, and how they may obtain referral services. The State will consult with tribal governments prior to approving the COC.

MCOs will provide training and orientation materials to Tribal governments upon request, and make training and orientation available to interested Tribal governments. Tribal governments may assist the State in presenting or developing materials describing various MCO options to their members. If a Tribal government revises any MCO materials, the MCO may review them. No MCO materials will be distributed until there is agreement between the MCO and Tribal government on any revisions.

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

### 2.22 Medical Education

**Medical education and research costs (MERC)** MA payments for the costs of medical education are removed from the capitation payments to the MCOs under PMAP and directed to a medical education trust fund for direct distribution to teaching entities. The State has established this medical education and research trust fund through the Minnesota Department of Health. The trust fund is calculated as follows:

A. Each hospital’s direct medical education costs from its cost report (resident and supervisor salaries and fringe benefits) is added to its indirect medical education costs, based on the Medicare indirect medical education percentage, to arrive at MERC costs.

B. The percent that MERC costs are of the hospital’s inpatient payments is calculated.
C. The percent that inpatient payments are of capitation is calculated

D. The percentages in B and C are multiplied together to arrive at the percent of capitation that is attributable to medical education costs.

On a statewide basis, approximately 4.4 percent of the MA capitation rate is derived from historical medical education payments under FFS. The MERC trust is funded at 95 percent of this amount, to assure capitation budget savings.

Distributions from the MERC trust fund are based on recommendations from a medical education and research committee of health care professionals and institutions appointed in accordance with state law. Through this process, historical medical education funds are expected to remain in the medical education field. The distribution formula is based on two factors.

- An education factor determined by the number of eligible trainees and statewide average costs per trainee, by type of trainee, in each program.
- A public program factor determined by the total volume of public program revenue (MA, GAMC, PMAP, and PGAMC) received by each training site as a percentage of all public program revenue received by all training sites in the trust fund pool.

Each factor is weighted equally. Training sites that receive no public program revenue are ineligible for payments from the PMAP funding transferred to the trust fund.

In addition, PMAP rates were increased $5.074 million per year, and this amount was transferred to the trust fund. The Legislature has directed that these funds be distributed as follows:

- Fifty percent to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians in rural areas, and efforts to increase the number of medical school graduates choosing careers in primary care.
- Twenty-four percent to the Hennepin County Medical Center for graduate clinical medical education.
- Twenty-six percent to fund grants to teaching institutions and clinical training sites for projects that increase dental access for under served populations and promote innovative clinical training of dental professionals.

Further,

- Beginning July 1, 2002 PMAP rates were increased by an additional $12.7 million per year; and
• Beginning July 1, 2003, PMAP rates were increased by an additional $4.7 million per year.

These amounts are also carved out and transferred to the trust fund. The additional $12.7 million available after July 1, 2002, and $4.7 million after July 1, 2003 are distributed to the University of Minnesota Academic Health Center for use in clinical graduate medical education.

2.23 County-Based Purchasing

In 1997 the Minnesota Legislature authorized the development of county-based purchasing (CBP) of MA services. County boards or groups of county boards may elect to contract with DHS to purchase or provide health care services for MA recipients who would otherwise be required or permitted to participate in PMAP. In January 1999, DHS submitted a request to CMS to amend PMAP+ to permit implementation of county-based purchasing. In response to CMS’s questions about the submission, an amended waiver request was submitted in September 1999. The first CBP project was approved in 2001. Currently, two groups of counties and a single county are operating as county-based purchasing plans. DHS continues to work with counties to ensure that county-based purchasing projects are responsive to CMS’s concerns. Proposals for additional county based projects will be submitted to CMS at the time that each project meets State county-based PMAP requirements.

2.231 Requirements for Participation

Counties are required to establish a local planning process that involves input from MA recipients, recipient advocates, providers, and representatives of local school districts, labor, and tribal governments, to advise on the development of a final proposal and its implementation. Counties intending to participate in county-based purchasing are required to submit certain information to DHS, including organization and governance plans, description of how risk will be managed, letters of intent to participate from providers, and options being considered for obtaining administrative services.

Counties that elect to implement county-based purchasing must do so for all services included in PMAP and must do so in accordance with PMAP requirements, except as otherwise specified. The county or group of counties must satisfy the Commissioner of Health that it meets the state licensing requirements for an HMO or a community integrated services network but is not required to obtain a certificate of authority.

DHS payments to county-based purchasing entities under this project are calculated not to exceed the payments that would otherwise be made to MCOs under PMAP for the applicable county or region. This payment is in addition to any administrative allocation to counties for managed care education, enrollment and advocacy. DHS and the Medicaid program are not liable for any costs incurred by a county that exceed the payments to the county-based
Section Two – Demonstration Design Overview

purchasing entity made under this project. A county-based purchasing entity may assign risk for the cost of care to a third party.

DHS may reject any proposal that substantially fails to meet the requirements outlined above (or any additional requirements imposed by CMS), that would substantially impair the State’s ability to purchase health care services in other areas of the state, would substantially impair an enrollee’s choice of care systems when reasonable choice is possible, or would substantially impair implementation and operation of MSHO or MnDHO. DHS may assume operation of a county’s purchasing of health care for MA enrollees in the event that the contract with the county is terminated.

2.232 Current CBP Projects

SouthCountry Health Alliance  The South Country Health Alliance (SCHA) CBP Project includes Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha and Waseca counties. A proposal for a demonstration waiver for the SCHA region was submitted to CMS in February 2001. Enrollment of all eligible recipients was completed by February 2002. Enrollment was approximately 12,100 in October 2004.

PrimeWest Health System  This county-based PMAP project is administered by PrimeWest Health System in Big Stone, Douglas, Grant, McLeod, Meeker, Pipestone, Pope, Renville, Stevens and Traverse counties in southwest and west central Minnesota. On June 26, 2003 the operational protocol amendment to permit implementation of the Prime West county-based purchasing project was approved. Project implementation began July 1, 2003. Enrollment in October 2004 was approximately 9,100 enrollees.

Itasca County  The Itasca County project met the Minnesota Department of Health requirements of a county-based purchasing arrangement as of November 13, 2002.

2.233 MSA Status

Under the provisions of 1931(a)(3) of the Balanced Budget Act of 1997, States must offer Medicaid beneficiaries in urban areas a choice of two or more managed care organizations. The regulation defines urban area as one which is considered to be a Metropolitan Statistical Area (MSA) by the U.S. Census Bureau. The U.S. Census Bureau has redefined the Rochester, Minnesota MSA to include the counties of Dodge and Wabasha, located in the southeast region of the state of Minnesota. The counties of Dodge and Wabasha are two of the nine counties that make up the South Country Health Alliance (SCHA) County-Based Purchasing Project. At the time the SCHA PMAP+ County-Based Purchasing Amendment was approved by CMS these two counties were not considered MSAs.
Section Two – Demonstration Design Overview

Dodge County Minnesota, with a population of 17,730, and Wabasha County, with a population of 21,610 are located approximately 80 miles south of Minneapolis and St Paul. The US Census Bureau considers these counties to be part of a metropolitan statistical area; however, it would be accurate to characterize Dodge and Wabasha counties as rural. While Dodge and Wabasha counties may be within a MSA, they are clearly rural for the purposes of evaluating choice of MCO.

A competitive procurement process was conducted in February 2001, which resulted in a contract being offered to the SCHA project. None of the nine counties making up South Country Health Alliance were participating in managed care prior to county-based purchasing. With UCare as its administrator partner, SCHA can pay particular attention to the goals of improved use of local resources and funding through integration and coordination of county health and social services with local medical services, within the SCHA service area. SCHA is based on the primary care management/medical home model of care. Enrollees select a primary care provider who is responsible for managing the enrollee’s services. UCare has contracts with both of the major care systems in the service area: Mayo Health System and Allina Health System. The network also includes the Mayo and Fairview/University of Minnesota Centers of Excellence, as well as other centers of excellence located in the Twin Cities. These centers are available to SCHA enrollees.

While all other aspects of county-based purchasing could continue under state plan managed care, the State will still require a waiver to allow these two counties to participate without choice of health plan.

2.3 Eligibility and Coverage Provisions

2.31 MinnesotaCare Expansion Populations

With FFP, the MinnesotaCare Program for Families with Children covers pregnant women with income up to 275 percent of FPG, children in families with income up to 275 percent of the federal poverty guidelines (FPG), and their parents with income of the lesser of 275 percent of FPG or $50,000. Effective July 1, 1995, expenditures for children under the age of 21 and pregnant women enrolled in MinnesotaCare became eligible for federal financial participation (FFP) as a part of Minnesota’s expanded Medicaid Program. Effective February 27, 1999, expenditures for parents and caretaker adults enrolled in MinnesotaCare became eligible for FFP.

Minnesota began claiming FFP for parents and caretaker adults with income at or below 175 percent of FPG for services provided on or after March 1, 1999. For parents and caretaker adults with income above 175 percent of FPG and at or below 275 percent of FPG, Minnesota began claiming FFP for services provided on or after January 1, 2001. Effective July 1, 2003 the gross
Section Two – Demonstration Design Overview

income standard for parents and adult caretakers was amended to the lesser of 275 percent of FPG or $50,000.

2.32 Coverage for Pregnant Women

Coverage for all pregnant women, including poverty related pregnant women, consists of the full MA benefit set for a qualified pregnant woman in accordance with §1902(a)(10)(A)(I)(iii).

2.33 Children Under Age Two

MA eligibility for children age one and under age two is determined using an income standard of 275 percent of FPG with no asset test. This extends the income standard of 275 percent of FPG that is applied to children under age one under the state plan, to include children under age two. This is an expansion of coverage under the state plan for children age one who would otherwise be eligible at 133 percent of FPG.

This provision improves access to postnatal and early childhood health care.

2.4 Medicaid Eligibility Quality Control Program

The PMAP+ waiver has allowed Minnesota to operate a MEQC system that differs from the traditional MEQC program activities required by regulation. In July 2004, Minnesota’s MEQC Pilot Project proposal for Federal Fiscal Year (FFY) 2005 was submitted to CMS Regional Office. Approval is pending.

2.5 Administrative Simplification

Elimination of Certain Six-Month Income Reviews  Six-month income reviews for medically needy recipients with only unvarying, unearned income or excluded income were discontinued.

This provision applies to medically needy recipient households who have only unvarying, unearned income. Unvarying, unearned income is defined as income from a source other than employment or self-employment that can reasonably be anticipated to be the same amount every month and for which changes, such as periodic cost-of-living increases, can be anticipated. Examples of this type of income include SSDI, Reemployment Insurance (Unemployment Compensation), veterans’ disability payments, and private pensions. Data matches currently exist to allow direct verification of SSDI, SSI, and Reemployment Insurance. The State hopes to develop additional matches with other sources such as the Veterans Administration.

This provision also applies to medically needy recipient households whose sole income is from a source excluded from consideration by law. Examples include federally excluded payments such
as certain tribal payments, German war reparations, WIC benefits, and earnings of a minor household member who is a full-time student.

For these two groups, income reported at the time of application or annual review is projected for 12 months. The amount of income reported is assumed to be the same unless the recipient notifies the local agency of a change. The State uses data matches where available to monitor and verify changes. Although income reports are not required, cases with spend downs are reviewed every six months to insure that the recipient continues to have sufficient medical expenses to meet the spend down.

Elimination of Quarterly Review for Extended or Transitional MA Recipients Quarterly income reviews no longer apply to transitional MA (TMA) recipients. In addition, the 185 percent of FPG income limit that normally applies during the second six months of the transitional eligibility period was eliminated. Enrollees are determined eligible for TMA once their increased earnings or loss of earned income disregard causes their countable income to exceed the 1931 standard. TMA is provided to the household for a 12-month period or until there is no longer a dependent child in the household, whichever occurs sooner. There are no income reviews conducted during the TMA eligibility period.

Gift Income Exclusion Gift income of less than $100 per month is excluded from countable income for all MA eligibility groups. Such income also is not required to be reported.

Elimination of Post-Partum Review for Certain Pregnant Women Women who were eligible under another basis before the pregnancy or who live with other eligible household members subject to the same basis and income limits are not required to reapply or have their eligibility reviewed until the household's next regularly scheduled review date after the end of the post-partum period.

2.51 Different Definition of “Family”

Under the MinnesotaCare waiver, “family” is defined differently than for MA. For MinnesotaCare eligibility, "family" means a parent or parents and their children; or guardians and their wards who are children; and grandparents, foster parents and relative caretakers residing in the same household; and includes children temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. "Family" also means an emancipated minor and an emancipated minor's spouse.

In general, families cannot choose to enroll only certain uninsured members in MinnesotaCare. Parents who enroll in MinnesotaCare must enroll any eligible children in MinnesotaCare or Medical Assistance, unless other insurance is available. If one child in a family is enrolled, all uninsured children must be enrolled. Children may be enrolled in MinnesotaCare even if their parents do not enroll. In families that include a grandparent, relative caretaker, foster parent or
Section Two – Demonstration Design Overview

legal guardian, the grandparent, relative caretaker, foster parent or legal guardian may apply as a family or may apply separately for the children.

2.52 Different Income Methodology

Under the MinnesotaCare waiver, income is determined using a different methodology than that used for MA eligibility. A complete description of the MinnesotaCare income methodology is found at Section 5.3.3 of the Operational Protocol.

2.53 Four-Month Penalty for Voluntary Terminations

An enrollee who voluntarily terminates coverage from the program or who is disenrolled for failure to pay the required premium is not eligible to reenroll until four calendar months after the date coverage terminates unless the person demonstrates good cause for voluntary termination or nonpayment and pays the unpaid premium for any month in which coverage was provided. The four-month penalty is not applicable to children under age 2 or pregnant women.

2.54 Continuous Eligibility

An enrollee remains eligible for MinnesotaCare regardless of the age or the presence or absence of children in the household as long as the enrollee:

- Maintains residency in Minnesota;
- Has annual income that is equal to or less than 275 percent of FPG and, for non-pregnant adults, is less than $50,000. Children in families whose income exceeds 275 percent of FPG may remain enrolled if 10 percent of their annual income is less than the annual premium for a policy with a $500 deductible through the Minnesota Comprehensive Health Association (MCHA). Children who are no longer eligible under this exception must be given a 12-month notice prior to disenrollment. Children in these families must pay full premium;
- Meets all other eligibility criteria; and
- Is continuously enrolled in MinnesotaCare or Medical Assistance.
Section Two – Demonstration Design Overview

2.6 Benefit and Cost-Sharing Provisions

2.61 Differing Benefit Sets

**Children and Pregnant Women** For children under age 21, MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients and, for pregnant women, MinnesotaCare covers the same benefit set as the state plan authorizes for qualified pregnant woman MA recipients.

**Caretaker Adults** For caretaker adults, MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients, except that the following services are not covered:

- Services included in an individualized education plan.
- Private duty nursing services.
- Dental care services other than:
  - diagnostic and preventive services;
  - basic restorative services; and
  - emergency services.

  These dental services are subject to a $500 annual benefit limit. Emergency services, dentures, and extractions related to dentures are not included in the $500 benefit limit.

- Orthodontic services.
- Nonemergency medical transportation services.
- Personal care services.
- Targeted case management services.
- Nursing facility services.
- ICF/MR services.

Outpatient mental health services other than diagnostic assessments, psychological testing, explanation of findings, medical management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.
Section Two – Demonstration Design Overview

2.611 Covered Access Services

**Interpreter Services.** MinnesotaCare covers sign and spoken language interpreters who assist an enrollee in obtaining MinnesotaCare eligibility and covered services.

2.62 Different Cost-Sharing and Premiums

2.621 Different Cost Sharing

The MinnesotaCare waiver permits greater cost-sharing than is permissible under Medicaid, including the following:

- For non-pregnant adult caretaker enrollees with family income less than or equal to 175 percent of FPG, MinnesotaCare applies a copayment of 50 percent of the fee-for-service MA payment rate for nonpreventive dental services, $3 per prescription, and $25 per pair of eyeglasses.

- For non-pregnant caretaker adult enrollees with family income greater than 175 percent of FPG but less than or equal to 275 percent of FPG, MinnesotaCare applies a copayment of $3 per prescription, $25 per pair of eyeglasses and coinsurance of ten percent of the charges for inpatient hospital services, subject to an annual out-of-pocket maximum of $1,000 per adult.

Copayments totaling $30 or more, paid by a pregnant woman after the date the pregnancy is diagnosed, are refunded.

2.622 Premium Payments

The MinnesotaCare waiver permits premiums that are higher than would be permissible under Medicaid to be charged to MinnesotaCare applicants and enrollees.

Applicants and enrollees must pay a premium to enroll and to continue enrollment in MinnesotaCare. The amount of premium is based on the family's gross annual family income. The amount of the premium is:

A. $4 per month for each child in a family whose income does not exceed 150 percent of FPG; plus

B. For any family member not included under Item A, the amount determined in accordance with premium tables; premium tables are updated annually in response to changes in federal poverty guidelines.

26
Section Two – Demonstration Design Overview

2.63 Crowd-Out Provisions

To address concerns at the inception of the MinnesotaCare program that this health coverage would supplant private, employment-based health coverage, crowd out provisions were added to eligibility requirements. First, applicants may not currently have other health coverage nor have had other health coverage during the four months immediately preceding the date coverage begins. Effective October 1, 2003 applicants who were recipients of Medical Assistance and had cost-effective health insurance that was paid by Medical Assistance are exempt from the four month requirement. Second, applicants may not have current access to employer-subsidized health coverage, and any employer-subsidized health coverage previously available was not lost because:

- the employer terminated coverage during the 18 months immediately preceding the date coverage would begin, except that this provision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage because the employer terminated health care coverage as an employee benefit, or
- the employee failed to take up coverage offered by the employer during an open enrollment period within the preceding 18 months.

2.7 MinnesotaCare Single Adults and Adults without Children

Minnesota covers single adults and adults without children with income less than or equal to 175 percent of the FPG in MinnesotaCare, but receives no FFP for these individuals. Coverage for this group differs from state plan coverage.

2.71 Benefit Set and Cost Sharing

Covered services for single adults and adults without children, with income above 75 percent of FPG but not exceeding 175 percent of FPG, include:

- Inpatient hospitalization benefits with a 10 percent copayment up to $1,000, subject to a $10,000 annual limit;
- physician services provided during an inpatient stay; and
- physician services not provided during an inpatient stay, outpatient hospital services, chiropractic services, lab and diagnostic services, and prescription drugs, subject to an aggregate cap of $2,000 per calendar year.
Section Two – Demonstration Design Overview

Covered services for single adults and adults without children, with income less than or equal to 75 percent of FPG include the same services as that of caretaker adults, except that there is a $10,000 per year limit on inpatient hospital services.

For non-pregnant single adults and adults without children, with family income that exceeds 75 percent of FPG and is less than or equal to 175 percent of FPG, MinnesotaCare applies a coinsurance of ten percent of the charges for inpatient hospital services, subject to an annual out-of-pocket maximum of $1,000, as well as copayments of $50 per emergency visit, $5 per non-preventative physician visits, and $3 per prescription up to a $20 monthly maximum. DHS does not receive FFP for this group.

For non-pregnant single adults and adults without children, with income less than or equal to 75 percent FPG, MinnesotaCare applies copayments of $3 per prescription and $25 per pair of eyeglasses.

2.72 Potential Additional Expansion

DHS would like to discuss with CMS the potential of using our unspent hospital disproportionate share allotment to finance the coverage of single adults and adults without children.
3.1 Organizational Structure of Minnesota Department of Human Services

The Minnesota Department of Human Services is the state Medicaid agency responsible for purchasing health services through fee-for-service and prepaid, capitated models for over 600,000 Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare enrollees. DHS’ Health Care administration supervises eligibility administration of MA and GAMC at the county level, administers the MinnesotaCare Program at the state level, purchases covered services, and provides for performance measurements and quality improvement of health care administration and service delivery for program enrollees.

3.2 Key Personnel of the Demonstration

3.21 DHS Commissioner

Kevin Goodno is the Commissioner of Human Services and is responsible for directing the activities of the Department, which include the publicly funded health care programs.

Christine Bronson serves as Acting State Medicaid Director.

Sandy Burge is responsible for contract negotiations, tribal relations and new waiver initiatives. Sandy serves as the primary contact for this waiver request.

Ann Berg is the manager of federal Centers for Medicare and Medicaid Services relations and federal Medicaid compliance.

Jan Kooistra is responsible for new waiver initiatives and serves as an additional primary contact for this waiver request.

Kathleen Vanderwall is responsible for new waiver initiatives and serves as an additional primary contact for this waiver request.

3.22 DHS Health Care Administration

Brian Osberg, Assistant Commissioner of Health Care Administration, is responsible for the publicly-funded health care programs and also serves as Acting Director for Health Care Purchasing and Service Delivery.

Pamela Parker is the Manager of the Minnesota Senior Care (MSC), Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MnDHO) projects.
Section Three – Organization and Administration of Demonstration

Karen Peed is the Manager of Health Plan Purchasing, including the management of PMAP contracts and education and enrollment for PMAP counties.

Vicki Kunerth is the Director of Performance Measurement & Quality Improvement, including quality assurance for managed care, performance management, and surveillance and integrity review.

Kathleen Henry is the Director of Health Care for Families with Children. This division is responsible for policy development and implementation related to eligibility for all MA, GAMC, and MinnesotaCare populations. The division supervises county administration of MA and GAMC eligibility and administers MinnesotaCare eligibility.

3.23 Administration of the Demonstration

3.231 MA Eligibility

MA Eligibility is currently supervised by DHS Health Care Administration and is administered by local county agencies.

3.232 MinnesotaCare Eligibility

MinnesotaCare eligibility is currently administered by DHS Health Care Administration. In 30 of Minnesota’s 87 counties, MinnesotaCare is also administered at the county agency. Enrollees in these counties have a choice of applying for MinnesotaCare at the county or at the State.

3.233 PMAP Purchasing

PMAP is administered by DHS Health Care Administration. State PMAP administration includes the following functions:

- contract negotiation and management.
- rate setting and financial management.
- quality improvement, utilization review, and consumer satisfaction analysis.
- program evaluation.
- management of the appeals process.
- oversight of the consumer education process.
- health plan payment.
Section Three – Organization and Administration of Demonstration

- reporting to health plans (e.g., enrollment reports).
- education of providers, health plans, advocates, and other interested groups.
- coordination of the Office of Ombudsman and coordination of advocate activities.
- coordination of the advocate network.
- coordination with county project officers.
- policy setting and dissemination.
- promulgation of rules.

County agencies are responsible for the following PMAP administrative functions:

- consumer education and recipient enrollment.
- coordination of the project at the county level including training of county workers.
- monitoring and evaluation of the project from the county’s perspective.
- project reporting to the county board and county advisory groups.
- information and technical assistance on the project to county staff, community and provider organizations, and the general public.
- identifying and responding to problem areas and problem cases.
- providing input to DHS in the development of PMAP policy.
- advocating for recipients who need assistance with accessing health care or with the appeal process.

3.234 MinnesotaCare Purchasing.

MinnesotaCare is administered by DHS Health Care Administration.

3.24 Public & Stakeholder Involvement

In preparation for the submission of the PMAP+ Waiver extension application, state agency staff held informal discussions with advocacy organizations, legislators and their staff, health plans, county agencies and other stakeholders regarding the proposed extension. On May 24, 2004 a request for public comment on the extension of Minnesota’s PMAP+ Waiver was published in
Section Three – Organization and Administration of Demonstration

the Minnesota State Register. This comment period provided an opportunity for public and stakeholder input on the current program and plans for the PMAP+ waiver extension.

DHS published official notice of a public meeting to receive comment on the waiver extension request in the Minnesota State Register on November 15, 2004. The notice included instructions about how to receive background and meeting materials. The notice was also mailed to advocacy organizations, health plans, county agencies and other stakeholders. A public meeting was held on December 17, 2004, and comments were accepted throughout the development of the waiver extension application. In addition, notice was sent to all Minnesota Tribal Chairs and Tribal Health Directors, in accordance with the federal requirement for adequate notice to American Indian tribes when states develop waiver requests. The waiver extension request was discussed at the November 17, 2004 Tribal Health Directors’ Meeting. A record of all comments received through these processes was maintained.

3.3 Managed Care Contract Development and Management

Contracts negotiations for a 15-month contract (October 1, 2003 – December 31, 2004) resulted in agreements with nine (9) Managed Care Organizations (MCOs): Blue Plus, First Plan of Minnesota, Health Partners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health Systems, South Country Health Alliance and UCare Minnesota. The PMAP, MSHO and MnDHO final contracts and documentation for the rate-setting methodology were submitted and approved by the CMS Regional office.

3.31 MCO Services Areas.

For a graphic representation of the location of MCO service areas and for information about the number of plans under contract in each county for PMAP and MinnesotaCare, refer to the maps at Appendices A1, A2 and A3.

3.32 Contract Development

DHS managed care development staff are responsible for initiatives and ongoing tasks associated with managed care expansion and implementation activities. They meet with county boards and tribal and county health and human services directors to introduce the concept and details of Minnesota health care programs provided under managed care models, answer related questions, obtain input, and develop planning and implementation processes and time lines. Development staff conduct informational meetings to discuss managed care issues with health care providers, and post-implementation meetings for county and tribal staff and MCOs after new areas are enrolled in managed care to ensure a smooth transition for new counties.

Development staff are also responsible for working with counties engaged in planning for county-based purchasing and tribes planning to implement tribal-based purchasing.
Section Three – Organization and Administration of Demonstration

provide information about parameters and requirements for these initiatives, as well as some technical assistance.

3.33 Contract Management

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

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

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

Contracts with health plans participating in PMAP were executed for the 2005 calendar year and are pending approval by CMS.

3.4 Managed Care Quality Improvement

Quality Improvement

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

Quality Strategy

Minnesota developed a Quality Strategy, as required by the Medicaid Managed Care Regulations. The draft strategy was posted on the DHS website, a notice and request for comment was published in the State Register on June 30, 2003, and it was discussed at the Medicaid Citizens Advisory Committee on June 26, 2003. The Quality Strategy will be updated to include EQRO recommendations and other appropriate changes annually.
Section Three – Organization and Administration of Demonstration

MCO Internal Quality Improvement System

MCOs are required to have an internal QI system that meets state standards set forth in the contract between the MCO and DHS. These standards are consistent with those required under state HMO and community integrated service network (CISN) certification requirements. The Minnesota Department of Health conducts audits of the HMO and CISN certification requirements. Beginning in January 2004, these audits are conducted once every three years.

External Review Process

DHS is required by federal law to conduct an external audit of quality of care provided by contracted MCOs. Studies have been conducted since 1988 by various organizations under contract with DHS. A list of External Quality Review studies is included as Appendix E. In addition, DHS meets annually with PMAP county staff to discuss issues or problems that have arisen during the previous year. DHS uses information gained during these meetings to help guide policy development and contract negotiations. DHS also maintains a Quality Advisory Committee that meets periodically to discuss quality assurance and improvement activities. A Quality Technical Committee meets every other month to advise DHS in the development of annual quality of care studies and other issues related to quality management.

2002/2003 External Quality Review (EQR) Studies. DHS conducted a study on Sexually Transmitted Diseases. This study is completed and findings of the STD study are published on DHS’s web site at: www.dhs.state.mn.us/studies.

Disenrollment Survey. DHS continues to conduct annual disenrollment surveys of enrollees who disenroll from their MCO’s by exercising their one-time change option or change MCOs at open enrollment. Starting in the year 2000 survey, MinnesotaCare clients were surveyed as well as Medicaid enrollees. Survey data is available on DHS’s web site at: www.dhs.state.mn.us/studies.

Survey results are summarized and sent to CMS in accordance with the Physician Incentive Plan (PIP) regulation. Survey results will also be provided to consumers who request the information and to MCOs and other interested parties, subject to data privacy limitations. Study reports on disenrollment and CAHPS surveys, as well as EQR studies, are posted on the public DHS web page.

Consumer Satisfaction

DHS contracted with The Meyers Group to conduct the 2003 DHS Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey. The Consumer Assessment of Health Plan Survey (CAHPS 2.0) Medicaid Module was used to survey the satisfaction of adults and seniors. Data from the 2003 DHS survey will become part of a pooled national database to facilitate cross-
Section Three – Organization and Administration of Demonstration

market comparisons and benchmarking efforts. Results of the 2003 DHS CAHPS survey are published on the public DHS web page.

Encounter Data

DHS now has eight years of encounter data and FFS data in the data warehouse. Some MCOs continue to struggle to provide treating provider information on the claims. Treating provider information is essential to monitor fraud, access, and quality. But, until there is a standardized National Provider Identification, it will be difficult to assure consistent information. Policies for the warehouse allow the system to use the same claim forms and provider, recipient, reference and pricing files as FFS. However, it does not apply all of the FFS edit or billing logic to the managed care service information encounter claim. Within this system, encounter claims are available to use in reviewing MCO performance to ensure that Minnesota health care program enrollees receive comprehensive health care.

Installation of Data Warehouse and Executive Information System (EIS)

The EIS/Data Warehouse consists of all health care claim, provider and recipient data collected by DHS during the most recent seven years. The system is a powerful tool for accessing data and defining the inter-relationships of data elements. The system allows DHS staff and managers to review program efficiency and effectiveness in a more flexible and timely manner and allows program staff access to data during program development as well as program evaluation.

DHS continues to add and refine data coming from the MMIS and MAXIS computer eligibility systems, as well as to add other data that expands the scope of analytical parameters, such as the recent addition of refugee data. DHS continues to make specialized models for specialized studies or interest areas, including the development of a specialized model to facilitate analysis and ensure completeness of encounter data from pre-paid health care organizations. DHS also continues to research availability of analytical tools and methodology to assist in health care analysis. Staff are evaluating report distribution mechanisms and are researching availability of software and methodology that would assist us in matching data between systems.

3.5 Consumer Education and Enrollment

Recipients are educated about their MCO options at the time they apply for MA. These new eligibles are offered choices from the prepaid MCOs available in their respective counties. This approach to enrollment and education of new eligibles facilitates a better understanding of PMAP and improves the likelihood that recipients will select MCOs that fit their medical needs.

The PMAP education and enrollment process for new eligibles is conducted by specially trained county staff. As recipients apply for MA, they are asked to attend a presentation at the county
Section Three – Organization and Administration of Demonstration

intake site and are directed to choose an MCO. County intake staff include the managed care presentation as part of the intake interview or direct recipients to the presentation site after the eligibility intake interview. Enrollment materials are mailed to recipients who do not attend a presentation. Assignment to an MCO occurs only if the recipient does not return the enrollment forms within a designated time period.

DHS has made the following modifications to the Minnesota health care program application process and materials to assure that potential enrollees receive the information necessary to make an informed choice regarding which health care program they apply for.

**Public Web Site on Minnesota Health Care Programs** DHS has added information to the Minnesota health care programs web site to clearly illustrate the differences between Medical Assistance and MinnesotaCare.

**MinnesotaCare and Medical Assistance Application Form** DHS has added language to the application form to highlight the basic differences between Medical Assistance and Minnesota Care. DHS will revise the instructions for where to send the application form, to better accommodate individuals who wish to apply for all programs.

**Minnesota Health Care Programs and MinnesotaCare Information Lines** DHS is providing an explanation of the differences between Medical Assistance and MinnesotaCare to people who call in to request an application or who inquire as to where to send their application. DHS has developed scripts along with instructions for DHS, county agency, and outreach grantee staff who receive call-ins from potential applicants. DHS has added information to the pre-recorded interactive voice response system to explain the differences between Medical Assistance and MinnesotaCare.

**Call-in Center** DHS will continue to pursue legislative approval to establish a single call-in center which would consolidate existing information lines into a single point of contact for individuals seeking to apply for Minnesota’s health care programs.

We are confident that these steps will help improve consumer awareness of the program options available and better guide potential enrollees toward the program appropriate to their individual circumstances. We do believe that to some extent this is working. We are seeing a reduction of approximately 300 persons per month in MinnesotaCare, and an increase of 1200 persons per month in MA, some of whom we believe are exiters from MinnesotaCare.

**3.51 Health Match**

DHS is working with Minnesota's counties, tribal governments, and other business partners to develop the Web-based Health Match system. Health Match will improve the way Minnesota
Section Three – Organization and Administration of Demonstration

Health Care Programs (MHCP) - including Medical Assistance, General Assistance Medical Care and MinnesotaCare - are administered statewide.

HealthMatch will combine functions of existing state computer systems with new technology and more comprehensive health care coverage information. HealthMatch will not only increase efficiency for some of the State’s most costly programs, but also advance a sound long-term vision for Minnesota’s publicly funded health programs.

For Minnesotans, Health Match will:

- Improve consumer access to publicly subsidized health care programs and services;
- Provide a tool for consumers to apply for health care programs easily over the Internet;
- Improve communication about eligibility for – and enrollment in – public health care programs.

For county and state health care eligibility workers, Health Match will

- Streamline eligibility determination functions and processes, allowing workers more time to focus on helping Minnesotans get and retain health care coverage;
- Enable workers to be more responsive to changes in eligibility rules;
- Improve program integrity by administering MHCP eligibility rules more consistently statewide.

The MAXIS system will still determine eligibility for cash and Food Stamps, and MMIS will still process claims. Health Match will interface with these systems and determine MHCP eligibility.

DHS is committed to improving access to health care programs, administrative efficiency and program integrity. HealthMatch is a major step toward these goals. This new system will better serve applicants and enrollees by offering individualized assistance with applications and clear information about benefits.

3.52 Implications of Health Match on PMAP Enrollment

The new HealthMatch system will change how Minnesotans are informed of and access MHCPs. It is anticipated that the ease of access to information on eligibility and enrollment will enable consumers to receive information about the programs that they are eligible for over the internet and make informed choices about the MHCP that best meets their needs.
The HealthMatch system will refer broadly to ‘Minnesota Health Care Programs’ and will not make distinctions by name between the MA and the MinnesotaCare Programs. These programs will be differentiated by identifying the benefit set(s) each individual qualifies for.

HealthMatch will also eliminate the need for consumers to visit their local county agency to enroll in MA. This is expected to reduce the disincentive to accessing MA that may have been related to the stigma associated with seeking public assistance.

These changes in consumer information and enrollment under Health Match will further the state’s effort to assure informed choice. It is anticipated that individuals who might otherwise have enrolled in MinnesotaCare may choose to forgo the premium-based program and apply for and enroll in Medical Assistance.

3.6 Advocacy and Ombudsman Activities

3.61 Grievance and Appeal Procedures

DHS has developed several mechanisms for protecting PMAP enrollees rights and fulfilling due process requirements. The grievances and appeals process is available to PMAP and MinnesotaCare enrollees who have problems accessing medically necessary care or have billing issues. Enrollees may file a grievance or appeal with the MCO and may file a state fair hearing through DHS. County advocates assist PMAP enrollees with these issues. The Office of Ombudsman for State Managed Health Care Programs assist PMAP and MinnesotaCare enrollees to resolve MCO service access and delivery issues. Enrollees are not required to exhaust grievance and appeal remedies at the MCO level prior to requesting a state fair hearing.

3.62 MCO Grievance and Appeal Procedures

A PMAP or MinnesotaCare enrollee, or a provider acting on behalf of the enrollee, may file a grievance or an appeal with the MCO either orally or in writing. A grievance is an expression of dissatisfaction about any matter other than an action, including, but not limited to, the quality of care or services provided, or failure to respect the enrollee’s rights. An appeal is a request for a review of an action, which means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner, the failure of the MCO to act within designated timeframes for grievances or appeals, or, for a resident of a rural area with only one MCO, the denial of an enrollee’s request to exercise his or her right to obtain services outside the network.

The MCO must make a determination as expeditiously as an enrollee’s health requires, but no later than ten days for an oral grievance, thirty days for a written grievance, and for appeals, no later than thirty days. An MCO may extend the timeframe for determination by fourteen days if
Section Three – Organization and Administration of Demonstration

requested by the enrollee, or if the MCO justifies both the need for more information and that the extension will be in the enrollee’s best interest.

Enrollees or providers acting on behalf of enrollees also have the right to request a state fair hearing with DHS any time during the grievance and appeal process. After a state fair hearing is filed, the hearing is scheduled within a few weeks. DHS’ appeals referees conduct the hearing and an order is written within ninety days of either the date the enrollee filed an appeal with the MCO, excluding the days it subsequently took the enrollee to file for the state fair hearing, or the date the request for the state fair hearing was filed, whichever is earlier. Enrollees may file a grievance or appeal with the MCO, file a state fair hearing with DHS, or file both procedures simultaneously. The MCO must comply with the decision in the state fair hearing promptly and as expeditiously as the enrollee’s health condition requires.

If an enrollee requests an appeal or a state fair hearing before either the date of the proposed action in the MCO’s DTR notice or the MCO’s determination of the grievance or appeal, the MCO may not reduce or terminate the service until 10 days after a written determination is issued in response to the appeal, or a written decision is issued by the State in the state fair hearing supporting the MCO’s action, or the enrollee withdraws the request for the appeal or the state fair hearing.

Enrollees also have the right to an independent external medical review of medical necessity determinations. The reviews are paid for by DHS, and reviewed as additional evidence in State Fair Hearings. DHS contracts with MAXIMUS for the independent external medical reviews.

There are two expedited processes, one for appeals and one for state fair hearings. If urgently needed care is denied by the MCO, the enrollee or his/her designated representative may request an expedited appeal through the MCO. The MCO is required to resolve and provide written notice for appeals as expeditiously as the enrollee’s health condition requires, but no later than 72 hours after receipt of the request. The second expedited process is for state hearings. If the enrollee requests an expedited state fair hearing, the DHS referee will conduct the state fair hearing and render a decision within 3 working days, or a time period commensurate with the level of urgency involved, based on the individual circumstances of the case.

3.63 Grievance, Appeal and State Fair Hearing

PMA enrolees receive a certificate of coverage (COC) from their MCO that provides a description of all grievance, appeal and state fair hearing rights and procedures available to enrollees, including the MCO’s internal system for the grievance and appeal process, the availability of an independent external medical review through DHS, the right to a second medical opinion within the MCO, and the ability of grievances, appeals and state fair hearings to run concurrently. Phone numbers of who to contact for the grievance and appeal procedures and how to access the state fair hearing process are also included in the MCO’s COC and other
Section Three – Organization and Administration of Demonstration

enrollee materials. A notice of grievance and appeal rights and the right to request a state fair hearing is sent to each enrollee with their initial enrollment materials each year at open enrollment and is included with the recipient notice that is sent whenever there are legislative changes to eligibility or covered services. County advocates and the DHS ombudsman also send the notice of rights each time an enrollee requests assistance with the grievance, appeal or state fair hearing process.

MCOs must notify the DHS ombudsman within three working days of the enrollee filing a written grievance or appeal and must include a copy of the grievance or appeal request. The MCO must also send a monthly electronic report of all written grievances and all appeals according to State specifications and a monthly summary report of oral grievances.

When services have been denied, terminated, or reduced (DTR), the MCO must notify the enrollee in writing of the action taken by the MCO in the DTR notice (also known as the Notice of Action in the federal managed care regulations). The DTR notice form must be prior approved by DHS and must include the following:

- a clear detailed description in plain language of the basis for the DTR and the enrollee’s rights;
- the action the MCO has taken or intends to take and the reasons for it;
- the type of service or claim that is being denied, terminated or reduced;
- the specific federal or state regulations or MCO policies that require or support the action;
- an explanation of the enrollee’s right, or provider on behalf of the enrollee with enrollee’s written consent, to file a grievance or appeal with the MCO, or requesting a state fair hearing with DHS, or both;
- the process the enrollee must follow in order to exercise these rights;
- the circumstances under which expedited determination is available for appeals and state fair hearings;
- the enrollee’s right to continuation of benefits;
- the notice of rights;
- the requirements and timelines for filing a grievance or appeal;
Section Three – Organization and Administration of Demonstration

- the right to seek an independent external medical review for consideration at state fair hearings;
- a language block in the languages required by Minnesota Statutes, Section 256B.69, subd. 27; and
- a phone number at the MCO where enrollees can call to obtain information about the DTR, including how to receive a translation of the notice.

A DTR notice must be provided ten days in advance of the MCO’s decision to reduce or terminate the enrollee’s ongoing medical services that an MCO provider (physician, osteopath, dentist, mental health professional, or chiropractor) has ordered. For standard and expedited authorizations that deny or limit services, notice must be provided as expeditiously as the enrollee’s health condition requires, and must not exceed ten business days following receipt of the request for standard authorizations, and within 72 hours of the receipt of the request for expedited authorizations. The MCO may extend the timeframe for resolution of standard and expedited authorizations by an additional fourteen days if the enrollee or the provider requests the extension, or if the MCO justifies a need for additional information and explains how the extension is in the enrollee’s interest.

3.64 County Advocates

Under Minnesota law, County Advocates are required to assist enrollees in each PMAP county. The advocates assist enrollees to resolve PMAP MCO issues. When unable to resolve issues informally, the county advocates help PMAP enrollees to state their complaints and to make informed decisions in resolving a complaint. County advocates provide assistance in filing grievances through both formal and informal processes, and are available to assist in the appeal process, including attending appeal hearings. State ombudsmen and county advocate staff meet regularly to identify complaint and appeal issues and to cooperate in resolving problematic cases.

3.65 Ombudsman Activities

The Ombudsman’s Office ensures enrollees receive medically necessary health care services through the complaint and appeals process. The Ombudsman’s Office also assists in resolving enrollee complaints regarding health care delivery and billing issues.
Section Four – Evaluation

Minnesota has taken a multifaceted approach to the evaluation of PMAP over the years. Evaluations have been designed to investigate the effectiveness of a prepaid, capitated Medicaid delivery system for a diverse group of Medicaid enrollees from a variety of perspectives. What follows is an overall description of many of the approaches taken to evaluate the various aspects of PMAP, both in the past and ongoing.

4.1 Historical Evaluation of PMAP

4.11 Federal Evaluation

4.111 Research Triangle Institute Study.

CMS contracted with the Research Triangle Institute (RTI) to conduct individualized and cross-project studies of the Medicaid managed care demonstration projects. RTI was charged with evaluating cost containment effects, utilization of services, quality of care, access to care, client satisfaction, and physician and institutional participation, using information gathered from encounter and client survey data, medical records, and case studies.

RTI reported that case management by health plans reduced utilization and that limitations on freedom of choice by enrollees did not adversely affect the quality of health care received.

4.112 Urban Institute Studies.

CMS (then HCFA) contracted with the Urban Institute to conduct several enrollee surveys. These studies concluded that, for children, there was little difference in utilization of, access to, or quality of or satisfaction with care between those enrolled in PMAP and those enrolled in fee-for-service MA. For adults, little difference in utilization or quality of care. PMAP enrollees were somewhat more likely to report a usual source of care, and that source was more likely to be a physician, than fee-for-service MA enrollees.

4.12 Health Plan Study

A 1992 study commissioned by the Medica Foundation evaluated input from 2000 people, including Medicaid enrollees and people who work in the community with public-sector consumers. The study concluded that health care provided by managed care plans must reflect the diversity of the Medicaid population, and must integrate social services with traditional medical services.
Section Four – Evaluation

4.13 Minnesota Department of Human Services Studies

4.131 Grievance panel survey.

DHS staff conducted a survey of those involved in the grievance panel process including panel members, staff, enrollees, health plan participants, enrollee advocates and volunteer advocates. The survey conclusion was that the grievance process would be extremely difficult to continue for the entire duration of the PMAP and would be too costly in staff and health plan. The report indicated that DHS oversight as a part of the external quality improvement review resulted in significant improvements in clinics visited in successive years.

4.132 Satisfaction surveys of providers.

State staff designed an instrument to survey providers involved in PMAP. Providers believed that quality health care was being delivered and, where the county was the health plan, the transition to a managed health care system caused few difficulties. Providers expressed dissatisfaction with levels of reimbursement, amount of paperwork required of them and level of enrollee knowledge of the managed health care system.

4.133 Inpatient utilization reporting (Utilization Data Definitions Committee).

One of the major outcomes of PMAP has been a redefinition of inpatient reporting requirements for state licensed health maintenance organizations to the state regulatory agency, the Minnesota Department of Health. Phase I covers the reporting of information regarding inpatient care, and Phase II deals with the reporting of information relating to ambulatory care. The committee elected to use proxies that would be reflective of important aspects of health care as provided by health plans. The committee decided to combine Phase I and Phase II of work under one cover, which has been published and is available from DHS.

4.134 Public health nursing study.

To address concerns raised by public health nursing agencies in both Hennepin and Dakota Counties, the State conducted a study to document the effects of prepayment on these agencies. Results suggested two tentative conclusions. First, although public health nurses often provide some social services in addition to medically necessary services covered under Medicaid, DHS is charged with paying for the costs of only those services that are medically necessary and covered under the state Medicaid plan.

The second conclusion was that greater attention to billing all possible reimbursable services would reduce some of the excessive costs that were being incurred by the public health nursing services.
Section Four – Evaluation

4.14 Managed Care Focus Groups

In 1996 DHS conducted two focus groups with seniors enrolled in Medicaid managed care and one focus group of county employees who work with seniors who are starting to enroll in managed care.

The two senior focus groups discussed consumer satisfaction with health care services and solicited suggestions for improving care and services in the managed care system. The county personnel focus group explored the perceptions and concerns of seniors making this transition to managed care from the point of view of the county workers and their knowledge about the needs and concerns of persons who are dually eligible (Medicare and Medicaid) in their counties.

4.15 Minnesota Health Data Institute Surveys

In 1995, the Minnesota Health Data Institute (MHDI), a public-private mechanism for coordination of data collection activities, conducted its first statewide consumer satisfaction survey of enrollees in both commercial and public health plans.

The analysis showed that the majority of public program enrollees reported being very or extremely satisfied with their health plans. Public program enrollees also report slightly higher ratings than private health plan enrollees for overall satisfaction with their health plan and access to care.

At the health plan level, DHS contracted with MHDI on the 1997 Health Plan Survey Project. Approximately 8,400 adults and children enrolled in the MinnesotaCare and the Medicaid Managed Care programs were surveyed. Findings from the survey showed an overall satisfaction rating of 8.43 on a 10 point scale (with 10 the highest rating). Senior respondents gave higher ratings than adult and child populations for most topic areas.

4.2 Continuing Studies

4.21 Consumer Satisfaction

DHS contracted with The Meyers Group to conduct the 2003 DHS Medicaid and MinnesotaCare Managed Care Member Satisfaction Survey. The Consumer Assessment of Health Plan Survey (CAHPS 2.0) Medicaid Module was used to survey the satisfaction of adults and seniors. Data from the 2003 DHS survey will become part of a pooled national database to facilitate cross market comparisons and bench marking efforts. Results of the 2003 DHS CAHPS survey are available on the public DHS web page 2004.
Section Four – Evaluation

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

4.23 Quality Strategy
Minnesota developed a Quality Strategy, as required by the Medicaid Managed Care Regulations. The draft strategy was posted on the DHS website, a notice and request for comment was published in the State Register on June 30, 2003, and it was discussed at the Medicaid Citizens Advisory Committee on June 26, 2003. The Quality Strategy was updated after review of the comments and will be updated on a regular basis.

4.24 Plan Switching (Disenrollment) Survey.
DHS continues to conduct annual disenrollment surveys of people who switch MCOs by exercising their one-time change option or change MCOs at open enrollment. Starting with the 2000 survey, in addition to Medicaid enrollees, MinnesotaCare clients were also surveyed. Survey results are summarized and sent to CMS in accordance with the Physician Incentive Plan (PIP) regulation. Survey results are also provided to consumers who request the information and to MCOs and other interested parties, subject to data privacy limitations. Study reports on disenrollment and CAHPS surveys, as well as EQR studies, are posted on the public DHS webpage.

4.25 Health Plan Quality Improvement Systems
MCOs are required to have an internal QI system that meets state standards set forth in the contract between the MCO and DHS. These standards are consistent with those required under state HMO licensure requirements. The Minnesota Department of Health conducts biennial audits of the HMO licensing requirements. Beginning in January 2004, these audits will be conducted once every three years.

4.26 External Review Process
DHS is required by federal law to conduct an external audit of quality of care provided by contracted MCOs. Studies have been conducted since 1988 by various organizations under contract with DHS. In addition, DHS meets annually with PMAP county staff to discuss issues or problems that have arisen during the previous year. DHS uses information gained during these meetings to help guide policy development and contract negotiations. DHS also maintains a Quality Advisory Committee that meets periodically to discuss quality assurance and
Section Four – Evaluation

improvement activities. A Quality Technical Committee meets every other month to advise DHS in the development of annual quality of care studies and other issues related to quality management.

4.27 Data Warehouse and Executive Information System (EIS)

The EIS/Data Warehouse consists of all health care claim, provider and recipient data collected by DHS during the most recent seven years. The system is a powerful tool for accessing data and defining the inter-relationships of data elements. The system allows DHS staff and managers to review program efficiency and effectiveness in a more flexible and timely manner and allows program staff access to data during program development as well as program evaluation. DHS continues to add and refine data coming from the MMIS and MAXIS computer eligibility systems, as well as to add other data that expands the scope of analytical parameters, such as the recent addition of refugee data. DHS continues to make specialized models for specialized studies or interest areas, including the development of a specialized model to facilitate analysis and ensure completeness of encounter data from pre-paid health care organizations. DHS also continues to research availability of analytical tools and methodology to assist in health care analysis. Staff are evaluating report distribution mechanisms and are researching availability of software and methodology that would assist us in matching data between systems.
## Section Five – Caseload and Cost Estimates

### 5.1 Case Load and Cost Estimates

#### MinnesotaCare Children

<table>
<thead>
<tr>
<th>SFY</th>
<th>Member Mo</th>
<th>Real PMPM</th>
<th>Expenditures</th>
<th>Annual % Change</th>
<th>Average % Change for 5 Year Period</th>
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<tr>
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<td>2007</td>
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<td>$231.50</td>
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#### MinnesotaCare Caretaker Adults

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<tr>
<th>SFY</th>
<th>Member Mo**</th>
<th>Real PMPM</th>
<th>Expenditures</th>
<th>Annual % Change</th>
<th>Average % Change for 5 Year Period</th>
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<td>1998</td>
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<td>2006</td>
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<td>2007</td>
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<td>$494.50</td>
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Section Six – Waivers Requested

6.1 Waivers Granted to Implement Phase 1

6.11 Waivers Granted under §1115(a)(1)

Minnesota was granted a waiver of the following provisions under the authority of §1115(a)(1) of the Act to enable the State to carry out Phase 1 of the MinnesotaCare Health Care Reform Waiver:

1. §1902(a)(1) of the Act as implemented by 42 CFR 431.50 and 434.25(a)(2).
   This waiver exempts the State from the requirement to administer medical assistance uniformly on a statewide basis.

2. §1902(a)(10) paragraph VII in the matter after 1902(a)(10)(F).
   This waiver exempts the State from the requirement that it limit medical assistance to pregnant women to services related to pregnancy and conditions which may complicate pregnancy.

3. § 1902(a)(23) of the Act and 42 CFR 431.51.
   This waiver permits the State to restrict the recipients’ freedom-of-choice of provider.

4. § 1902(a)(30) of the Act as implemented by 42 CFR 447.361.
   § 1902(a)(4) of the Act as implemented by 42 CFR 434.23.
   These waivers enable the State to enter into capitation contracts without the need to establish contract-specific upper payment limits.

5. §1902(a)(10) of the Act and 42 CFR 440.240(b).
   This waiver allows differences in the amount, duration, and scope of benefits provided to recipients.

6. §1902(a)(4)(A) of the Act as implemented by 42 CFR 431.806(a), 431.810 - 431.816, 431.820 - 431.822, and 431.865. 431.804 is also waived, except that the regulatory definitions of “claims processing error” and “state agency” shall continue to be applicable to the State. “Claims processing error” should also apply for a service not authorized under the terms of the demonstration.

   This waiver enables the State to employ a Medicaid eligibility quality control (MEQC) system which varies from that required by the cited statute and regulations.
Section Six – Waivers Requested

6.12 Expenditures Allowed under §1115(a)(2)

Under the authority of §1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under §1903) shall, for the period of the project, be regarded as expenditures under the State’s Title XIX plan.

1. Expenditures for capitation payments provided by managed care organizations not meeting the 75 percent Medicare/Medicaid enrollment limitation, as designated under §1903(m)(2)(A)(ii) and 42 CFR 434.26(a).1

2. Expenditures for capitation payments provided by managed care organizations which restrict enrollees’ right to disenroll on demand, as designated under §1903(m)(2)(A)(vi) and 42 CFR 434.27(b)(1).

3. Expenditures for prepaid capitation payments to non-health maintenance organizations, as designated under §1903(m)(2)(A)(I) and 42 CFR 434.20.

4. Expenditures to permit Medicaid coverage to children through age 20 with incomes at or below 275 percent of the Federal poverty level, who would not otherwise be eligible for Medicaid.

6.2 Waivers Granted Under Phase 2

Minnesota was granted waiver of the following provisions under the authority of §1115(a)(1) of the Social Security Act (the Act) to enable the State to implement Phase 2 of the MinnesotaCare Health Care Waiver:

1. 42 CFR 435.831(a)(1) requiring use of budget periods of not more than six months for all medically needy groups. The state would continue to follow 42 CFR 435.916 which requires annual eligibility reviews for all groups

2. §1925(b)(2) of the Act to eliminate quarterly review requirements.

3. §1902(e)(4), (5) and (6) of the Act which allows for automatic eligibility only through the end of the post-partum period.

4. §1902(a)(30) of the Act which requires that payment rates are consistent with efficiency, economy and quality of care.

1This provision is no longer required due to the enactment of §4703(a) of the Balanced Budget Act of 1997 (P.L. 105-33).
Section Six – Waivers Requested

5. §1903(i) of the Act which prohibits FFP for home health services unless the home health provider has provided to the State a $50,000 surety bond.

6.21 Expenditures Allowed under §1115(a)(2)

Under the authority of section 1115(a)(2) of the SSA, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) are, for the period of the project, regarded as expenditures under the State’s Title XIX plan.

1. Expenditures for payments to managed care organizations that do not provide an initial 90 day period within which an enrollee may disenroll without cause, and an annual right to disenroll on demand without cause, as required under Section 1903(m)(2)(A)(vi) and 42 CFR 434.27(b)(1).

2. Expenditures to permit Medicaid coverage to children through age 20 and pregnant women with incomes at or below 275 percent of the federal poverty level, who would not otherwise be eligible for Medicaid.

3. Expenditures to permit Medicaid coverage to parents and caretaker relatives of children who are enrolled in this demonstration or under the Medicaid State Plan with family incomes at or below 275 percent of the federal poverty level who would not otherwise be eligible for Medicaid.

4. Expenditures to permit Medicaid coverage for a 12-month period for medically needy Medical Assistance recipients, who are receiving only unvarying unearned income or whose sole income is from a source excluded from consideration by law, to the extent that they would be ineligible for Medicaid coverage if the State were to comply with the requirements related to the use of budget periods of not more than six month for all medically needy groups required by 42 CFR 435.831(a)(1).

5. Expenditures to permit Medicaid coverage to transitional Medical Assistance beneficiaries who have received extended assistance under Section 1925(a) of the Act, to the extent that they would be ineligible for coverage for the second six months if they were to comply with the quarterly reporting requirements of Section 1925 (b)(2)(B) because their income exceeds 185 percent of the gross family earned income, less child care expenses, during the second six-month period.

6. Expenditures to permit Medicaid coverage to pregnant women after the end of the post-partum period under Section 1902(e)(4)(5), without a review, until the time of the household’s next regularly scheduled eligibility review date, provided they were eligible for Medical Assistance prior to their pregnancy under another basis or live with other eligible household members subject to the same basis and income limits.
Section Six – Waivers Requested

7. Expenditures to permit the removal of medical education costs from the PMAP capitation rate to provide payment to a medical education trust fund for direct distribution to teaching entities.

8. Expenditures to permit Medicaid coverage to beneficiaries who receive gifts of money that do not exceed $100 per month, who might not be eligible for coverage if this gift were reported and included as countable income when determining program eligibility.

9. Expenditures to cover services for eligible pregnant women other than services related to pregnancy and conditions which may complicate pregnancy.

6.3 Waivers Requested to Implement PMAP+ Extension

6.31 Waivers Requested Under §1115(a)(1)

Minnesota requests waiver of the following provisions under the authority of §1115(a)(1) of the Social Security Act (the Act) to enable the State to implement Phase 2 of the MinnesotaCare Health Care Waiver:

1. §1902(a)(1) of the Act as implemented by 42 CFR 431.50 and 434.25(a)(2).

   This waiver exempts the State from the requirement to administer medical assistance uniformly on a statewide basis.

2. §1902(a)(10) paragraph VII in the matter after 1902(a)(10)(F).

   This waiver exempts the State from the requirement that it limit medical assistance to pregnant women to services related to pregnancy and conditions which may complicate pregnancy.

3. §1902(a)(10) of the Act and 42 CFR 440.240(b).

   This waiver allows differences in the amount, duration, and scope of benefits provided to recipients.

4. §1902(a)(4)(A) of the Act as implemented by 42 CFR 431.806(a), 431.810 - 431.816, 431.820 - 431.822, and 431.865. 431.804 is also waived, except that the regulatory definitions of “claims processing error” and “state agency” shall continue to be applicable to the State. “Claims processing error” should also apply for a service not authorized under the terms of the demonstration.

   This waiver enables the State to employ a Medicaid eligibility quality control (MEQC) system which varies from that required by the cited statute and regulations.
Section Six – Waivers Requested

5. 42 CFR 435.831(a)(1) requiring use of budget periods of not more than six months for all medically needy groups. The state would continue to follow 42 CFR 435.916 which requires annual eligibility reviews for all groups.

6. §1925(b)(2) of the Act to eliminate quarterly review requirements.

7. §1902(e)(4), (5) and (6) of the Act which allows for automatic eligibility only through the end of the post-partum period.

6.32 Expenditures Requested Under §1115(a)(2)

The State requests that, under the authority of section 1115(a)(2) of the SSA, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) are, for the period of the project, be regarded as expenditures under the State’s Title XIX plan.

1. Expenditures to permit two MSA counties to continue to participate in South Country Health Alliance (SCHA) County-Based Purchasing Project without choice of health plan as required under Section 1931(a)(3) and 42 CFR 438.52(a).

2. Expenditures to permit Medicaid coverage to children through age 2 and pregnant women with incomes at or below 275 percent of the federal poverty level, who would not otherwise be eligible for Medicaid.

3. Expenditures to permit Medicaid coverage to parents and caretaker relatives of children who are enrolled in this demonstration or under the Medicaid State Plan with family incomes at or below 275 percent of the federal poverty level who would not otherwise be eligible for Medicaid.

4. Expenditures to permit Medicaid coverage for a 12-month period for medically needy Medical Assistance recipients, who are receiving only unvarying unearned income or whose sole income is from a source excluded from consideration by law, to the extent that they would be ineligible for Medicaid coverage if the State were to comply with the requirements related to the use of budget periods of not more than six month for all medically needy groups required by 42 CFR 435.831(a)(1).

5. Expenditures to permit Medicaid coverage to transitional Medical Assistance beneficiaries who have received extended assistance under Section 1925(a) of the Act, to the extent that they would be ineligible for coverage for the second six months if they were to comply with the quarterly reporting requirements of Section 1925 (b)(2)(B) because their income exceeds 185 percent of the gross family earned income, less child care expenses, during the second six-month period.
Section Six – Waivers Requested

6. Expenditures to permit Medicaid coverage to pregnant women after the end of the post-partum period under Section 1902(e)(4)(5), without a review, until the time of the household’s next regularly scheduled eligibility review date, provided they were eligible for Medical Assistance prior to their pregnancy under another basis or live with other eligible household members subject to the same basis and income limits.

7. Expenditures to permit Medicaid coverage to beneficiaries who receive gifts of money that do not exceed $100 per month, who might not be eligible for coverage if this gift were reported and included as countable income when determining program eligibility.

9. Expenditures to cover services for eligible pregnant women described in §1902(a)(10)(VII) in addition to services related to pregnancy and conditions which may complicate pregnancy.

10. Expenditures to permit Medicaid coverage to children through age 20 with incomes at or below 275 percent of the Federal poverty level, who would not otherwise be eligible for Medicaid.