

Minnesota Medicaid Managed Care Comprehensive Quality Strategy

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Executive Summary

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

Together with its stakeholders, DHS revises its comprehensive quality strategy to renew its focus on health equity and improve the quality of health care for all Minnesotans enrolled in the Medicaid program.

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

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

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

Table 1 DHS goals and objectives for continuous quality improvement.

| Goals | Objectives |
|---|--|
| Goal 1. Increase Accountability and Transparency | DHS’ objective is to increase public transparency about Medicaid’s administration and outcomes. |
| Goal 2. High Value Care | DHS’ objective is to assure that the delivery system provides care and services in the appropriate quantity, quality and timing to realize the maximum attainable health care improvement at the most advantageous balance between cost and benefit. |
| Goal 3. Patient-centered Care | DHS’ objective is to eliminate barriers that prevent Medicaid enrollees from being active participants in their care. |
| Goal 4. Improve Quality of Care and Achieve Better Health Outcomes | DHS’ objective is to evaluate performance on quality metrics and engage health plans, providers, and enrollees in continuous quality improvement. |
| Goal 5. Increase Independence and Community Integration | DHS’ objective is to ensure that seniors and Minnesotans with disabilities have the opportunity to live close to their families, to live more independently, to engage in productive employment, and to participate in community life. |
| Goal 6. Integrate Mental Health and Increase Recovery from Substance Use Disorders | DHS’ objective is to integrate behavioral health services with primary care services and substance use services. |
| Goal 7. Achieve Racial Equity and Close Disparities | DHS’ objective is to procure high quality health care services for all Medicaid enrollees regardless of race, ethnicity, age, sex, or disability status. DHS’ objective is to be an anti-racist organization. |

Introduction

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

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

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

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

This quality strategy is comprehensive not only because it describes quality improvement activities under all types of payment arrangements – managed care, fee for service, and value-based payments – but also because this document includes a wealth of practical information about the state's and MCOs' duties with regards to federal managed care regulations (see Appendix A), the role of quality in demonstration waivers (see Appendices D and E), lists of quality measures (see Appendix F), and other helpful information.

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

¹ MN DHS, Mission and Vision. Available at: <https://mn.gov/dhs/general-public/about-dhs/who-we-are/#%3A%7E%3Atext%3DMission%2Cand%20achieve%20their%20highest%20potential>. Accessed on February 26, 2024.

Chapter I. Minnesota Health Care Programs

Minnesota Health Care Programs have a long history of helping Minnesotans meet their health care needs.² This report describes the current status of the DHS Managed Care Quality Strategy.

Most Minnesotans enrolled in Medicaid receive services through the state’s contracted managed care organizations (MCOs), which include both health maintenance organizations and county-based purchasing plans. Currently, MN DHS contracts with nine managed care organizations (MCOs) across five subprograms: Medical Assistance, MinnesotaCare,³ Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC).

The remaining enrollees receive services through the traditional fee-for-service system, where providers receive a payment from the DHS directly for each service provided to an enrollee. At the end of 2023, about 188,828 people were enrolled in the state’s fee-for-service system with 1,276,530 people enrolled in managed care.⁴

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

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

The State has also applied for federal waivers to test additional ways to deliver and pay for health care services. A waiver program allows the state to waive some requirements of the Medicaid state plan – the agreement between the state and the federal government – to better meet the needs of enrollees.

Some of the current waivers include the Substance User Disorder waiver that addresses the opioid crisis, the Reform 2020 waiver that supports older adults at risk of nursing home placement, the Prepaid Medical Assistance Project Plus waiver that expands Medicaid coverage for certain populations, the Long Term Services and Supports (LTSS) waiver that supports the growth of LTSS services, and five home and community-based waivers: the Developmental Disabilities Waiver, the Elderly Waiver, the Community Access for Disability Inclusion waiver, the Brain Injury waiver, and the Community Alternative Care waiver.

To support providers who participate in payment and care delivery innovations, the State may direct managed care plans to make payments to these providers in line with federal regulations (known as State Directed Payments or “SDPs”). Current contracts with managed care plans include provisions for SDPs

² See Medicaid Matters / Minnesota Department of Human Services (mn.gov) Accessed on January 11,2024.

³ While MinnesotaCare is held within the Families and Children managed care organization contract, MinnesotaCare is a Basic Health Plan under 42 CFR Part 600, and not a Medicaid program.

⁴ Total enrollment from Medicaid Matters Renewal dashboard / Minnesota Department of Human Services (mn.gov) . Managed Care enrollment from Minnesota Managed Care Enrollment Figures Totals Reports (state.mn.us)

for the following benefits or programs:

- Behavioral Health Homes;
- Certified Community Behavioral Health Clinics;
- Dental Services;
- Long-Acting Reversible Contraceptives;
- Managed Long Term Services and Supports;
- Medical Transportation;
- Certain Mental Health Services;
- Certain SUD Programs;
- A safety net hospital for enrollees in a large metro county in the state (Hennepin County Medical Center);
- Integrated Health Partnerships program, an ACO-type payment arrangement.

The current SDPs support providers by requiring provider payment of at least the fee-for-service fee schedule, except for the IHP program and the Hennepin County Medical Center program. The IHP program functions as an accountable care organization strategy. The Hennepin County Medical Center program supports this safety net health system by payments at an average of their commercial insurance payments. Further information on the SDPs is found in Appendix G: State Directed Payments.

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

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

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

The Minnesota Medicaid program performs comparably to other States on access to preventive care services like cancer screenings. Almost 54 percent of adult women in the Minnesota Medicaid programs were screened for breast cancer and cervical cancer which is above the median rate calculated among the states that reported the measures.⁵

Indicators of potentially preventable complications show that chronic conditions like diabetes, asthma, and heart failure are being well managed compared to other states. Blood pressure is well controlled among adult Minnesotans diagnosed with hypertension. Also, compared to other states, the ratio of asthma controller medication to total asthma medication among children and adults is indicative of good asthma control.⁶

Children in the Minnesota's Medicaid program, however, are not accessing recommended well-child visits during the first years of life at the same rate as children in other states. In fact, Minnesota's well-child visit rates are below the 25th percentile of the states' median.⁷ Moreover, although only a small percent of newborn weigh less than 2,500 grams⁸, a disproportional percentage of low birthweight babies are Black and Native American.

When we compared the quality of care provided to Medicaid enrollees with the quality of care provided to the commercially insured populations, we saw that Medicaid enrollees are not receiving preventive care services at the same rate as their commercially insured counterparts.

Also, Medicaid enrollees do not achieve optimal control of chronic conditions at the same rate as commercially insured patients.⁹

The Medicaid population in Minnesota not only receives lower quality of care compared to commercially insured patients, but Black Americans and Native Americans receive the lowest quality of care among Medicaid enrollees.¹⁰

Due to the COVID-19 pandemic, rates for vaccinations, primary, and preventive services declined during the 2020 calendar year. Going forward, the decline in utilization of services may have significant impact

⁵ Medicaid.gov. Medicaid & CHIP in Minnesota. Quality of Care in Minnesota. Adult Quality Measures Data. Care for Acute and Chronic Conditions. Available at: <https://www.medicaid.gov/state->

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Minnesota Community Measurement. Minnesota Disparities by Insurance Type. Available at: <https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20Insurance%20Type/2021-MY-Disparities-by-Insurance-Type.pdf> Accessed on January 11, 2024.

¹⁰ Ibid.

on long-term health outcomes for children and under-resourced populations. DHS is closely monitoring and initiating activities to ensure that Medicaid enrollees do not fall further behind.

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

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

Chapter III. Goals and Objectives for Continuous Quality Improvement

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

Goal 1: Increase Accountability and Transparency

As a steward of public funds, DHS must hold its contracted managed care organizations (MCOs) accountable for the quality of the health care services MCOs provide to Medicaid enrollees. The MCO procurement process – the process of selecting an MCO – gives DHS the opportunity to reset the state's expectations of MCOs performance and replace poorly performing contractors.¹¹ DHS evaluates MCOs' performance through the use of consistent quality and performance measures. DHS also aims to increase public transparency about Medicaid's administration and outcomes through managed care reporting webpages (including monthly enrollment data)¹², public dashboards^{13, 14} and Medicaid Matters report.¹⁵

Goal 2: High Value Care

DHS aims to provide high value health care to Medicaid enrollees. Value is understood here as a ratio of quality over cost: the better the quality and the lower costs, the higher the value of provided services. The value of services provided is determined in relation to long-term health care outcomes and satisfaction of principal consumers. DHS' objective is to assure that the delivery system provides care and services in the appropriate quantity, quality and timing to realize the maximum attainable health care improvement at the most advantageous balance between cost and benefit.

Goal 3: Patient-centered Care

The most effective and efficient health care delivery system includes the patient in the health care decision making process. In order for patients to participate, they must have access to the prerequisite health care information. Medicaid patients are surveyed about their experiences with health plans and health care providers. Information about enrollees' experiences is also gathered through community and stakeholder engagement activities. DHS' objective is to eliminate barriers that prevent Medicaid enrollees from being active participants in their care.

¹¹ Georgetown University Health Policy Institute. Medicaid Managed Care Procurement: Opportunity for Transparency? Available at <https://ccf.georgetown.edu/2020/11/18/medicaid-managed-care-procurement-opportunity-for-transparency/> Accessed on January 11, 2024.

¹² MN DHS. Managed Care Reporting. Available at: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/> Accessed on January 11, 2024.

¹³ MN DHS. Investments in Health Care Available at: <https://mn.gov/dhs/medicaid-matters/investments-in-health-care/> Accessed on January 11, 2024.

¹⁴ MN DHS. Oral Health. Available at: <https://mn.gov/dhs/medicaid-matters/oral-health/> Accessed on January 11, 2024.

¹⁵ MN DHS. Medicaid Matters. Available at: <https://mn.gov/dhs/medicaid-matters/> Accessed on January 11, 2024.

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

DHS continues to design programs, benefits, and payment structures to improve care and health outcomes for Medicaid enrollees. Minnesota's Medicaid program includes a comprehensive array of services for Medicaid enrollees at different stages of life and across different health care settings. We also leverage research about social drivers of health to improve quality and access to services for all enrollees who need them. For example, the 2020 report on deep poverty documents how living in deep poverty leads to poor health and provides recommendations on how to improve the health of people living in deep poverty.¹⁶ DHS' objective is to effectively evaluate performance on quality metrics and engage health plans, providers, and enrollees in continuous quality improvement.

Goal 5: Increase Independence and Community Integration

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

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

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

Goal 7: Achieve Racial Equity and Close Disparities

DHS' goal is to procure high quality health care services for all Medicaid enrollees regardless of race, ethnicity, age, sex, and disability status. However, for years there have been measurable disparities in health care outcomes identified by race and ethnicity, largely due to structural racism and inequity. The department has implemented specific policies to help close racial disparities. DHS' objective is to be an anti-racist organization.

Equity analysis is incorporated into new legislative proposals, which determine the population and scope of every benefit, and each DHS project is evaluated from the perspective of how it will positively or negatively affect disadvantaged groups. Quality measures are stratified by race, ethnicity, age, sex, as well as payer type to identify any health care disparities. MCOs and IHP providers receive financial incentives for improving equity in health care.

The previously described goals and objectives guide DHS' quality improvement efforts. DHS currently oversees a number of programs that include well-structured quality improvement components. These

¹⁶ MN DHS. Deep Poverty and Health Report. Available at: <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-8061-ENG>

quality improvement initiatives and interventions are described in the next chapter.

Chapter IV. Quality Improvement Initiatives

In this chapter, we discuss the numerous quality improvement efforts occurring throughout the department where DHS collaborates with our partners to support the needs of communities we serve. Quality improvement requires collaboration. This comprehensive quality improvement strategy provides an opportunity to coordinate all of the initiatives. The following initiatives are assets and tools that we use to improve the quality of health care for Medicaid enrollees.

COVID-19 Response, 2020 and Ongoing

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

During the COVID-19 public health emergency, MN DHS issued extensive modifications to public program requirements to ensure access and continuity of enrollee care. Among other flexibilities, current Medicaid enrollees retained eligibility and benefits without the need to reapply. The prescription drug limits on maintenance medications for certain therapeutic drug classes have been increased from 34 days to 90 days. Quarterly reassessments of services for older adults and people with disabilities were conducted by phone instead of in-person. Telemedicine was also broadened in primary care as well as in mental health and substance use disorder treatments.^{17, 18} Since the end of the pandemic, several of these benefits have been retained in the state plan, including extended prescription limits, telemedicine changes, and changes in eligibility including continuous eligibility for children under age six. MN DHS also worked with contracted MCO partners and the Minnesota Department of Health (MDH) to implement a focused COVID-19 vaccine outreach campaign to assist members living in zip codes with high Social Vulnerability Index (SVI) scores in getting their initial vaccination with notable positive results.¹⁹

Medicaid Core Set Measures

Supports DHS' Goals 1, 4 and 7

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

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

Starting in 2024, reporting will be mandatory. States will have to report child core set measures (the Bipartisan Budget Act of 2018, P.L. 115-123) and behavioral core set measures including the adult core set (the SUPPORT for Patients and Communities Act, P.L. 115-271). The state is prepared to report measures that use the administrative method of data collection (i.e., information that is collected through claims). Some quality measures require clinical information (e.g., blood sugar level or blood

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

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

¹⁹ <https://www.health.state.mn.us/diseases/coronavirus/vaccine/mnsvivaxsum.pdf>

pressure rate) that DHS cannot access directly; this type of quality measure can be collected through chart reviews as in the NCQA audits performed on many of our MCOs.

The FFY 2024 Child Core Set includes quality measures (all mandatory) organized into six categories:

1. Primary Care Access and Preventive Care,
2. Maternal and Perinatal Care,
3. Care of Acute and Chronic Conditions,
4. Behavioral Health Care,
5. Dental and Oral Health Services,
6. Experience of Care.

The FFY 2024 Adult core set includes quality measures organized into six categories:

1. Primary Care Access and Preventive Care,
2. Maternal and Perinatal Care,
3. Care of Acute and Chronic Conditions,
4. Behavioral Health Care,
5. Experience of Care,
6. Long-term Services and Supports.

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

Annual External Independent Reviews

Supports DHS' Goals 1 and 4

Medicaid Managed Care External Quality Review

Each year, in compliance with 42 CFR §438.350 the External Quality Review Organization (EQRO; IPRO of New York State) performs an independent review of the quality outcomes, timeliness of and access to the services included in the contract between DHS and each MCO. The review focuses on federally mandated quality review activities.

The EQRO is charged with assessing the strengths and weaknesses of the MCOs and reporting on their:

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

For the purpose of the external quality review, DHS collects contractually required reports directly from the MCOs, including the annual MCO Quality Work Plans and the Quality Assessment and Performance Improvement Program Evaluations. The external quality review also includes DHS initiatives such as the annual Minnesota Health Care Disparities Report and Minnesota's response to the opioid crisis.

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

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

Triennial Compliance Assessments

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

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

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

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

Managed Care Organizations' Performance Improvement Projects

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

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

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

DHS publishes the [summary reports online as part of the Annual Technical Report](#).²⁰

The 2021-2023 PIPs focused on two topics: 1) Healthy Start for Mothers and Their Children (for Families and Children contracts) and 2) Improving Comprehensive Diabetes Care (for Seniors and SNBC contracts). The 2024 PIPs continue to focus on two topics: 1) Healthy Start for Mothers and Their Children (for Families and Children contracts) and 2) Addressing the Impact of Behavioral Health Diagnoses on Selected Physical Health Conditions or Diseases (for Seniors and SNBC contracts). The disease selected is diabetes.

DHS' Self-reported MCO Quality Improvement Initiatives

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

MCOs submit annual summaries of how their quality improvement program identifies, monitors and works to improve service and clinical quality issues for Minnesota Health Care Program enrollees. Each summary highlights what each MCO considers significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement. The [reports](#) are posted on the DHS public website.²¹

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

- Blue Plus: www.bluecrossmn.com/qualityimprovement
- HealthPartners: www.healthpartners.com/hp/about/understanding-cost-and-quality/quality-improvement/index.html
- Itasca Medical Care: www.co.itasca.mn.us/657/Community
- Medica: www.medica.com/providers/quality-and-cost-programs/quality-improvement-program
- Hennepin Health: <https://www.hennepinhealth.org/about-us/quality-management>
- PrimeWest Health: <https://primewest.org/annual-report>
- South Country Health Alliance: http://mnscha.org/?page_id=5924
- UCare: <https://www.ucare.org/providers/policies-resources/quality-initiatives>
- UnitedHealthcare <https://www.uhc.com/communityplan/minnesota/plans/quality>

Managed Care Withholds

Supports DHS' Goals: 1, 2, and 4

The overall purpose of the financial withhold is to emphasize and focus MCO and health care provider improvement efforts in the areas of prevention or early detection and screening of essential health care services. The measures are tied to decreasing racial disparities. Specifically, the DHS-MCO contract

²⁰ MN DHS. Managed care: quality, outcome, and performance measures. MCO performance improvement projects. Available at <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp> Accessed on February 26, 2024.

²¹ MN DHS. Managed care: quality, outcome, and performance measures. HEDIS and quality assurance reports. Available at <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp>. Accessed on February 27, 2024.

allows DHS to withhold a percentage of the capitation payments due to the MCO, only to be returned if the MCO meets performance targets determined by the state. The performance targets are based on improvement over previous annual performance rates.

Measures for PMAP and MinnesotaCare members:

- Childhood immunization rates
- Child and adolescent well care visits rates
- Well child visits in first 30 months
- Prenatal and postpartum care
- Follow-up after hospitalization for mental illness
- Initiation and engagement substance use disorder treatment;
- Healthcare equity community engagement activities
- No repeat deficiencies on quality assurance examinations administered by MDH.

Measures for SNBC members:

- Annual dental visits;
- Ambulatory care – emergency department visits;
- Follow-up after hospitalization for mental illness;
- Follow-up after emergency department visit for people with multiple high-risk chronic conditions;
- Service accessibility/care plan audit;
- Stakeholders group reporting and;
- Senior health risk assessment;
- Colorectal cancer screening
- Ambulatory care emergency department visits
- Follow-up after emergency department visit for people with multiple high-risk chronic conditions
- Healthcare equity stakeholder or community engagement activities; and
- No repeat deficiencies on quality assurance examinations administered by MDH.

Measures for Senior members:

- Annual dental visits;
- Dental network equity;
- Dental service utilization;
- Initial Senior health risk assessment;
- Colorectal cancer screening;
- Follow-up after emergency department visit for people with multiple high-risk chronic conditions;
- Emergency department utilization rates;
- Hospital admission rates;
- 30-day hospital readmission rates;
- Service accessibility/care plan audit;
- Stakeholders group reporting, and
- No repeat deficiencies on quality assurance examinations administered by MDH.

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

specifications are posted on the DHS website.²²

Managed Care Grievances

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

The Managed Care Ombudsperson office collects grievance data from all managed care organizations (MCOs) on a quarterly basis for all healthcare service deliverables. Data reported to the Managed Care Ombudsperson office are reviewed to identify trends and analysis to ensure quality of care and contract compliance for managed care members.^{23, 24}

A grievance or complaint is defined as a member's expression of dissatisfaction about the quality of care or service(s) provided by the MCO or a contracted provider. Managed care members can file a grievance with their health plan orally or in writing. Oral grievances are required to be resolved within (10) days and results are communicated verbally to members. Written grievances are required to be resolved within (30) days with a written resolution mailed to the member.

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

DHS compiles an annual report summarizing data on enrollee grievances and appeals filed with MCOs including MCO denials, terminations or reductions of health services; and the managed care state appeal system (state fair hearings) with DHS. The five (5) most common grievances reported across all MCOs between 2022 and 2023 were:

1. Transportation (i.e., unassisted non-emergency medical transportation)
2. Not Applicable – no service associated with this grievance (i.e., not applicable-not related to a service)
3. Professional Medical Services (i.e., other, specialty care, primary care)
4. Dental (i.e., preventative, dentures, crowns, and fillings).
5. Pharmacy (i.e., formulary, other, non-formulary)

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

The Managed Care Ombudsperson office may bring grievance concerns and questions directly to the MCO, discuss trends at the quarterly MCO Workgroup meeting or use the MDH Audit review to address

²² MCO incentive and withholds specifications, available at <https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/mcos/contract-information-forms-and-resources/incentive-and-withhold-specifications/>

²³ Minnesota Statutes 2020. M.S. § 62Q.68 – 62Q.73 Available at: <https://www.revisor.mn.gov/statutes/cite/62Q/pdf> Accessed on February 26, 2024.

²⁴ Minnesota Statutes 2020 M.S. § 256B.69, subd. 20. Available at: <https://www.revisor.mn.gov/statutes/cite/256B.69> Accessed on February 26, 2024.

concerns and ask questions. If the data suggests there may be an MCO contract issue or a coverage concern, the Ombudsperson office brings concerns to DHS management.

Consumer Experience

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

Understanding patients' experiences with health care is an essential component of health care quality. DHS measures patients' experience of care using Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS is a program spearheaded by the Agency for Healthcare Research and Quality (AHRQ). Different CAHPS surveys are designed to assess patients' experience in different health care settings: at a hospital, in a clinic, with home and community-based services, or with health plans. All CAHPS surveys are standardized and tested for validity to allow comparisons.²⁵

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

- The *Adult Health Plans CAHPS* survey assesses enrollees' experience with their health plan and health care providers. DHS administers this survey to our managed care and fee-for-service enrollees. The survey consists of standardized questions, standardized supplemental questions as well as other supplemental questions that have not been standardized but are of interest to DHS. The most recent survey includes supplemental questions developed by DHS to assess racial equity. The Adult Health Plans CAHPS survey goes hand in hand with the evaluation of enrollees' grievances and with community and stakeholder engagement activities. The survey results are submitted to the AHRQ Data Warehouse for the purpose of Medicaid Adult Core Set reporting. The results are included in the ATR compiled by the EQRO and in open enrollment materials for new members. The survey results are also published on the DHS website in a form of an annual summary report.²⁶
- The *Minnesota Senior Health Options (MSHO) CAHPS* survey assesses experiences of senior enrollees enrolled in the Medicare-integrated Minnesota Senior Health Options (MSHO) program. DHS and CMS collaborate to send MSHO enrollees a single, annual CAHPS survey. The survey is design to assess patients' experiences with the Medicare Advantage and Medicare Advantage Prescription Drug plans. DHS adds questions on topics of special interest to the state Medicaid agency. DHS contracts with a vendor to collect the results from CMS and to write a report summarizing experiences of MSHO enrollees. The annual report is available on the DHS website.²⁷

²⁵ Agency for Healthcare Research and Quality. About CAHPS. Available at: <https://www.ahrq.gov/cahps/about-cahps/index.html> Accessed on February 26, 2024.

²⁶ MN DHS. Managed care: Quality, outcome and performance measures. Enrollee Surveys and Grievances. Consumer satisfaction survey results 2022, (DHS-5541N). Available at: <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-5541N-ENG> Accessed on February 26, 2024.

²⁷ MN DHS. Managed care: Quality, outcome and performance measures. Enrollee Surveys and Grievances. MSHO consumer satisfaction survey results 2019, (DHS-7396C). Available at: <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-7396C-ENG> Accessed on February 26, 2024.

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

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

Integrated Care System Partnerships

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

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

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

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

Examples of the assortment of ICSPs implemented with various providers, target populations and

payment models under different MCOs:

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

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

Examples of outcome measures ICSPs may choose:

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

MCOs must report annually on a standardized template for each ICSP including the payment model, performance measures, outcomes and next steps planned to increase effectiveness of each ICSP. Some key takeaways are:

- The state sets the larger vision, and the MCO in cooperation with providers, together move forward through the ICSPs to foster a culture of learning to 1) support improved provider performance, 2) incentivize provider efficiency, 3) reduce unnecessary spending, and 4) improve health outcomes.
- Flexibility is important as MCOS move providers of various sizes serving diverse populations

- to a higher degree of integration, accountability and increased risk. The goal is to pay for good outcomes, high quality care and to reward strongly performing providers.
- ICSPs are an opportunity to provide quality health care for Minnesotans while transforming the relationship among health care users, providers and payers.

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

Integrated Health Partnership, a Value-Based Payment Program

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

The MN DHS value-based payment initiative is called the Integrated Health Partnership (IHP) program. The IHP program uses direct contracts with providers to enhance accountability through the potential for shared savings or losses, and creating incentives for quality improvement.

From its beginning in 2013 through 2022 providers participating in the IHP program have shown a total savings of \$540.9 million dollars. From that overall savings, a total of \$298.1 million was shared out to IHP participants through shared savings and quarterly population-based payments used to support enhancements to care coordination, care delivery innovations, and health equity interventions.

The goal of the demonstration is to improve the health of the Medicaid population by delivering high-quality, lower cost care. In this effort, the State contracts with a consortium of health partnerships, each of whom works with an associated group of Medicaid providers. The providers work together to coordinate their efforts, with the goal of achieving a demonstrable level of savings when compared to targets developed by the State. Providers that demonstrate an overall savings across their population, while maintaining or improving quality of care, may receive a portion of the savings. Providers that cost more over time may be required to pay back a portion of the losses. Performance is reviewed annually.

The methods used to determine savings and quality are the same for all providers, except when a provider's patient population differs measurably from the average Medicaid population. In those instances, the State may apply quality measures that are more appropriate to the type of patients served by the provider. For example, a quality measure related to the provision of cancer screening for adults may be substituted with a child-focused wellness measure when evaluating quality for a provider of pediatric services. IHP quality measures are listed in Attachment F.

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

IHP 2.0 Track 1 – Population Based Payment

IHP 2.0 includes a population-based payment (PBP). For the purpose of the population-based payment, IHPs are evaluated on health equity, quality, and utilization measures. Each IHP is required to design an intervention to address specific health care disparities observed among the IHP's population. The role of the health equity measures is to gauge the effectiveness of each intervention as the State reviews both

qualitative and quantitative information. For the qualitative aspect, the IHP must complete an annual assessment of the intervention, reporting on predetermined metrics and providing narrative detail on the intervention’s progress.

Utilization and clinical quality measures make up the quantitative aspect and these measures are based on the goals of the equity intervention. Some examples of current IHP health equity interventions include: community collaborative addressing food insecurity, integration of behavioral and physical health to support adolescents who screen positive for depression, an opioid management program, and several interventions focused on screening for social determinants of health and connection to needed services.

IHP 2.0 Track 2 – Population-Based Payments and Total Cost of Care

While all IHP 2.0 participants receive population-based payments only some enter into a shared risk arrangement that requires a calculation of the total cost of care (TCOC). For the purpose of the TCOC model, IHPs are evaluated for quality on a core set of measures to determine the share of any savings an IHP will receive or losses that must be paid to the State. In each demonstration year, fifty percent of an IHP’s portion of potential shared savings is contingent on its overall quality score. Similarly, fifty percent of an IHP’s shared losses can be mitigated based on overall quality performance. The overall quality score is calculated based on IHP performance on measures and specific goals of the following domains:

- The **quality core set domain** which focuses on monitoring performance for a variety of conditions and aspects of care quality in the following categories: Prevention and Screening for Adults, Care for At-Risk Populations, Behavioral Health, Patient-Centered Care, and Quality of Outpatient Care.
- The **care for children and adolescents domain** which includes preventive health measures for those 21 years of age and younger. These measures focus on well visits and immunizations, as well as an oral health component.
- The **quality improvement domain** which focuses solely on quality improvement for select measures. The measures in this domain focus on priority areas for the IHP program and the state, specifically focusing on improving quality for the selected measures.
- The **closing gaps domain** which focuses on reducing and eliminating disparities in care for different populations. Currently, this domain will monitor disparities in care for the MHCP population compared to that of the commercial population for select measures.
- The **equitable care domain** includes an array of measures that align with the State’s goals to eliminate health disparities and ensure equitable care across racial and ethnic groups. The IHP focuses on two measures from this group, working toward closing gaps in care.

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

Table 2: DHS Goals and IHP Objectives

| DHS Goals | IHP Objectives |
|---|---|
| DHS Goal 1: Increase Accountability and | The IHP program continues to evolve the quality scoring methodology to reward higher performance, shifting point assignment to more significantly |

| DHS Goals | IHP Objectives |
|---|---|
| Transparency | reward performance that is above the IHP benchmark, thus increasing accountability for higher performance. The quality score has a direct impact on shared savings or losses. |
| DHS Goal 2: High Value Care | <p>The IHP program addresses this in multiple ways:</p> <ol style="list-style-type: none"> 1) At its core the IHP program aims to drive high value care and reinforce this goal. It includes a variety of performance areas such as clinical performance, utilization, patient experience, and cost of care, assessing IHP performance in each of these areas. During each RFP cycle, the value levers are assessed and refined so we are constantly evaluating how the program best drives value. 2) Ensuring that IHPs have the data they need to look at the individual factors (e.g., utilization, cost, etc.) and measure improvement or focus on particular areas for improvement. IHPs receive robust data as a part of their involvement in the program. The overall quality score methodology was also restructured to give more weight to quality improvement as IHPs focus on specific measures scored solely based on improvement. |
| DHS Goal 3: Patient-centered care | <p>The IHP program addresses this in multiple ways:</p> <ol style="list-style-type: none"> 1) Driving improvement of patient clinical quality of care by significantly rewarding performance that is above the IHP average. This has a direct impact on shared savings or losses. 2) Ensuring all equity interventions include monitoring patient feedback within the contract metrics. |
| DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes | <p>The IHP program addresses this in several ways:</p> <ol style="list-style-type: none"> 1) Incenting focus on the particular needs of the IHP population and developing an intervention to address those needs through the PBP. This focuses efforts on a concrete population need, while constantly evaluating progress from both a qualitative and quantitative perspective. 2) Continuing the evolution of the IHP quality scoring methodology to more significantly reward performance improvement, thus increasing the incentive to improve quality performance across years. A domain focused solely on quality improvement rewards IHPs for improving their performance on measures that are important to the State and the IHP program goals. Both items have a direct impact on shared savings or losses. 3) Increasing the number of tools available to IHPs for performance comparison to other IHPs, as well as performance improvement. These new tools enhance the ability of an IHP system to be successful with their improvement efforts. |
| DHS Goal 7: Achieve Racial Equity and Close Disparities Gaps | <p>The IHP program addresses this in several ways:</p> <ol style="list-style-type: none"> 1) Increasing transparency regarding disparate performance across racial and ethnic groups by providing quality performance data stratified by racial and ethnic groups, as well as payer type (when available). The program will also utilize this data to inform conversations with IHPs about closing performance gaps. |

| DHS Goals | IHP Objectives |
|-----------|--|
| | 2) The overall quality score methodology includes components which, 1) assess disparities in care for the MHCP population compared to that of the commercial population, and 2) assess closing gaps in care for different racial and ethnic groups. Both items have a direct impact on shared savings or losses. |

Behavioral Health Homes Model

Supports DHS’ Goals: 3, 4, and 6

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

The BHH services launched in 2016 as Minnesota’s version of the “Health Home” benefit under the Affordable Care Act.²⁸ The model was planned and designed with input from over 26 stakeholder and community member groups. Since then, the model has been continuously improved and refined based on ongoing feedback from engaged stakeholders. In 2023, 28 Health Home providers provided behavioral health home services to 10,320 adults and 909 children.

In order to receive BHH services, an individual must meet the criteria for serious mental illness or emotional disturbance and have a current diagnosis of serious mental illness or emotional disturbance from a qualified health professional. Individuals receive comprehensive care management through a collaborative process designed to effectively manage medical, social, and behavioral health conditions.

BHH providers draft a person-centered health action plan based on guidance developed by the state Medicaid agency. The person-centered plan requires the team to maintain regular contact with the individual, coordinate services among other providers involved in the individual’s care, and monitor progress towards achieving the goals outlined in the plan. When the individual is a child, all activities must include the consent of the child’s parent or guardian.

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

²⁸ See <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html#:~:text=The%20Medicaid%20Health%20Home%20State,Medicaid%20beneficiaries%20with%20chronic%20conditions>.

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

BHH Services Model Evaluation

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

In addition to the Medicaid Health Homes core set, DHS also evaluates the implementation of the overall BHH model. The initial program evaluation of the BHH services delivery model was completed in September 2019. The goal was to evaluate the program implementation by assessing how sites were using the BHH services model and documenting the successes, challenges and preliminary outcomes associated with it. The state also conducted individual interviews and focus groups with enrollees receiving BHH services.

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

DHS continues to evaluate BHH services to better understand key outcomes and identify trends in cost and quality of care. As part of this process, DHS surveyed BHH providers to help identify key outcomes for BHH services. In the second evaluation phase, completed in May 2021, the state examined outcomes based on age, race, ethnicity, and mental health diagnosis, selected measures from the Medicaid Health Home Program Core Set, and the Healthcare Effectiveness Data and Information Set (HEDIS), and additional quality measures.

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

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

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

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

Table 3: Goals and BHH Objectives

| DHS Goal | BHH Objectives |
|---|--|
| DHS Goal 3: Patient-centered care | All persons receiving BHH services will work with their BHH services team to collaboratively develop a Health Action Plan within six months of enrollment. |
| | All persons receiving BHH services have a completed BHH services consent form indicating informed consent and individual choice to participate. |
| DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes | <p>Increase the number of BHH patients receiving follow up care after ED visit for alcohol and other drug abuse (FUA-HH Core Measure set).</p> <p>Increase the number of BHH patients receiving follow up care within 7 days after hospitalization for mental illness (FUH-HH Core Measure set)</p> <p>Reduce the number of hospital admissions for complications that could have been potentially prevented by good outpatient care for chronic conditions (PQI-HH Core Measure set)</p> |
| DHS Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders | <p>The BHH providers have multidisciplinary teams that maintain regular contact with the individual, coordinate services among other providers involved in the individual's care, and monitor progress towards achieving the goals outlined in the Health Action Plan.</p> <p>Measure and evaluate BHH patients' access to preventive care (e.g. cancer screenings, child and adolescent care visits) and appropriate care for chronic conditions.</p> <p>Improve coordination of care after hospital discharge to reduce the number of unplanned hospital readmissions (PCR-HH Core Measure set).</p> <p>Increase the number of BHH patients who initiated and stayed engaged in treatment for alcohol and other drug dependence (IET-HH Core Measure set).</p> <p>Increase the number of BHH patients receiving follow up care for mental illness after an ED visit with a principal diagnosis of mental</p> |

| DHS Goal | BHH Objectives |
|----------|---|
| | illness or intentional self-harm (FUM, NCQA). |

Certified Community Behavioral Health Clinics (CCBHC)

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

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

The 19 Certified Community Behavioral Health Clinics (CCBHCs) and the Minnesota Department of Human Services (DHS) are required to collect and report on quality, client perception of care, and impact data as a condition of participation in the CCBHC Section 223 federal demonstration program²⁹ and the concurrent federal authority of the state plan. The data reporting requirements are designed to evaluate whether the priorities of the CCBHC program are met: to improve access to care and high-quality services.

Currently, CCBHC federal reporting requirements include 19 quality measures: six measures calculated by CCBHCs from clinical data collected in their electronic health records; 13 measures calculated by DHS from claims data; and two client experience of care surveys (one for adults, and one for families and children). Beyond the 19 federally required quality measures, the CCBHC program is also evaluated on eight Minnesota impact measures.

Under the current CCBHC Section 223 federal demonstration payment policy and concurrent SPA policy, seven of the federally required measures – Comprehensive Diabetes Care: Hemoglobin A1c Control for Patients with Diabetes, Depression Remission at Six Months, Follow up after Hospitalization for Mental Illness for adults and children, and the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, and Plan All-Cause Readmission Rate – are tied to financial incentives.

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

²⁹ See <https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223-ccbhc-medicaid-demonstration-state-programs>

Table 4: DHS Goals and CCBHC Objectives

| DHS Goals | CCBHC Objectives |
|---|---|
| DHS Goal 1: Increase Accountability and Transparency | DHS will establish and maintain a process for periodically reviewing and revisiting the CCBHC quality measures by: <ol style="list-style-type: none"> 1) Eliciting partner/stakeholder input. 2) Engaging quality measurement subject matter experts. |
| DHS Goal 2: High Value Care | CCBHC will integrate mental health and substance use disorder services as well as coordinate care with primary care providers by: <ol style="list-style-type: none"> 1) Administering identified primary care screenings and preventive services: 2) Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) 3) Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC) 4) Coordinating care with primary care providers: 5) Schedule an appointment and close the loop by following up with the provider and the client. 6) Ensuring that a primary care provider is identified, and contact information is in the client file. 7) Continuously monitor progress on the quality measures to ensure improvements are being made and identify areas for continuous quality improvement. |
| DHS Goal 3: Patient-centered care | CCBHC will offer person and family centered care by: Using Culturally and Linguistically Appropriate Services (CLAS) standards to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. |
| DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes | CCBHC will expand providers’ capacity to serve more people via an expanded workforce by: <ol style="list-style-type: none"> 1) Creating more staff positions that reflect the cultures, languages and ethnicity of communities served to increase access to services and serve more underserved clients. 2) Paying more adequately and increase the ability to offer a living wage to CCBHC staff. 3) Hiring a more diverse population from different cultural backgrounds to reflect cultural backgrounds of the people they serve. |
| DHS Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders | <ol style="list-style-type: none"> 1. Providers will provide the full scope of CCBHC services. <ol style="list-style-type: none"> a) CCBHCs will provide services from the nine required service categories (outpatient mental health and substance use disorder, crisis services, screening, assessment and diagnosis, treatment planning, targeted case management, peer family supports, psychiatric rehabilitative, community-based services for veterans and outpatient primary care screening and monitoring) serving as a “one-stop-shop” to meet the needs of the population served. |

| DHS Goals | CCBHC Objectives |
|---|---|
| | <ul style="list-style-type: none"> b) CCBHCs ensures all nine service categories, if not available directly through the CCBHC, are provided through a Designated Collaborating Organization (DCO). c) Individuals will receive CCBHC services in a person- centered and family-centered manner. d) Providers will consider the client’s choice in care services provided, as well as the physical, behavioral health, and social service needs of each individual as these factors influence the well- being of the whole person. <ol style="list-style-type: none"> 2. Coordinated, integrated care provided by CCBHCs is cost effective since a client will receive an array of services at one location, potentially on the same day instead of accessing care at multiple locations and times. 3. CCBHCs will provide care coordination. <ul style="list-style-type: none"> a) Care coordinators will coordinate care across settings and providers to ensure seamless transitions for clients across the full spectrum of health services, including acute, chronic, and behavioral health needs. b) CCBHCs will have partnerships with a variety of community or regional services, supports, and providers. Partnerships ensure joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. c) Care coordination activities are carried out in keeping with the client’s expressed preferences and needs for care. |
| <p>DHS Goal 7: Achieve Racial Equity and Close Disparities</p> | <ol style="list-style-type: none"> 1. CCBHCs will increase access and availability of services to communities experiencing behavioral health disparities, especially American Indian Tribes and communities of color. 2. Quality measures will be stratified by race and ethnicity in order to monitor racial disparities in access and treatment. 3. Social determinants of health (SDOH) screening will be required by all CCBHCs, linking underserved/under-resourced communities to additional supports. |

Substance Use Disorder (SUD) System Reform Demonstration Waiver

Supports DHS' Goals: 3, 4, and 6

The Substance Use Disorder (SUD) System Reform demonstration waiver supports an evidence-based and person-centered, coordinated system of care using nationally recognized criteria for the treatment of SUD for Medicaid. DHS created this system through:

- Increasing the use of evidence-based placement criteria to match a client's individual needs with the appropriate American Society of Addiction Medicine's Criteria (ASAM³⁰) level of care; and
- Expanding Medical Assistance coverage for Institutions for Mental Disease (IMDs), defined as residential facilities with 17 or more beds.

Minnesota is working to achieve state and federal goals through improved coordination between providers and different levels of care, integrating primary and mental health care into the SUD treatment planning process, and improving access to medication-assisted treatment (MAT) and medications for opioid use disorder (MOUD). The ASAM criteria guide clinicians in assessing a client's individual risks, needs, skills, and strengths to create a personalized treatment plan based on a biopsychosocial assessment.

Under ASAM guidelines, Minnesotans will receive the right level of care at the right time based on medical necessity. This effort moves SUD treatment toward a long-term chronic disease management model that uses evidence-based treatment methods.

Through implementation, Minnesota is working on establishing a comprehensive and coordinated network of providers who offer ASAM levels of care to Medicaid recipients with SUD. To meet requirements for enhanced rates, SUD providers must have patient referral agreements with facilities providing the levels of care they do not offer, facilitating recipients referral and transition. Additionally, residential programs must provide medications for opioid use disorder on-site or facilitate access to the service off-site. A person seeking SUD treatment through an approved or certified provider is able receive treatment within in the level of care that best meets the person's needs, even if that requires a referral to a provider. Providers use ASAM's six dimensions criteria for assessments and level of care recommendations. An individualized treatment plan is written for each person and includes transition planning in preparation for the client's next phase of treatment. The treatment plan must consider cultural and socioeconomic factors that may affect that person's access to services and individual treatment needs.

Outcome and trend data are reported to CMS quarterly. An external independent evaluator conducts mid-point assessment, interim evaluation report, and provider capacity assessment. The SUD waiver evaluation is available for review.³¹

The focus is on CMS' six goals and objectives:

1. Increase rates of identification, initiation, and engagement in treatment for SUD;
2. Increase adherence to and retention in treatment;
3. Reduce use of emergency department or hospital inpatient settings for SUD;

³⁰ <https://www.asam.org/asam-criteria/about-the-asam-criteria>

³¹ [Evaluation Design MN SUD System Reform Section 1115\(a\) Demonstration Res... \(medicaid.gov\)](#)

4. Reduce preventable or medically inappropriate readmissions for SUD treatment;
5. Reduce overdose deaths, particularly those due to opioids;
6. Improve access to other health care services.

An external utilization management process assures Medical Assistance recipients who are receiving SUD treatment receive the proper care based on their diagnoses. Health outcomes, system usage data, utilization management data, external partnerships, and continuing community engagement guides the next steps in Minnesota’s SUD treatment system innovation.

Table 5: DHS Goals and SUD 1115 Waiver Objectives

DHS Goals and SUD 1115 Waiver Objectives

| DHS Goals | SUD Objectives |
|---|--|
| DHS Goal 3: Patient- centered care | <ul style="list-style-type: none"> • Increase the utilization of ASAM’s evidence-based assessment and placement criteria through payment incentives for participation in the demonstration. • Implement a utilization management program focused on matching clients with the right level of care at the right time. |
| DHS Goal 4: Improve Quality of Care and Achieve Better Health Outcomes | <ul style="list-style-type: none"> • Increase the utilization of ASAM Criteria through payment incentives for participation in the demonstration. • Providers must offer Medication Assisted Treatment (MAT)/Medication for Opioid use Disorder (MOUD)services and maintain formal referral arrangements with other demonstration providers offering level of care transitions. • Eligible providers must have medical, psychological, laboratory, toxicology, and pharmacological services available through consultation and referral • Tracking of health outcomes through trend predictions as a component of the required monitoring reports and through an independent evaluation of the demonstration |
| DHS Goal 6: Integrate Mental Health and Increase Recovery from Substance Use Disorders | <ul style="list-style-type: none"> • Providers must offer Medication Assisted Treatment (MAT)/Medications for Opioid Use Disorder (MOUD) services and maintain formal referral arrangements with other demonstration providers offering level of care transitions. • Eligible providers must have medical, psychological, laboratory, toxicology, and pharmacological services available through consultation and referral. • Requirements for participation focused on increased treatment coordination and interdisciplinary treatment planning that incorporate the consultation and referral requirements outlined previously. |

Opioid Prescribing Improvement Program

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

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

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

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

The Opioid Prescribing Work Group (OPWG) is the expert advisory body charged with developing recommendations for all of the program components. The OPWG members include physicians and mid-level providers who treat pain and opioid use disorder; pharmacists, a pain psychologist, a dentist, a medical examiner, health plan representatives, a law enforcement representative, and consumer/patient members who experience chronic pain and/or have been impacted by opioid use disorder. Non-voting OPWG members include representatives from MDH, DHS and the Minnesota Department of Labor and Industry (DLI). Patient populations excluded from this work include patients with cancer and patients receiving hospice services. The program does not apply to opioid therapy used to treat opioid use disorder, including methadone and buprenorphine formulations.

Quality improvement (QI) program

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

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

- Index opioid prescription prescribing rate;
- Index opioid prescription: prescribing rate over recommended dose (100 morphine milligram equivalents (MME) for medical specialties or 200 MME for surgical specialties);
- Rate of prescribing 700 cumulative MME or more during an initial opioid prescribing episode;
- Chronic opioid analgesic therapy (COAT) prescribing rate;

- Rate of prescribing high-dose COAT;
- Rate of prescribing concomitant COAT and benzodiazepine therapy;
- Rate of prescribing COAT to patients with multiple opioid prescribers.

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

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

- Prescribers whose acute pain practice is flagged for QI will be asked to review their data to better understand the opportunities for improving their prescribing, the barriers that might limit their success in improvement, and the assets available to them. This group will submit a quality improvement attestation form to DHS for review and approval.
- Prescribers who chronic pain practice is flagged for QI will engage with DHS in other ways. DHS and the Institute for Clinical Systems Improvement (ICSI) will work with chronic pain providers refine the QI work for patients with High Impact Chronic Pain (HICP) in 2021.

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

Improvement in prescribing practices

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

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

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

Managed Long Term Services and Supports (MLTSS)

Supports DHS' Goals: 3, 4, and 5

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

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

Because the MCOs will be paying the same rates as the FFS system they will be paying for, as well as sharing in, the improved quality and efficiency expected from the projects and administrative processes promoted by the state. See, for example, the nursing facility quality improvement projects on page 35 below. In addition, uniform payment floors for all MLTSS supports DHS' overall efforts for consistency in providers' expectations, and results in administrative simplification which lowers costs for providers. Approval was granted by CMS for a Minimum Fee Schedule directed payment.

Home and Community-based Services (HCBS)

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

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

DHS currently oversees five HCBS waivers: [Community Access for Disability Inclusion](#), [Community Alternative Carer](#), [Brain Injury](#), [Elderly Waiver](#), and [Developmental Disabilities](#).

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

- National Core Indicators - Aging and Disability (NCI-AD): DHS uses NCI-AD to survey Elderly Waiver (EW) and home care participants. Results are used to support Minnesota's efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life and outcomes of older adults, with a focus on identifying and closing racial disparities where they exist. To measure and track results over time, Minnesota implements the NCI-AD survey on a yearly basis for varying populations, with older adult sampling occurring every other year. Survey sampling methods allow DHS to look at survey results for MCO enrollees.
- Long Term Services and Supports Improvement Tool: In 2017, DHS launched the Long-Term Services and Supports (LTSS) Improvement Tool to gather feedback from older adults and people with disabilities who receive long-term services and supports. Elderly Waiver

participants who receive adult day, customized living, or foster care services under managed care provide feedback about their experiences in these settings through a brief survey conducted by MCO care coordinators as part of annual reassessment.

Survey results help DHS measure and improve quality and outcomes for home and community-based services. The tool is built on recommendations from the National Quality Forum report, *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*.

- Assisted Living Report Card: In 2019, DHS received funding from the Minnesota Legislature to develop and implement an Assisted Living Report Card. Assisted living is one service available through the Elderly Waiver and is used by approximately 40 percent of EW participants. The report card provides information and ratings on assisted living quality at the provider setting level across a number of measures. Measures related to resident quality of life, experience, and outcomes will be supported by an annual resident survey. Measures related to family satisfaction and regulatory compliance will be supported by a family survey and regulatory data from DHS and the Minnesota Department of Health.
- The report card launched in early 2024 with resident quality of life and family satisfaction data. Regulatory data from MDH will be added in the next year.

Reform 2020 Demonstration Waiver

Supports DHS' Goal: 3, 4, and 5

The [Reform 2020](#) demonstration waiver provides federal financial support for the Alternative Care program, which provides supports to help older adults at risk of nursing home placement to stay in their homes. The Reform 2020 waiver assists the state in its goals to increase and support independence, increase community integration, and reduce reliance on institutional care. To see how the success of the Reform 2020 waiver is evaluated, refer to Appendix E.

Olmstead Plan

Supports DHS Goals: 3 and 5

The Olmstead Plan³² is Minnesota's program to improve the integration of persons with disabilities into the community. This includes the identification and migration of disparities and inequities. The ultimate success of the Olmstead Plan will be measured by an increase in the number of people with disabilities who, based upon their choices, live close to their friends and family, and as independently as possible, work in competitive, integrated employment, are educated in integrated school settings, and fully participate in community life. While there is much work to be done to achieve the goals of the Olmstead Plan, significant strides have been made.

Nursing Home Quality

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

Minnesota administers four coordinated strategies to improve the quality of care in nursing homes: the

³² See https://mn.gov/olmstead/assets/2022-04-olmstead-plan_tcm1143-526399.pdf

nursing home report card, value-based reimbursement, the performance-based incentive payment program, and the quality improvement incentive payment program. All four efforts are managed by the Nursing Facility Rates and Policy Division of DHS. Each effort is described below.

Minnesota Nursing Home Report Card

In 2006, MDH and DHS collaborated with the University of Minnesota School of Public Health to introduce the [Minnesota Nursing Home Report Card](#). The Report Card was a response to state legislative actions calling for greater transparency about nursing home quality. The Report Card provides comprehensive quality information in areas that matter to people needing care and their families, and includes all facilities certified to participate in the Medical Assistance (MA) Program.³³

The Report Card has multiple features to help users:

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

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

Minnesota uses the following guidelines when selecting measures:

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

The national [Informed Patient Institute \(IPI\)](#) has given the Minnesota Report Card its highest grade (A). IPI has credited the Report Card for the breadth of information included; the ability to individualize the site to the user’s preferences; and the use of star ratings.

Maintaining the Report Card is a challenge, requiring several staff for ongoing data analysis and reporting and additional personnel contracted to conduct up to 30,000 in-person, mailed, telephone and online user surveys each year. The use of multiple quality measures requires considerable attention to data integrity, necessitating audit and quality assurance processes on a scheduled basis and as issues arise.

³³ MDH and DHS may add the state’s Veteran’s Administration facilities in the future in collaboration with MVH.

Value-Based Reimbursement (VBR)

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

VBR means to:

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

Nursing facility daily rates under VBR have four parts:

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

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

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

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

Performance-based Incentive Payment Program (PIPP)

The Performance-based Incentive Payment Program (PIPP) was established by the Minnesota Legislature in 2006. PIPP strives to improve nursing home quality and to increase the quality improvement (QI) capacity of nursing facility providers. PIPP has \$18 million annually, available in increased payments given to nursing facilities that develop and successfully implement QI projects after a competitive selection process. Total funding includes state, federal matching, and private payments.

Individual facility improvement targets are negotiated with DHS, establishing a portion of incentive payments at risk if performance targets aren't met.

DHS' goals for PIPP are to:

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

To date, almost all nursing facility providers in the state operating today have participated. Their projects have focused on a wide variety of topics, including but not limited to:

- Clinical Quality: Fall reduction, strength training, sleep, pain management, osteoporosis, antibiotic stewardship, skin care, congestive heart failure, wound care, pressure sore prevention, incontinence, targeted therapy
- Psychosocial: Trauma-informed care, dance, music therapy, art therapy, healing touch, end of life planning, behavior management, cognitive care, hearing loss
- Organizational Change: Person-centered care, culture change, community outreach, staff mentoring
- Transitions: Community transition skills, hospitalizations, rehabilitation, Alzheimer's-related community caregiver support
- Technology: Safe patient handling, call or alarm systems, environmental modifications, electronic health records, social robots

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

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

DHS provides multiple resources to interested applicants, including proposal review and the facilitation of collaborative learning among providers as they develop their QI project(s). PIPP has been independently evaluated through an Agency for Healthcare Research and Quality (AHRQ) grant, with the conclusion that PIPP leads to successful outcomes in areas specifically targeted by PIPP-funded projects and closely associated with more improved quality overall at participating nursing facilities. The use of state-maintained quality measures has improved data efficiency and integrity, but the process is still a major challenge requiring substantial knowledge of measures and resources to administer the program.

Quality Improvement Incentive Payment Program (QIIP)

The Minnesota Quality Improvement Incentive Payment Program (QIIP) was established by the

Minnesota Legislature in 2013. QIIP's purpose is to recognize quality improvement efforts, and to ensure that all Medical Assistance-certified nursing facilities in the state have the opportunity to receive financial rewards for improving their quality of care or quality of life.

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

To date:

- Almost all providers statewide participate annually.
- About 90 percent of facilities choose clinical outcomes while 10 percent work on quality of life.
- About 75 percent of providers earn a full or partial payment (average QIIP for providers with any improvement is over \$2.50/resident day).

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

Health Care Disparities by Insurance Type

Supports DHS' Goals: 1, 4, and 7

Health care disparities are differences in health care between groups that cannot be explained by health needs, treatment recommendations, or performance. They can be explained, however, by social and economic disadvantages.³⁴ Health care disparities affect under-resourced communities and are a result of underlying structural problems.

DHS has partnered with the Minnesota Community Measurement (MNCM) to monitor health care disparities between Medicaid enrollees and patients insured through Medicare and commercial insurance. For over a decade, MNCM has analyzed data submitted to MNCM by health care providers across the State of Minnesota and summarized the findings in an annual Minnesota Health Care Disparities by Insurance Type report.³⁵

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

³⁴ Kaiser Family Foundation. Disparities in Health and Health Care: 5 Key Questions and Answers. Available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>. Accessed on May 20th, 2021

³⁵ Minnesota Community Measurement. 2021 Minnesota Health Care Disparities by Insurance Type. Available at <https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20Insurance%20Type/2021-MY-Disparities-by-Insurance-Type.pdf>. Accessed on February 26, 2024.

DHS recognizes its unique position to work with our partners, including MCOs and IHPs, to prevent health care disparities by designing equitable programs and policies. To that effect, since 2018, our IHP partners have been required to propose at least one equity intervention intended to reduce health care disparities among their population of patients. The DHS-MCO managed care contracts include significant requirements to improve health care disparities, including feedback to the MCOs about their measured disparities and requirements to convene community focus groups.

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

Prepaid Medical Assistance Project Plus (PMAP+) Demonstration Waiver

Supports DHS' Goals: 1, 3, and 4

The Prepaid Medical Assistance Project Plus (PMAP+) demonstration waiver has been in place for over 30 years and provides federal authority to:

- Cover children as “infants” under Medical Assistance who are 12 to 23 months old with income eligibility above 275 percent and at or below 283 percent of the federal poverty level (FPL) (referred to as “MA One Year Olds”);
- Waive the federal requirement to redetermine the basis of Medical Assistance eligibility for caretaker adults with incomes at or below 133 percent of the FPL who live with children age 18 who are not full-time secondary school students; and
- Provide Medicaid benefits to pregnant persons during the period of presumptive eligibility.

On Nov. 15, 2023, CMS approved Minnesota’s request to extend the PMAP+ waiver from Jan. 1, 2024 through Dec. 31, 2028. To see how the PMAP+ waiver is evaluated, refer to Appendix D.

Integrated Care for High Risk Pregnancies (ICHRP)

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

Adverse birth outcomes result in high care costs due to intensive treatment requirements for newborns, related to prematurity, low birthweight, and maternal substance use, especially opiates. This program directs resources for prenatal prevention and treatment to improve birth outcomes.

Minnesota has excellent birth outcomes overall, with among the lowest rates nationally for prematurity, low birth weight, and infant mortality. However, the state has some of the nation’s highest disparities for these outcomes for African Americans and American Indians, in comparison to the White population. Also, Neonatal Abstinence Syndrome (NAS), which occurs when newborns withdraw from opiates due to maternal opiate use during pregnancy, is rapidly growing in Minnesota. There is an eight-fold higher rate of NAS in Minnesota among infants born to American Indians. Prematurity, low birth weight and NAS are the leading causes of costly neonatal intensive care unit admissions, and these adverse birth

outcomes are known to be strongly associated with behavioral risks and disadvantaged social conditions. Integrated prenatal care that links risk assessment with community-supported interventions has been shown to result in lower rates of these adverse outcomes.

Integrated Care for High Risk Pregnancies is a grant program designed to provide integrated services for pregnant people who are at high risk of premature birth or low birth weight. A state funded grant program allows us to direct resources to Medicaid enrollees. These services are expected to improve birth outcomes, reducing the number of pre-term birth and low birth weight infants. Based on experience from similar interventions across the country, this proposal is expected to improve birth outcomes and reduce maternal and infant mortality and morbidity rates.

Participating enrollees are connected to existing services through community and public health programs. The program works with community organizations, doulas, medical providers, and other professionals to develop local systems of care that are community held, community monitored and maintained with appropriate state oversight. Participating clinics may include Tribal health providers and community clinics; local public health and social service agencies; and substance abuse treatment providers.

Project goals include:

- Early identification of opiate dependency and abuse during pregnancy, effectively coordinated referral and follow-up of identified patients to evidence-based treatment, and integrated perinatal care services with behavioral health and substance abuse services.
- Access to, and effective use of, needed services by bridging cultural gaps within systems of care, through integration of community-based paraprofessionals such as doulas and community health workers, as a component of perinatal care.
- Patient education including prenatal care, birthing, and postpartum care, nutrition, reproductive life planning, breastfeeding, parenting, and documentation of the processes used to educate patients.
- Systematized screening, care coordination, referral, and follow up for behavioral and social risks known to be associated with poor birth outcomes and prevalent within the targeted populations, such as substance abuse, homelessness, domestic violence and abuse, chronic mental illness, and poorly developed self-care knowledge and skills.
- Facilitated ongoing continuity of care, including postpartum coordination and referral for inter-conception care, provision for ongoing substance abuse treatment, identification and referral for maternal depression, continued medical management of chronic diseases, and appropriate referral to tribal or county-based social and public health nursing services.

If the project is expanded to where its services can be offered to most pregnant people in the communities, DHS anticipates:

- Lower rates of untreated maternal opiate and other substance use disorders at birth.
- A decline in rates of prematurity and low birth weight resulting in lowered statewide disparities for these outcomes.
- A reduction in the incidence of newborns exposed to illicit substances.
- Better integration of existing resources for high-risk pregnancies.

- Development of a mechanism to sustain this work via a Medicaid payment model.

The project began as a pilot program in 2015 and was cemented as a grant program in DHS by the Minnesota Legislature in 2019. ICHRP demonstrates that pregnant people at high risk of adverse perinatal outcomes can be successfully engaged by care collaboratives, assessed for unmet needs, and connected to appropriate supports and services by paraprofessional navigators.³⁶

³⁶ Minn. Statutes § 256B.79

Chapter V. Managed Care Regulations

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

Elements of the State Quality Strategy

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

- The State-defined network adequacy and availability of services standards for MCOs required by §§ 438.68 and 438.206, and examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.
 - Minnesota access standards in state law require that primary care providers are available within 30 minutes or 30 miles and specialty care within 60 minutes or 60 miles, unless there are no providers within those limits. In such cases, state law permits application of a community standard. For more information see Appendix A: *42 CFR §438.68* and *42 CFR §438.206*.
 - The agency requires MCOs to adopt guidelines based upon valid and reliable clinical evidence, or a consensus of Health Care Professionals in the particular field. The MCOs are required to publish these guidelines to providers and to use them in utilization management, coverage of services, and enrollee education. For examples of evidence-based clinical practice guidelines see Appendix A: *42 CFR §438.236*.
- The State's goals and objectives for continuous quality improvement.
 - The state's goals and objectives for continuous quality improvement are described in Chapter 3. Also, see Chapter 4: *Quality Improvement Initiatives* for objectives pertinent to specific quality initiatives and defined in terms of measurable steps toward meeting the state's goals.
- A description of quality metrics and performance targets to be used in measuring the performance of each MCO.
 - Overall, DHS evaluates the quality of health care using quality metrics organized into the following categories: primary care access and preventive care, maternal and perinatal care, care of acute and chronic conditions, behavioral health care, experience of care, dental health services, and long-term services and supports.

Quality measures are used across various improvement initiatives. For the list of quality metrics used in

measuring MCOs performance, see Appendix F (“Annual Technical Report” and “MCO Risk Corridors”).

- Performance targets are population-specific and described per each applicable quality improvement initiative in Chapter 4.
- A description of quality improvement projects, including a description of any interventions the State proposed to improve access, quality, or timeliness of care for enrollees.
 - Quality improvement projects and interventions are described in Chapter 4. Also, see Appendix A: *42 CFR §438.330* for information specific to MCO’s quality improvement projects.
- Information about arrangements for annual external independent reviews.
 - The External Quality Review Organization performs an annual independent review of the quality outcomes, timeliness of and access to the services included in the contract between Minnesota Health Care Programs (MHCP) and each health plan. For more information see Chapter 4: *Annual External Independent Reviews*.
- A description of the State’s transition of care policy.
 - The state agency requires by contract that MCOs assist enrollees in transition of care, both when the enrollee is new to their plan and in transition from one setting to another. State law governs transition procedures. For more information see Appendix A: *42 CFR §438.62(b)(3)*.
- The State’s plan to identify, evaluate and reduce health disparities based on age, race, ethnicity, sex, primary language, disability status, and also payer type.
 - The State’s plan to achieve racial equity and to close disparities is described in Chapter 3 (see Goal 7). Also, see the following quality improvement initiatives in Chapter 4: *MCO Risk Corridors, Value-based Payments, Consumer Experience, Health Care Disparities by Insurance Type, and Integrated Care for High-Risk Pregnant Women*.
- Appropriate use of intermediate sanctions.
 - The contract between the state agency and the MCO contain provisions for intermediate sanctions. These sanctions are referred to as “remedies” for partial breach of the contract. A sanction may be applied for any breach of the contract, including quality of care. For more information see Appendix A: *42 CFR §438.700, 42 CFR § 438.702, and § 438.704*.
- Mechanisms to comply with 438.208 (c)(1), identification of persons who need long-

term services and supports or persons with special needs.

- The State uses the Long-Term Care Consultation (LTCC) assessment and the Personal Care Assistance (PCA) assessment as mechanisms to identify persons who need LTSS or persons with special health care needs. For more information see Appendix A: *42 CFR §438.208*.
- If the state utilizes the non-duplication option in 42 CFR 438.360 for EQR, it must explain the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities.
 - DHS contracts with the Minnesota’s regulatory agency for HMOs, the Minnesota Department of Health (MDH), for review of network, quality, and other HMO licensure activities. MDH determines whether the MCO’s quality activities meet the contractual guidelines provided by DHS, including whether activities performed for another accreditation meet the requirements of the Triennial Quality examination. For more information see in Chapter 4: Annual External Independent Reviews: *Triennial Compliance Assessment* and Appendix C: *Data Collection Burden Reduction*.
- The State’s definition of “significant change” for the purposes of revising the quality strategy per 42 CFR 438.340(c)(3)(ii).
 - DHS defines “significant change” as a change in the state’s organizational priorities triggered by circumstances outlined in Chapter 5: *Development, Evaluation, Revision, and Availability of the State Quality Strategy*.

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

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

The External Quality Review Organization (EQRO) reviews the state’s comprehensive quality strategy and comments on it in its Annual Technical Report. According to the most recent EQRO review, “(t)he DHS quality strategy aligns with CMS’s requirements and provides a framework for MCOs to follow while aiming to achieve improvements in the quality of, timeliness of and access to care.”³⁷

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

³⁷ IPRO. Minnesota Department of Human Services. 202119 External Quality Review Annual Technical Report. Issued April 20231. Available at: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6888I-ENG> Accessed on February 26, 2024.

enrollees and their representatives, is taken into consideration and incorporated into the comprehensive quality strategy updates.

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

- Input received from stakeholders (e.g., EQRO) and senior leadership;
- A pervasive pattern of quality deficiencies identified through analysis of the annual data;
- Changes to quality standards resulting from regulatory authorities or legislation at the state or federal level; and
- A change in membership demographics or the provider network.

DHS posts its quality strategy³⁸, EQR technical report³⁹, and managed care plan accreditation information⁴⁰ on its website.

³⁸ MN DHS. Managed care: Quality, outcome and performance measures. Available at: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp> Accessed on February 26, 2024.

³⁹ MN DHS. Managed care: Quality, outcome and performance measures. Annual technical reports. Available at: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp> Accessed on February 26, 2024.

⁴⁰ MN DHS. Managed care reporting. Reports and audits. Accreditation Status (PDF). Available at: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/> Accessed on February 26, 2024.

List of Appendices

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

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

Appendix A: Managed Care Core Quality Strategy Components

Title 42, Part 438 of the Code of Federal Regulations (CFR) includes a set of rules issued by the Centers of Medicare and Medicaid Services governing managed care. In 42 CFR §438, Subparts A through K include standards and rules around availability of services, coordination and continuity of care, coverage and authorization, provider selection, confidentiality, grievance systems, sub-contractual relationships, health information systems etc.⁴¹ Standards and rules relevant to this State Quality Strategy are described in the following.

42 CFR § 438.206 Availability of services

MCO Duties

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

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

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

The MCO must meet the requirements of 42 CFR §438.214(b) for credentialing of its providers. The MCO must ensure that female enrollees have direct access to women's health specialists within the network, both for covered routine and preventive health care services. An OB/GYN may serve as a primary care provider. The MCO must provide for a second opinion from a qualified health care professional within its network or arrange to obtain one outside the network at no cost to the enrollee. If an MCO's provider network is unable to provide services required by an enrollee, the MCO must adequately and in a timely manner cover services outside the network for as long as the current MCO

⁴¹ <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438>. Accessed on February 29, 2024.

provider network is unable to provide the needed services.

The state agency offers special needs programs that either integrate Medicaid and Medicare benefits and requirements or combine Medicaid benefits with a Medicare Advantage Special Needs Plan (SNP) to serve persons with disabilities, or persons age 65 years and older, who often have comorbid chronic care needs. For community-based special needs plan enrollees (MSHO, and SNBC), MCOs are also liable to provide a specified limited nursing facility benefit. Through these special needs plans enrollees have access to coordinated benefits and care, including Medicare pharmacy benefits, to meet their specific health care needs. The State's special needs programs are described here:

Minnesota Senior Health Options (MSHO):

MSHO is a voluntary managed care program that integrates Medicare and Medicaid through State contracts with SNPs. MSHO operates under §1915(a) authority and provides eligible persons aged 65 and older all Medicare benefits including Part D pharmacy benefits, Medicaid state plan services, Elderly Waiver (EW) home and community-based services (as permitted under a §1915(c) waiver), and the first 180 days of care in a nursing facility after which time coverage reverts to fee-for-service. The MCO agrees to provide EW services and must have a network of providers for home and community-based services. A significant feature of the MSHO program is the provision of care coordination assigned to each MSHO enrollee upon initial enrollment. Each MSHO enrollee is assigned a care coordinator upon initial enrollment.

Care coordinators assist enrollees in navigating the health care system and work with them to ensure that care is provided in appropriate settings. Enrollees must have both Medicare Parts A and B in addition to Medical Assistance (dual eligibility) to enroll in the MSHO program. Enrollment in MSHO is an alternative to mandatory enrollment in the MSC+ program.

Special Needs Basic Care (SNBC):

SNBC is a voluntary managed care program for people age 18 to 64, who are certified disabled and eligible for Medical Assistance. Integrated SNBC incorporates Medicare Parts A, B and D for enrollees who qualify for that coverage. A care coordinator or navigator is assigned to each enrollee to help access health care and other support services. DHS contracts with five Medicare Advantage Special Needs Plans to provide SNBC. SNBC offers all medically necessary Medicaid state plan services with the exception of HCBS waivers, Personal Care Assistance (PCA), and private duty nursing (PDN). HCBS waiver services, PCA, and PDN services are paid by the MA fee-for-service program. If an enrollee is Medicare eligible, the MCO covers all Medicare services under a SNP contract, including prescription drugs covered by Part D and any supplemental services the MCO may choose to offer. The MCO pays for the first 100 days of nursing facility care for community enrollees who enter a nursing facility after enrollment.

Oversight Activities

An annual assessment of available services is based on a review of provider networks, including review of provider directories, and an ongoing assessment of changes to MCO networks, the results of the MDH triennial Quality Assurance Examination, the DHS Triennial Compliance Assessment (TCA), and review of complaint data regarding access to services.

DHS uses specific protocols to review evidence of coverage (EOCs), provider directories, and other

enrollee-directed materials. This includes review of information on what services may be accessed directly and services which require a referral. Availability of services are assessed including primary care, specialty care, women's health services, second opinions, access to out-of-network services, and transitional services. Other elements reviewed include limitation on cost-sharing not to exceed the in-network cost, and access to covered MA services not covered by the MCO contract.

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

DHS monitors patterns of written and oral grievances and appeals to determine whether there are specific concerns regarding availability of services, access to women's health services, second opinions or complaints about services in or out-of-network. The DHS Managed Care Ombudsperson's Office staff assists enrollees with access, care or provider complaints, and resolving issues. Issues and trends are addressed at periodic meetings with the MCOs. Identified issues are referred to the MCO for correction.

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

Reports and Evaluation

Annually, the EQRO will summarize and evaluate all information submitted to DHS and assess each MCO's compliance with this standard. A standard report is submitted to CMS as the regulator for this program, and CMS may make comments to improve the program. The EQRO will also make recommendations for improving the quality of health care services furnished by each MCO.

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

At the time an individual applies for Medical Assistance or other public health care programs, the application collects information on each applicant's race, ethnicity and primary language spoken. There are fields in the State's eligibility systems to store this data. Race categories mirror the United States Census categories. Ethnicity is collected based on the applicant's report. Primary language is also collected at the time of application and applicants are asked if they require an interpreter to access the health care system. Upon receipt of this enrollment information indicating the need for interpreter services. The MCO contacts the enrollee by phone or mail in the appropriate language to inform the enrollee how to obtain primary health care services. DHS transfers race or ethnicity and language information to MCOs in the MCO's enrollment file, to the extent that the enrollee is willing to provide such information.

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

State and MCO duties

The state agency requires its contracted MCOs to comply with the standards for all HMOs in the state, which are in state law.⁴² The state law and MCO contract requirements include distance and travel time standards for primary care, specialty care (including behavioral health and OB/GYN), hospitals, dental, optometry, laboratory, and pharmacy services. All other services must be as available to Medicaid enrollees as they are to the general population.

MCO duties

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

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

DHS requires MCOs to pay out-of-network providers for required services that the MCO is not able to provide within its own provider network. The MCO is required to provide enrollees with common carrier transportation to an out-of-network provider if necessary. If a particular specialty service is not available within the MCO's immediate service area, the MCO must provide transportation. Treatment and transportation are provided at no cost to the enrollee except for permitted cost sharing arrangements.

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

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

Elderly Waiver services provider networks for MSHO and SNBC

⁴² Minnesota Statutes, § 62D.124; §62Q.19.

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

Oversight activities

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

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

During site visits, MDH assesses appointment availability and waiting times. Utilization management activities are also reviewed. Grievances are audited to determine if any patterns resulting from access issues can be identified. The results of the MDH assessments are made available to DHS. DHS reviews the results to determine whether there are any issues that affect contract compliance and if so, requires corrective action by the MCO. Results of the MDH QA Exam are also made available to the EQRO for review.

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

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

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

Additionally, MCOs must annually submit a data certification that they offer an appropriate range of preventive, primary care, specialty services, and LTSS (if applicable) that is adequate for the anticipated number of enrollees for the MCO's service area. The MCO must also attest that they maintain a network

of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the MCO's service area per 42 CFR §438.207(b)(2).

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

Reports and evaluation

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

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

42 CFR §438.62(b)(3) State's transition of care policy

State and MCO duties

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

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

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

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

Oversight activities by the state agency

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

Reports and evaluation (if applicable)

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

42 CFR §438.208 Coordination and continuity of care

State and MCO duties

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

MCO duties

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

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

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

The MCO must also have procedures for an initial screening, followed by a diagnostic assessment, as needed; development of an individual treatment plan based on the needs assessment; establishment of treatment goals and objectives; monitoring of outcomes, and a process to ensure that treatment plans

are revised as necessary. For enrollees with identified special needs, a strategy to ensure that all enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment if an enrollee requires a treatment plan for any condition. The enrollee must be allowed to participate in the development and review of his or her plan to the extent possible according to the enrollee's health status.

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

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

Oversight

DHS reviews the Evidence of Coverage materials to assess each MCO's procedures for ensuring coordination and continuity of care and ensuring that each enrollee has access to a primary care provider.

MSHO/ MSC+ MCOs are required to audit a sample of care plans of waiver enrollees to assess the implementation of care plan requirements for each care system and county care coordination system. The care plan audit examines evidence of comprehensive care planning as stipulated in the Comprehensive Care Plan Audit Protocol.

DHS also reviews grievance and appeal data to identify whether access to primary care providers, care coordination or continuity of care are issues requiring systematic follow-up. DHS follows up on a case-by-case basis on specific grievance and appeals regarding coordination and continuity of care.

The state agency contracts with the Minnesota Department of Health as the regulator for HMOs for a triennial "look behind" audit of a sample of MSHO/MSC+ MCO care plan audits to assess each MCO's compliance with the standard outlined in the Comprehensive Care Plan Audit Protocol to identify areas for a closer examination.

MCO duties

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

In addition to claims data, the MCO may use other data to identify enrollees with special health care needs such as health risk assessment surveys, performance measures, medical record reviews, and enrollees receiving PCA services, requests for prior authorization of services and/or other methods developed by the MCO or its contracted providers.

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

MSHO/SNBC

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

In MSHO, the MCO is required to have providers with geriatric expertise and to provide Elderly Waiver HCBS services to eligible individuals.

In SNBC, the MCO must offer primary care providers with knowledge and interest in serving people with disabilities. The MCO also coordinates Community Access for Disability Inclusion (CADII) and Brain Injury (BI) waiver services with counties for eligible individuals. Contracts with MCOs also require them to have mechanisms to pay for additional or substitute services. Contracts also ensure enrollee privacy in care coordination for Special Health Care Needs services.

Oversight

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

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

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

Reports and evaluation

Annually, the EQRO will summarize and evaluate all information gathered and assess each MCO's

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

42 CFR §438.210 Coverage and authorization of services

MCO duties

Article 6 of the MCO contracts specifies which services must be provided and which services are not covered. Medical necessity is defined. The contract requires that all medically necessary services⁴³ are covered unless specifically excluded from the contract. The MCO must have in place policies for authorization of services and inform enrollees how services may be accessed (whether direct access is permitted, when a referral is necessary, and from whom). In the contract, federal, and state laws specify time frames for decisions and whether standard or expedited. (See Grievances and Appeals in Article 8 of the contract). The EOC must inform enrollees how to access state plan services not covered by the MCO's contract.

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

Oversight activities

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

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

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

MSHO /SNBC

⁴³ Medically necessary services-Those services which are in the opinion of the treating physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage, may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 CFR §440.230). Medicaid EPSDT coverage rules (42 USC §1396(r)(5) and 42 USC §1396 d(a)).

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

Reports and evaluation

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

42 CFR §438.214 Provider selection

MCO duties

In a managed care delivery system, the MCO selects, reviews, and retains a network of providers that may not include all available providers. Since the MCO has a limited network of providers from which the enrollee may select, the MCO has a responsibility to monitor these providers for compliance with state licensing requirements and MCO operational policies and procedures. The MCO is required to have a uniform credentialing and re-credentialing program that monitors and reviews the panel of providers for the quantity of provider types and the quality of providers offering care and service. The MCO's credentialing and re-credentialing program must follow National Committee for Quality Assurance (NCQA) standards. For organizational Providers, including hospitals, and Medicare certified home health care agencies, MCOs must adopt a uniform credentialing and re-credentialing process and comply with that process consistent with state law.

The MCO must ensure that its network providers are enrolled with the state as MHCP providers.⁴⁴ Network Providers must comply with the provider disclosure, screening, and enrollment requirements in 42 CFR § 455.

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

Oversight activities

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

⁴⁴ 42 CFR §438.602(b)

Reporting and evaluation

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

42 CFR §438.10 Information requirements

Enrollee information must meet the requirements of 42 CFR §438.10 (Information Requirements). There are specific requirements for current managed care enrollees and potential enrollees. In Minnesota, the state agency or the local agency provides most information to potential enrollees. Most, but not all, information for existing enrollees is provided by the MCOs.

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

State duties

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

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

MCO duties

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

Oversight activities

The state agency provides model enrollment materials – which meet the previously described requirements – to the local agency for distribution to all enrollees or potential enrollees. By contract, the state agency must review and approve all MCO notices and educational/enrollment materials prior

to distribution to enrollees or potential enrollees. MCO enrollees receive a membership card and other materials, including a Provider Directory and the Member Handbook upon enrollment.

Reporting and evaluation

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

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

42 CFR §438.224 Confidentiality

MCO duties

All managed care contracts require MCOs to comply with 45 CFR Parts 160 and 164, subparts A and E to the extent that these requirements are applicable and expects MCOs comply with subpart F of Section 42 CFR § 431, in addition to state law requirements for enrollee privacy protection.

Oversight activities

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

Reporting and evaluation

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

42 CFR §438.228 Grievance and appeal system

MCO duties

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

- MCOs are required to have a grievance and appeal system which includes an oral and written grievance process, an oral and written appeal process, and access to the State Fair Hearing system. The process must allow a provider to act on behalf of the enrollee with the enrollee's written permission.
- The MCO must assist enrollees, as needed, in completing forms and navigating the grievance and appeal process. The appeal process must provide that oral inquiries

seeking to appeal an action be treated as an appeal with the opportunity to present evidence in person as well as in writing.

- The MCO must resolve each grievance and each appeal, whether orally or in writing, and provide notice, as expeditiously as the enrollee's health condition requires, but no later than the timeframes established by state and federal laws, and that are specified in the contract.
- A State Fair Hearing must be permitted as specified by the State. The MCO must be a party to the State Fair Hearing and comply with hearing decisions promptly and expeditiously.
- The MCO must send a notice of action to each enrollee when it denies, terminates, or reduces a service or when it denies payment for a service. The notice must state the action taken; the type of service or claim that is being denied, terminated, or reduced; the reason for the action; and the rules or policies which support the action. The notice must include a rights notice, explaining the enrollee's right to appeal the action. Minnesota uses a model notice format with required language, from which the MCOs may not deviate. The MCO must continue to provide previously authorized benefits when an enrollee appeals the denial, termination, or reduction of those benefits and the timelines and other conditions for continuation of benefits are met, as specified in Section 8 of the contract.
- The MCO must maintain grievance and appeal records, and provide notification to the State, as specified in the contract.

MSHO/Integrated SNBC:

Enrollees of these programs also have access to Medicare grievance and appeals processes. In order to simplify access to both the Medicare and Medical Assistance grievance systems, the state agency has developed an integrated process in conjunction with CMS that allows the MCO to make integrated coverage decisions for both Medicare and Medical Assistance. The contracted MCOs are "Fully Integrated" or "Highly Integrated" special needs plans under the Medicare Advantage regulations. Enrollees continue to have access to grievance and appeal procedures under both programs.

Oversight activities

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

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

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

Reporting and evaluation

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

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

42 CFR §438.230 Sub-contractual relationships and delegation

MCO duties

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

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

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

MSHO/ SNBC:

MCOs are also required to audit their care systems annually.

Oversight activities

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

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

MSHO/ SNBC:

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

Reporting and evaluation

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

42 CFR §438.236 Practice guidelines

MCO duties

Adoption and application of practice guidelines are essential to encourage appropriate provision of health care services and promote prevention and early detection of illness and disease.⁴⁵ Providers that agree and follow guidelines based upon current clinical evidence have the potential to identify and change undesirable health care processes and reduce practice variation.

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

The agency requires MCOs to adopt guidelines based upon valid and reliable clinical evidence, or a consensus of Health Care Professionals in the particular field. The MCOs are required to publish these guidelines to providers and to use them in utilization management, coverage of services, and enrollee education. This contract requirement (in section 7.1.6 of the Families and Children contract, 2024) is consistent with the requirements of 42 CFR § 438.236, which does not require the state to mandate use of any particular set of guidelines.

Examples of guidelines used by current MCOs are:

- Medica: <https://www.medica.com/providers/policies-and-guidelines/clinical-guidelines>
- HealthPartners: <https://www.icsi.org/guidelines/>
- PrimeWest Health: <https://www.primewest.org/practice-guidelines>
- UCare: <https://home.ucare.org/en-us/providers/clinical-practice-guidelines/>

⁴⁵ Refer to Appendix B DHS Supplemental Triennial Compliance Assessment item 5.

Oversight activities

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

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

Reporting and evaluation

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

42 CFR §438.330 Quality assessment and performance improvement program

MCO duties

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

Conducting quality improvement projects provides a mechanism for the MCO to target high risk, high volume or problem prone care or service areas that can be improved with a focused strategic intervention(s).⁴⁶ These projects are designed to identify and subsequently introduce evidence-based interventions to improve the quality of care and services for the at-risk enrollees. Quality improvement projects reflect continuous quality improvement concepts including identifying areas of care and service that need improvement, conducting follow-up, reviewing effectiveness of interventions, making additional changes, and repeating the quality improvement cycle as needed.

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

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

- Have a favorable effect on health outcomes,

⁴⁶ Refer to Appendix B DHS supplemental Triennial Compliance Assessment item 6.

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

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

Oversight activities

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

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

Reporting and evaluation

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

42 CFR §438.242 Health information systems

MCO duties

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

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

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

The Health Information System is required to possess a reasonable level of accuracy and administrative

feasibility, be adaptable to changes as methods improve, incorporate safeguards against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status.

This section of 42 CFR 438 has recently been amended to require MCOs, among other payers, to implement and offer application programming interfaces (APIs) for patients, providers, and on a payer-to-payer basis. DHS has begun this technical process and required its contracted MCOs to offer APIs in compliance with the law.⁴⁷

Oversight activities

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

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

Reporting and evaluation

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

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

42 CFR §438.340(b)(6) Health disparities reduction

The state agency works to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The state agency strives to identify this demographic information for each enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. Age and sex indicators are included in all enrollment files, along with the basis for eligibility which includes disability status. Identification of race, ethnicity, and primary language are requested as part of the enrollment process and provided to the MCOs; improving the quality of these data is an ongoing process of training enrollment workers. DHS defines disability for adults as the inability to engage in substantial gainful activity by reason of medically determinable impairment that has lasted or is expected to last 12 months or longer or result in death. For children it is defined as a

⁴⁷ See CMS-0057, April 8, 2024.

physical or mental condition (or combination of conditions) that very seriously limits their activities and has lasted or is expected to last 12 months or longer or result in death.

The Health Care Disparities Report provided by Minnesota Community Measurement (MNCM), provides performance rates on clients enrolled in Minnesota Health Care Programs (MHCP). The purpose of this report is to provide transparency on data, specifically on performance and health outcomes, to optimize system-wide changes. The Health Care Disparities Report is inclusive of 11 medical group and clinic level measures, which also presents analysis based on race, ethnicity, and region. The report also aligns with the Minnesota Statutes, § 256B.072(d), "Performance Reporting and Quality Improvement System." The Health Care Disparities Report includes analysis on comparison between MHCPs and Other Purchasers, in order to ensure equity of care, access, and utilization of services. It is published and posted on the Minnesota Community Measurement and the Department of Human Services websites. By making this document available, it provides an insight on current challenges and identifies opportunities to reduce health disparities in the state.

42 CFR §438.700 Basis for imposition of sanctions

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

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

In determining a remedy or sanction, the state agency is obligated to consider the number of enrollees or recipients, if any, affected by the breach, the effect of the breach on enrollees' health and enrollees' and recipients' access to health services or, in the case that only one enrollee or recipient is affected, the effect of the breach on that enrollee's or recipient's health, whether the breach is an isolated incident or part of a pattern of breaches, and the economic benefits, if any, derived by the MCO as a result of the breach. The type of sanctions included in the contract satisfies most of the requirements of 42 CFR §438.700.

42 CFR § 438.702 Types of intermediate sanctions and § 438.704

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

Appendix B: Triennial Compliance Assessment

SUMMARY

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

TRIENNIAL COMPLIANCE ASSESSMENT (TCA) ELEMENTS

- 1. QI Program Structure:** The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D (access, structure and operations, and measurement and improvement) as stated in contract section 7 of the DHS/MCO Contracts.
- 2. Information System:** The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement programs as stated in contract section 7 of the DHS/MCO Contracts.
- 3. Review of Utilization Management:** The MCO shall adopt a utilization management structure consistent with state regulations and federal regulations and current NCQA "Standards for Accreditation of Health Plans."⁴⁸ Pursuant to 42 CFR §438.330(b)(3), this structure must include an effective mechanism and written description to detect both under and over utilization as stated in contract section 7 of the DHS/MCO Contracts.
- 4. Special Health Care Needs:** The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.
- 5. Practice Guidelines:** The MCO shall adopt, disseminate, and apply practice guidelines consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans," QI 7 Clinical Practice Guidelines as stated in contract section 7.1.6 of the DHS/MCO Contracts.
- 6. Annual Quality Assurance Work Plan (QA Work Plan):** The MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, part 4685.1130, subpart 2, and current NCQA "Standards and Guidelines for the Accreditation of Health Plans", as stated in contract section 7 of the DHS/MCO Contracts.
- 7. Annual Quality Assessment and Performance Improvement Program Evaluation (QAPI):** The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations and current NCQA "Standards and Guidelines for the Accreditation of Health Plans."
- 8. Performance Improvement Projects (PIPs):** The MCO must conduct PIPs designed to achieve,

⁴⁸ 2024 Standards and Guidelines for the Accreditation of Health Plans, effective July 1, 2024

through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Projects must comply with 42 CFR § 438.30(b)(1) and (d) and CMS protocol entitled “CMS External Quality Review (EQR) Protocols October 2019.” The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

9. Population Health Management (PHM) Program. The MCO shall create and report annually to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July 31 of the contract year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate plan MCO’s performance on its process outcomes (for example, clinical care, or Enrollee experience of care). The plan must be updated within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.11.3, Service Delivery Plan, as stated in contract section 7 of the DHS/MCO Contracts.

10. Advance Directives Compliance: The MCO agrees to provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the Elements stated in contract section 14 of the DHS/MCO Contracts.

11. Validation of MSHO and MSC Care Plan Audits: MDH will collect information for DHS to monitor MCO Care Plan Audit activities as outlined in the DHS/MCO MSHO/MS+ Contract.

12. Subcontractors (Including Pharmacy Benefit Managers): All subcontracts must be current, in writing, fully executed, and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include elements stated in contract section 9 of the DHS/MCO Contracts. Subcontractors must not be located outside of the United States.

13. EW Care Plan Audit: Since July 1, 2009, MDH has been collecting information on Elderly Waiver Care Planning Audit, required by the DHS/MCO Minnesota Senior Health Options (MSHO) / Minnesota Senior Care Plus (MS+) Contract. A Care Plan Audit Protocol is developed each year for use by the MCOs. The seventeen elements included in the Care Plan Audit Protocol are as follows:

- a. Enrollee Assessment
- b. Comprehensive Care Plan
- c. Comprehensive Care Plan – Assessed Needs Addressed
- d. Comprehensive Care Plan – Goals
- e. Comprehensive Care Plan – Choice
- f. Comprehensive Care Plan – Safety/Person Risk Management
- g. Comprehensive Care Plan – Informal and Formal Services
- h. Comprehensive Care Plan – Caregiver Support
- i. Comprehensive Care Plan – Housing and Transition
- j. Communication of Care Plan/Summary – Physician
- k. Communication of Care Plan/Summary – Enrollee and Providers
- l. Comprehensive Care Plan – Enrollee Request for Updates
- m. Care Coordinator Follow-up Plan
- n. Annual Preventive Health Exam
- o. Advance Directive
- p. Appeal Rights
- q. Data Privacy

Appendix C: Data Collection Burden Reduction

To avoid duplication, the Managed Care Quality Strategy's assessment of mandatory activities includes information obtained from the National Committee for Quality Assurance (NCQA) in addition to the Minnesota Department of Health's triennial Quality Assurance Examination (QAE)

DHS, the Minnesota Department of Health, MCOs and NCQA have spent considerable time meeting to determine how information gathered by NCQA and Medicare can be used to minimize the data collection burden and still provide the External Quality Review Organization information to complete its assessment consistent with 42 CFR §438.364.

Currently, six MCOs are accredited by NCQA; if an NCQA accreditation review indicates the MCO did not obtain 100 percent compliance with a standard (or element), MDH completes the entire review of that standard during their triennial onsite review. If the MCO is in 100 percent compliance with NCQA standards considered by DHS as equal or greater than state and federal requirements, then MDH will not audit the applicable section. Likewise, equivalent CMS Medicare Audit Standards will be used to reduce the triennial audit data collection burden. Data collection burden is reduced since:

- MDH and DHS agree on joint aspects of the review, for example Credentialing, and delegation oversight. MDH does the review for both entities.
- MDH's QAE and TCA review is done at the same time.
- Same Quality documents, annual work plan and annual evaluation – submitted to DHS only; MDH gets these documents from DHS at time of audit. DHS accepts MDH review of written Quality plan. Complaint and Appeal System as per Minnesota Statutes §62Q.69-§62Q.73; Grievances and Appeal system and State Monitoring as per 42 CFR §438.228; Information requirement as per §438.10; Enrollee rights as per §438.100; and Section 8 of the DHS/MCO contracts.
- Access and availability or continuity of care, for example, Geographic Accessibility, Network Adequacy as per Minnesota Statutes §62k.10 and §62D.124; and Inappropriate Utilization, Essential Community Providers; Coverage for Court Ordered Mental Health Services; Coverage of Non-formulary Drugs for Mental Illness; and Continuity of Care as per §62Q.56.
- Overlapping requirement for UM, for example:
 - DTR requirements in 42 CFR §438.404 regarding timing of notice and written and oral notifications as well as §438.210 (coverage and authorization of services) as interpreted by DHS are consistent with the requirements of the contract.
 - Appeal requirements in 42 CFR §438.406 and 438.408 are reviewed in concert with MS §62M.06 requirements since requirements overlap.
- Same timelines for submission of audit materials and CAPs with submission to one agency.

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

Table 6: Private accreditation (NCQA) and Medicare quality standards that are comparable to Managed Care standards

| Medicaid Regulation | 100% Compliance with the NCQA Standard** |
|---|---|
| Utilization Review and Over/Under Utilization of Services 42 CFR §438.330 (b)(3) | UM 1-5, UM 10-11, UM 13 |
| Health Information Systems 42 CFR §438.242 | Annual NCQA Certified HEDIS Compliance Audit 1 |
| Clinical Practice Guidelines 42 CFR §438.236 (b-d) | *PHM 1-7 (2024 NCQA) |
| Case Management and Care Coordination 42 CFR §438.208 (b)(1-3) | MSHO and MSC+ Elderly Waiver Care Planning Audit Protocols, MED 5: Care Coordination; and PHM 5: Elements A, B, C, D, E |
| Confidentiality 42 CFR §438.208 (b)(4), §438.224, and 45 CFR Parts 160 and 164, Part 431, Subpart F | RR5, Elements A-G |
| Credentialing and Re-credentialing 42 CFR §438.214 | CR 1 - 8 |

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

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

**Details can be found in the CY2024 TCA Info Pack.

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

Evaluation Plan 2021 to 2025

Introduction

The PMAP+ Section 1115 Waiver has been in place for over 30 years, primarily as the federal authority for the MinnesotaCare program, which provides comprehensive health care through Medicaid funding for people with income in excess of the standards in the Medical Assistance (MA) Program. On January 1, 2015, the MinnesotaCare program converted to a Basic Health Plan. Even though the PMAP+ waiver is no longer necessary to continue the MinnesotaCare program, several aspects of the PMAP+ waiver continue to be necessary.

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

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

- Preserving eligibility methods currently in use for children ages 12 through 23 months;
- Waiving the federal requirement to redetermine the basis of MA eligibility for caretaker adults with incomes at or below 133 percent of the FPL who live with a child(ren) age 18 who are not full-time secondary school students;
- Providing full MA benefits for pregnant women during the period of presumptive eligibility; and
- Payments for graduate medical education costs through the MERC fund. Waiver Populations and Expenditure Authorities for PMAP+ 2021-2025 Evaluation MA One-Year-Olds.

The PMAP+ waiver provides for Medicaid coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medicaid, with incomes above 275% and at or below 283% of the federal poverty level (FPL).

Caretaker Adults with Children

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

The household size for the parent is independent of the required tracking of the child’s full-time student status. For non-tax filing families, Minnesota has chosen age 19 as the age at which a child is no longer in the household. In a tax filing household, the parent’s household size would depend on whether they expect to claim the child as a dependent, regardless of age. By waiving the requirement to track the full-

time student status, Minnesota avoids requesting private data that will not be consequential to the consumer’s eligibility for health care. In addition to relieving the burden on consumers and not requesting personal information that is not relevant to eligibility, coverage, or cost-sharing, Minnesota expects the waiver to result in administrative efficiency by simplifying the procedures that case workers need to follow.

Pregnant Women

The Patient Protection and Affordable Care Act (ACA) established the hospital presumptive eligibility (PE) program effective January, 2014 allowing qualified hospitals to make MA eligibility determinations for people who meet basic criteria. Under hospital PE, covered benefits for pregnant women during a presumptive eligibility period are limited to ambulatory prenatal care. Minnesota has secured PMAP+ waiver authority to allow pregnant women to receive services during a presumptive eligibility period that are in addition to ambulatory prenatal care services. The benefit for pregnant women during a hospital presumptive eligibility period will be the full benefit set that is available to qualified pregnant women in accordance with section 1902(a)(10)(i)(III) of the Act. Implementation of presumptive eligibility began in July 2014.

MA One-Year-Olds -- Goal/Objective

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

Research Question

- Did the MA one-year-old child population experience comparable utilization of services (i.e. childhood immunization status, well-child visits, and access to primary care practitioners) when compared to national Medicaid averages?
 - Do the rates for each of the measures vary by race within Minnesota’s MA one-year-old child population?

Hypothesis

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

| Research Question(s) | Comparison Population(s) | Measures | Comparison Years | Data Source(s) |
|--|--|--|--|--|
| 1. Did the MA one-year-old child population experience comparable utilization of | Children 12-24 months who are enrolled in Medicaid in the United States. | Childhood immunization status (2 yr) (CIS)* Well-child visits (first 15 months) | Measurement Years (MY) 2021-2025 Reference Years (RY) | MMIS claims data and national Medicaid NCQA Quality Compass rates national Medicaid data |

| Research Question(s) | Comparison Population(s) | Measures | Comparison Years | Data Source(s) |
|---|--|--|------------------------------|------------------|
| preventative and chronic disease services, when compared to national Medicaid averages? | | (W15) * Child access to primary care practitioners (ages 12-24 mos) (CAP)* | RY 2019-2020 | |
| 2. Do childhood immunization status, well- child visits, or access to primary care | Comparisons by race will be made within the population of MA enrollees who are | a) Childhood immunization status (2 yr) (CIS)* | MY 2021-2025 RY 2019-2020 | MMIS claims data |
| Research Question(s) | Comparison Population(s) | Measures | Comparison Years | Data Source(s) |
| practitioners vary by race within the one-year-old child population? | between 12 and 24 months of age. | Well-child visits (first 15 months) (W15) * Child access to primary care practitioners (ages 12-24 months) (CAP)* | | |

*NCQA HEDIS Measures

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the MA one- year-old child population compared to other children enrolled in public health care programs. A comparison and stratification of the selected HEDIS and other performance measures will be made between the MA one-year-old population and the Medicaid national child (12-24 months) population to show the ongoing improvement in care for children enrolled in Medicaid in Minnesota. The HEDIS performance measures are rates that are generally defined as the sum of eligible individuals who received a service (numerator) divided by the total number of individuals who qualified for the service (denominator).

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

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

Medicaid Caretaker Adults with 18-Year-Old Goal/Objective

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

Research Questions

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

Hypothesis

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

| Research Question(s) | Comparison Population(s) | Measures | Comparison Years | Data Source(s) |
|---|--|--|----------------------------------|------------------|
| 1. Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to other adults who are enrolled in MA in Minnesota? | MA parents in Minnesota MA adults without children in Minnesota | For both comparison populations, the following measures will be used: Annual dental visit Cervical cancer screening Comprehensive diabetes care Follow-up after hospitalization for mental illness Medication management for people with asthma Access preventative/ambulatory health services | MY 2021-2025 RY 2019-2020 | MMIS claims data |

| Research Question(s) | Comparison Population(s) | Measures | Comparison Years | Data Source(s) |
|---|--|---|------------------------------|--|
| 2. Did the MA caretaker adult waiver population experience comparable utilization of preventative and chronic disease care services for adults when compared to national Medicaid averages (i.e. annual dental visit, cervical cancer screening, comprehensive diabetes care, follow-up after hospitalization for mental illness, medication management for people with asthma, and access preventative/ ambulatory health services)? | Other adults enrolled in MA in the United States | Cervical cancer screening Comprehensive diabetes care Follow-up after hospitalization for mental illness Medication management for people with asthma Access preventative/ ambulatory health services | MY 2021-2025 RY 2019-2020 | MMIS claims data and national Medicaid NCCA Quality Compass rates national Medicaid data |

Statistical Methods

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

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

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

Pregnant Women in a Presumptive Eligibility Period

Goal/Objective

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

Research Question

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

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

Statistical Methods

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

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

Evaluation Implementation Strategy and Timeline Waiver Populations

Beginning in 2026, performance measurement data will be extracted from DHS’ managed care encounter and fee-for-service database to allow for a sufficient encounter/claim run-out period. Performance measurement rates for the baseline period (CY 2019 and 2020) will be calculated for the targeted populations and compared to CY 2021, 2022, 2023, 2024, and 2025. In addition, national

benchmarks will be obtained from NCQA's Medicaid Quality Compass to compare performance of Minnesota's populations with national and other states' performance.

The DHS Health Care Research and Quality Division will conduct this component of the waiver evaluation and review results over the second half of calendar year 2026 with the draft final report submitted to CMS in December 2026.

Here is an overview of evaluation activities and timelines:

- August 2025: DHS will calculate measurement rates for baseline goals.
- September-October 2025: DHS will calculate and stratify HEDIS 2020-2024 performance measures.
- October 2026: HEDIS results will be reviewed and evaluated.
- November-December 2026: Draft final waiver report is written, reviewed and submitted to CMS. March 2027: CMS submits feedback to DHS.
- May 2027: DHS incorporates CMS feedback. Final report is submitted to CMS.

Appendix E

Evaluation Plan for Reform 2020 Section 1115 Demonstration Waiver

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

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

Minnesota has been reducing use of institutions through development of home and community-based long-term supports and services for over thirty years. Minnesota has rebalanced its system so that a large majority of the older adults (74% in 2018) and people with disabilities (95% in 2018) who are enrolled in MA and need long term care services are living in the community rather than in institutional settings.

Minnesota has five home and community-based services waivers: Developmental Disability (DD)⁴⁹, Community Alternatives for Disabled Individuals (CADI)⁵⁰, Community Alternative Care (CAC)⁵¹, Brain Injury (BI)⁵² and Elderly Waiver (EW)⁵³. Similar services to support individuals living in the community are offered under each waiver, but since each was developed over time and under different constraints, opportunities, and different populations, HCBS waivers differ from one another in areas such as eligibility criteria and annual spending.

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

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

Minnesota's Reform 2020 demonstration enables the state to continue its history of on-going improvement to enhance its home and community-based service system by enabling the state to provide preventive services to seniors who are likely to become eligible for Medicaid and who need an institutional level of care. The demonstration goals align with those of Medicaid and assist the state in promoting title XIX program objectives in the following ways:

- Achieving better health outcomes;
- Ensuring that the demonstration increases the participants' level of support for

⁴⁹ DD: 2019 unduplicated enrollment was 21,120

⁵⁰ CADI: 2019 unduplicated enrollment was 31,715

⁵¹ CAC: 2019 unduplicated enrollment was 649

⁵² BI: 2019 unduplicated enrollment was 1,242

⁵³ EW: 2019 unduplicated enrollment was 36,680 (managed care and fee-for-service)

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

Background on the Reform 2020 Section 1115 Waiver for Alternative Care

The Alternative Care or AC program was implemented under Reform 2020 beginning November 1, 2013. Formerly a state-funded program, the Reform 2020 waiver allows Minnesota to receive federal financial participation to provide Alternative Care services to people over age 65 whose functional needs indicate eligibility for nursing facility care but have combined adjusted income and assets exceeding state plan Medicaid standards for aged, blind and disabled categorical eligibility.

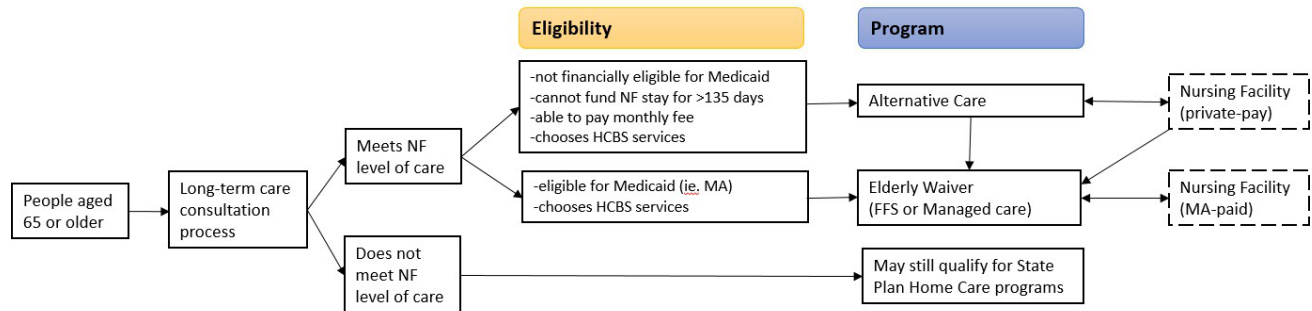
Acute and primary care services are not covered under the program. However, connecting seniors with community services earlier may divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established. Minnesota has a home and community-based waiver for people over age 65 that need nursing facility care called the Elderly Waiver. Although Alternative Care covers fewer services, service definitions and provider standards for the Alternative Care program are the same as the service definitions and provider standards specified in Minnesota’s federally approved Elderly Waiver. Services are provided by qualified enrolled Medicaid providers.

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

- Those with combined income and assets insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate
- Those not within an uncompensated transfer penalty period
- Those with home equity within the home equity limit applicable under the state plan

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

Figure 1. Minnesota Health Care Program Options for the Elderly



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

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

spenddown to MA. A person may also spend-down and become eligible for Medicaid while enrolled in Alternative Care. In that case, he/she can also transition to the Elderly Waiver. For details on how a person transitions from Alternative Care to Elderly Waiver program, refer to the “AC Operational Protocol”.

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

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

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

The comprehensive list of Alternative Care services is below.

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

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

Program Goals

The goals of the Alternative Care program are to:

- Provide access to coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.

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

Figure 2: Alternative Care Program Logic Model

| Inputs | | Outputs | | Outcomes | |
|---|--|--|---|--|--|
| Resources | Legislative Oversight | Service and Access | Activities | Short-term | Long-term |
| <ul style="list-style-type: none"> • LTCC/MnChoices assessors • LTC screening assessment to determine whether a person qualifies for nursing facility level of care • Training of staff (e.g. case managers, assessors) • Continuing training (e.g. bulletins, webinars, video conferencing) • Legislative authority • State funding • DHS administrative resources • Local HCBS provider networks • External evaluators and volunteers to survey AC beneficiaries | <p>Policy Changes</p> <ul style="list-style-type: none"> • Changes in financial eligibility determination • Changes in program fees • Changes in covered services • Changes in provider standards <p>Budget Changes</p> <ul style="list-style-type: none"> • Rate changes | <p>Accessed in the person's home and community</p> <p>Covered Services</p> <ul style="list-style-type: none"> • Adult Day service • Case management • Chore services • Companion services • Consumer-directed community supports • Home health aides • Home-delivered meals • Homemaker services • Changes to make homes and equipment accessible • Nutrition services • Personal care • Respite care • Skilled nursing • Specialized equipment/supplies • Personal emergency response system • Training and support for family caregivers • Nonmedical transportation • Discretionary services | <p>State-level</p> <ul style="list-style-type: none"> • Monitoring spending at a county-level* • Monitor AC enrollment and program spending • Issue policies, guidance, and resources • On-site lead agency review of cases every 3 years to assure program compliance • Further develop a HCBS provider network • Add/remove/redesign services per stakeholder feedback • Facilitate participant feedback surveys <p>County-level</p> <ul style="list-style-type: none"> • Assess program eligibility • Determine financial eligibility (includes citizenship validation) † • Develop a support plan to meet assessed needs • Authorize services • Monitor implementation of the support plan • Feedback to DHS on barriers to AC use <p>Provider-level</p> <ul style="list-style-type: none"> • Support the person through provision of services | <p>Program Beneficiaries</p> <ul style="list-style-type: none"> • Able to live in their homes and communities with necessary supports • Direct their services and supports <p>State-level</p> <ul style="list-style-type: none"> • Collect and internally analyze AC enrollment across time | <p>Program Beneficiaries</p> <ul style="list-style-type: none"> • Prevent and delay transitions to a nursing facility • Prevent seniors from spending down their assets • Increase the quality-of-life of seniors by spending more time in the community with their family and friends <p>State-level</p> <ul style="list-style-type: none"> • Save Medicaid dollars • Change in expectations about the state's ability to serve older adults in the community rather than in institutions • Rebalancing of public dollars away from institutions and toward HCBS for older adults • Continued AC funding |

*Minnesota DHS stopped monitoring county spending on AC program at the 2015 legislative session.

†After the federal match for AC program, DHS began validating citizenship.

Evaluation



Evaluation Questions and Hypotheses

The Reform 2020 demonstration waiver extension is approved for the period February 1, 2020 through January 31, 2025. Since the federal waiver authorization has not resulted in any substantial changes to the Alternative Care program structure, we expect that key evaluation metrics will not change over the extension period (2020–2025) as a result of the continuation of the AC waiver. We will be testing the null hypotheses of no change attributable to the AC waiver extension. We will test these null hypotheses by tracking trends in service use and outcomes and drawing comparisons with a matched sample of EW participants who presumably will be subject to the same external events, such as COVID-19, as AC participants. We plan to assess the following hypotheses.

As a consequence of the AC Waiver extension from 2020-2025:

- The demographic characteristics and service needs of AC participants will not change.
- AC participants will not experience a change in the types of HCBS services or a decrease in the intensity of services, i.e., number of hours or units of service.
- AC participants will experience equal or better access to consumer-directed service options;
- AC participants will not experience an increase in nursing facility use;
- AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits; and
- The rate of Medicaid conversion for AC participants through transitions between AC and EW and other waiver programs or nursing home use will not increase.

We must consider the possibility of changes occurring in these metrics due to external events outside of the AC waiver itself. These events could influence access to or use of HCBS or other services or change health status over the extension period. For example, the COVID-19 pandemic is an external event that has likely influenced service use patterns and outcomes in 2020-2021 and it may continue to do so in the future. The evaluation design, therefore, should attempt to separate out changes over time due to the AC Waiver from those attributable to COVID-19 or other external events.⁶

To strengthen the evaluation design, we propose to examine trends over a five year period prior to the waiver (2015-2019) as a backdrop to the trends during the extension period. In addition, we will compare the AC participants with a balanced sample of Elderly Waiver participants. By examining past trends, we can estimate the impact of COVID-19 or other identifiable external events, such as HCBS policy changes. We anticipate some disruption of HCBS, acute care, and other service use. In the period 2021-2025, some changes associated with the COVID-19 pandemic may continue. By selecting an EW comparison group that is similar to AC participants in demographics, need, and access to services, we can check for parallel trends and perform difference in difference calculations in an attempt to isolate waiver-related changes from COVID-19

Available at <https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-covid19-implications.pdf>. or other external events. If AC and EW participants follow the same patterns of HCBS or other service use disruption during or after the COVID-19 pandemic, we have a stronger basis for inferring that it was COVID-19 rather than the AC waiver that contributed to these changes. Given data limitations and the complexity of events during and after COVID-19, we must be cautious in our interpretations of patterns in the data.

Methodology

To test these hypotheses, we will employ multiple strategies: (1) examine trends in repeated 12-month cross sectional measures of demographics, service use and other patterns for AC participants beginning with the baseline period (2015-2019) and continuing through the extension period (i.e., 2020-2025); (2) conduct a parallel cross-sectional analysis for a comparison groups of EW participants selected through balanced sampling; (3) track patterns in key metrics for longitudinal cohorts of AC participants and EW participants beginning in 2019, 2020, and 2021 and then followed through 2025. In conducting the trend and cohort analyses, we will look for changes in service use and other metrics, particularly any unintended consequences for program participants that could be attributable to the AC waiver compared to external events such as COVID-19.

Comparison of AC Participants and EW Sample

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

Some EW participants will use residential services (i.e., customized living, adult foster care). We will identify EW participants in non-residential settings by excluding participants with any claims for residential services. Internal program monitoring and evaluation show that the number of unique participants in AC remained relatively constant from 3,679 in 2015 to 3,652 in 2018; whereas the number of EW participants in non-residential settings increased somewhat from 19,934 in 2015 to 22,042 in 2018.⁵⁴

We will select a comparison group of EW participants according to balance sampling techniques in order to ensure that the EW comparison group is as similar as possible to the AC participants in demographics, health, and functioning.

Metrics Aligned with Hypotheses

Hypothesis 1. The demographic characteristics and service needs of AC participants will not change.

- Gender, race/ethnicity, age composition, living arrangement, and residential location
- Case mix status (low-need vs. high-need)⁵⁵
- Professional recommendations for service need and supports
- ADL dependencies
- Health status – major diagnoses

Hypothesis 2. AC participants will not experience a change in the types of HCBS services or a decrease in the intensity of services, i.e., number of hours or units of service.

- Prevalence of HCBS waiver services
- Prevalence of state-plan LTSS services, e.g., PCA
- Hours/units of HCBS waiver services
- Hours/units of state-plan services, e.g., PCA

⁵⁴ Evaluation of Minnesota's Reform 2020 Section 1115 Demonstration Waiver, Alternative Care Program. Minnesota Department of Human Services, June 2021

⁵⁵ See section 2.42 for details on case mix is determined and level of need is defined.

Hypothesis 3. AC participants will experience equal or better access to consumer-directed service options.

- Prevalence of authorized consumer-directed community supports
- Number of units/hours of consumer-directed community supports

Hypothesis 4. AC participants will not experience an increase in nursing facility use.

- Proportion of participant days spent in nursing facilities
- Frequency of nursing facility admission, by length of stay
- Case mix adjusted nursing facility admission
- Number of nursing facility days
- Return or new use of AC or Elderly Waiver programs after discharge from nursing facility

Hypothesis 5. AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits.

- Rate of acute inpatient admissions
- Rate of ED visits
- Mortality rate

Hypothesis 6. The rate of Medicaid conversion for AC participants through transitions between AC and EW and other waiver programs or nursing home use will not increase.

- AC participants converting to Medicaid
- Transition from AC to EW or other HCBS waiver program
- AC participant transition to Essential Community Supports⁵⁶
- Days alive in the community and not on Medicaid

Data Sources and Variable Construction

Data Sources

MMIS

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota. Health care providers, county staff, and DHS administration uses the MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs. The MMIS contains both fee-for-service claims and data on use of services by individuals enrolled in managed care plans. The following types of data will be used for the current evaluation:

- Program begin and end date
- Claims for HCBS and other services
- Death date
- Demographics

⁵⁶ The Essential Community Supports Program (ECS) program was established by the Minnesota Legislature and became effective January 1, 2015. Initially designed to provide support for individuals who might lose their HCBS program eligibility as a result of changes to the nursing facility level of care criteria that also became effective January 1, 2015, it was also adopted as an ongoing program for individuals aged 65 and older with emerging needs for HCBS but who do not yet meet level of care criteria and who are not MA eligible but meet the AC financial eligibility criteria. This program has a relatively small basket of services and monthly budget.

- In residential or non-residential setting

LTC Screening Document

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

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

Minimum Data Set (MDS)

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. These assessments contain the following variables that will be used for the current evaluation:

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

Medicare Data

Medicare claims will provide utilization for non-Medicaid-covered services (particularly for AC participants or for periods when a participant is not covered by Medicaid), but otherwise will largely duplicate what we can learn from MMIS. Medicare files will be requested for persons age 65+ who were enrolled in Medicaid or AC (from existing MMIS) and anyone using skilled nursing facilities (from MDS). The MBSF and MedPAR files will provide sufficient information for the outcome variables.

- Dates of acute hospital stays and emergency department visits
- Utilization outside of periods of Medicaid eligibility or for services not covered by Medicaid
- Associated diagnoses and procedure codes

- Date of death
- Special Variable Construction
- Case mix

Case mix is a classification tool that is used in both AC and EW programs to establish monthly budget limits for HCBS services. A copy of the Case Mix Classification Worksheet describing the factors used to determine a case mix classification for all AC and EW participants is at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG>. The classification is based on assessed need in:

- Eight activities of daily living (ADLs): bathing, dressing, grooming, walking, toileting, positioning, transferring, and eating
- The need for clinical monitoring in combination with a physician-ordered treatment, and
- The need for staff intervention due to behavioral or cognitive needs.

After assessment, the individual is assigned a case mix classification of A-L based on their combination of ADLs, clinical monitoring and behavioral/cognitive needs.⁵⁷

Level of Need

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

- Low Need (A, L): This group includes individuals with 0-3 ADL dependencies
- Moderate Need (B, D, E): This group includes individuals with 4-6 ADL dependencies and/or behavioral/cognitive needs.
- High Need (G, H, I, J): This group includes individuals with dependencies in 7 or 8 ADLs (G), and those with specific other needs in combination with 7-8 ADL dependencies.
- High Need Clinical (C, F, K, V): This group includes individuals with varying number of dependencies but who have an assessed need for clinical monitoring at least once every 8 hours.

Analytic Methods

We propose the following methods to address the hypotheses for the evaluation. The sections below provide information about each approach, including the comparison group(s), metrics, and statistical methods.

Data Set Development

The cross-sectional data sets will be developed by assembling data each calendar year from 2015-2025 for AC and EW participants, constructing all relevant variables, and sample balancing matching to select the EW participant sample.

For each calendar year, we will identify AC and Elderly Waiver participants using LTC screening assessment data (also available in MMIS). We will further identify Elderly Waiver participants in non-residential settings by excluding participants with any claims for procedure codes denoting residential services (i.e., customized living, adult foster care, and residential care services). While living in the community, if an AC participant uses CDCS, this information will be recorded in the MMIS claims data, as

⁵⁷ EW also has a case mix V for people who are ventilator dependent

well as the total dollars paid for CDCS in a fiscal year. We will categorize acuity into two categories: low-need and high-need and calculate differences in case mix for each year between AC and Elderly Waiver participants by acuity type.

The cohort data sets will consist of participants selected from the cross-sectional data sets in 2019-2021. Longitudinal data will be assembled for three participant cohorts from the beginning cohort year (2019, 2020, or 2021) through 2025. Although the cross-sectional and cohort samples will be separated analytically, the data sets will have overlapping participants who were receiving waived services in more than one year.

Comparison Sample Selection

We will employ a sample balancing methodology to select samples of EW participants that match as close as possible on key characteristics of the AC participants.⁵⁸ Predictor variables include gender, race/ethnicity, age composition, living arrangement, and residential location, case mix status (low-need vs. high-need), professional recommendations for service need and supports, ADL dependencies, and health status and major diagnoses.

The matching sample with the minimum total difference (Mahalanobis distance) will be used for the analysis.⁵⁹ Individual characteristics will be compared between the pseudo control and assisted groups and tested for significant differences ($P < 0.05$) with t-tests and Fisher's exact test.

Repeated Cross-Sectional Analysis

In the first step in the analysis, will compare annual cross-sections of AC participants to the matched samples of EW participants. We will calculate the proportions and intensity (hours or units) of HCBS other Medicaid services. We will also count the number of acute care episodes and nursing home admissions. We will calculate the proportion of individuals that remain enrolled in AC, those that switched to Elderly Waiver, and the days alive in the community and not on Medicaid (i.e., not using residential services). We will also account for death and loss of AC eligibility.

For all measures, we will report the denominator, number and percent of participants, and person months in each service category, program category, and care setting. We will test the difference in proportions and means between AC and EW participants in each year, as well as differences between years. We will apply t- tests or Z-tests to test for differences in means and proportions. We will also test for differences in trends in service use over time with generalized estimating equations (GEE).⁶⁰

Cohort Analysis

Patterns in outcomes (e.g., transitions between program statuses or care settings) for AC and EW participants in the three cohorts (2019, 2020, 2021) will be visualized with time plots. Separate Cox-proportional hazard models were used to test for differences in the time to event. Variables causing a violation of the proportional hazards assumption will be removed. Multilevel or mixed effect growth models will be used to evaluate HCBS and other service utilization. The models will be calendar quarter time periods from 2019 – 2021. Service use will be the outcome. Calendar quarter, AC participation, and interaction between quarter and AC participation will be fixed effects.

⁵⁸ Deville, J. C., & Tillé, Y. (2004). Efficient balanced sampling: the cube method. *Biometrika*, 91(4), 893- 912.

⁵⁹ Rosenbaum, P. R. (1989). Optimal Matching for Observational Studies. *Journal of the American Statistical Association*, 84(408), 1024-1032.

⁶⁰ Hardin JW, Hilbe JM (2003) *Generalized estimating equations*. Boca Raton: CRC Press.

Design Table for the Evaluation of the Demonstration

| Research Question | Outcome measure used to address the research question | Data Sources | Sample or population | Analytic Methods |
|--|---|------------------------------------|---|--|
| Hypothesis 1. The demographic characteristics and service needs of AC participants will not change | | | | |
| 1a. What are demographic characteristics of people who use the AC waiver? | - Gender, race/ethnicity, age composition, living arrangement, and residential location | - MMIS - LTC assessment | Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) | - Multiple cross-section comparisons - Descriptive statistics - Chi-square test/Fishers exact test |
| 1b. What are the service needs of people who use the AC waiver? | - Case mix status (low-need vs. high-need) ⁶¹ - Professional recommendations for service need and supports - ADL dependencies - Health status – major diagnoses | - LTC Screening Document - MMIS | Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics | - Multiple cross-section comparisons for successive years - Descriptive statistics - Chi-square test/Fishers exact test - Regression models with service need as an outcome, controlling for demographics |
| Hypothesis 2. AC participants will not experience a change in the types of HCBS services or a decrease in the intensity of services, i.e., number of hours or units of service. | | | | |
| 2a. What are the types of services used by AC participants? | - Prevalence of HCBS waiver services - Prevalence of state-plan LTSS services, e.g., PCA | - MMIS | Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) | - Multiple cross-section comparisons for successive years - Descriptive statistics |

⁶¹ See section 2.42 for details on case mix is determined and level of need is defined.

| Research Question | Outcome measure used to address the research question | Data Sources | Sample or population | Analytic Methods |
|---|--|--------------|--|--|
| | | | AC compared to all EW participants and to EW sample matched to AC on demographics and service need | <ul style="list-style-type: none"> - Chi-square test/Fishers exact test - Regression models with service use as an outcome, controlling for demographics and service need |
| 2b. What is the intensity of services used by AC participants? | <ul style="list-style-type: none"> - Hours/units of HCBS waiver services - Hours/units of state-plan services, e.g., PCA | - MMIS | <p>Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW)</p> <p>AC compared to all EW participants and to EW sample matched to AC on demographics and service need</p> | <ul style="list-style-type: none"> - Multiple cross-section comparisons for successive years - Descriptive statistics - t-tests - Regression models with service intensity as an outcome controlling for demographics and service need |
| Hypothesis 3. AC participants will experience equal or better access to consumer-directed service options. | | | | |
| 3a. What is the utilization of consumer-directed support (CDCS) options for AC waiver participants? | <p>Prevalence of authorized consumer- directed community supports</p> <hr/> <p>Number of units/hours of consumer-directed community supports</p> | - MMIS | <p>Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW)</p> <p>AC compared to all EW participants and to EW sample matched to AC on demographics and service need</p> | <ul style="list-style-type: none"> - Multiple cross-section comparisons for successive years - Descriptive statistics - t-tests - Regression models with CDCS use as an outcome controlling for demographics and service need |

| Research Question | Outcome measure used to address the research question | Data Sources | Sample or population | Analytic Methods |
|---|---|--------------|--|--|
| Hypothesis 4. AC participants will not experience an increase in nursing facility use. | | | | |
| 4a. What are the utilization trends in nursing facility use? | <ul style="list-style-type: none"> - Time to nursing home use - Proportion of participant days spent in nursing facilities - Frequency of nursing facility admission, by length of stay - Case mix adjusted nursing facility admission - Number of nursing facility days - Return or new use of AC or Elderly Waiver programs after discharge from nursing facility | MDS, MMIS | Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics and service need AC and EW longitudinal cohorts consisting of current and new participants in 2019, 2020, and 2021 through 2025. | <ul style="list-style-type: none"> - Multiple cross-section comparisons for successive years - Descriptive statistics - Chi-square/Fishers exact test, t-tests - Regression models with NH use as an outcome controlling for demographics and service need - Time-to-event models (e.g., Cox proportional hazard) |
| Hypothesis 5. AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits. | | | | |

| Research Question | Outcome measure used to address the research question | Data Sources | Sample or population | Analytic Methods |
|---|---|---|---|---|
| 5a. What is the rate of acute events of people participating in AC waiver? | <ul style="list-style-type: none"> - Rate of acute inpatient admissions - Rate of ED visits - Mortality rate | <ul style="list-style-type: none"> - MMIS - Medicare data | Multiple cross-sections of people who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics and service need AC and EW longitudinal cohorts consisting of current and new participants in 2019, 2020, and 2021 through 2025. | <ul style="list-style-type: none"> - Multiple cross-section comparisons for successive years - Descriptive statistics - Chi-square/Fishers exact test, t-tests - Cross-sectional regression and growth models controlling for demographics and service need - Time-to-event models (e.g., Cox proportional hazard) |
| Hypothesis 6. The rate of Medicaid conversion for AC participants through transitions between AC and EW and other waiver programs or nursing home use will not increase. | | | | |
| 6a. What are the trends of Medicaid conversion for AC participants through transitions to EW, other waiver use, or nursing home use? | <ul style="list-style-type: none"> - Time to conversion - AC participants converting to Medicaid - Transition from AC to EW or other HCBS waiver program - AC participant transition to Essential Community Supports - Days alive in the community and not on Medicaid | <ul style="list-style-type: none"> - MMIS - Medicare data | Multiple cross-sections of people who are eligible for Alternative Care (AC) AC longitudinal cohorts consisting of current and new AC participants in 2019, 2020, and 2021 - 2025. | <ul style="list-style-type: none"> - Multiple cross-section comparisons for successive years - Descriptive statistics - Cross-sectional regression models - Time-to-event models (e.g., Cox proportional hazard) |

Methodological Limitations

Establishing a Baseline

Prior Alternative Care Evaluation reports have chosen the period prior to the introduction of the waiver

(2010-2013) as the pre-waiver baseline, while 2014-2017 served as the implementation period after the waiver. The AC program underwent significant changes, as did the Elderly Waiver program over these years. However, we found no evidence that these changes occurred because of the waiver. There were other external events, such as policy, programmatic, and demographic changes) that affected the program. The evaluation of the waiver extension will involve a baseline period of 2015-2019 and an evaluation period from 2020-2025. We selected this baseline for the extension period in order to estimate trends prior to the extension period, while avoiding a baseline that is too lengthy and where major policy changes had occurred, such as the change in the nursing facility level of care criteria at the end of 2014.

Selecting a Comparison Population

The Elderly Waiver population serves as a comparator for Alternative Care in most of the analysis. EW participants differ significantly from AC participants in some respects. Controlling statistically for these differences would strengthen the evaluation design. A sample balancing methodology will be used in order that the EW comparison group is as similar as possible to the AC participants in demographics, health, and functioning. Consideration will be given to characteristics and matching techniques for this population throughout the baseline and extension periods.

External Events – COVID-19

The COVID-19 public health emergency is likely to have had an impact on service needs and use of care for the AC population at the beginning of the extension period and perhaps continuing throughout the period. We will address this and other potential confounders by conducting a trend analysis for a period prior to COVID-19 and extending beyond the pandemic, assuming hopefully that it is nearing an end in mid-2021. Additionally, the EW participant comparison group will be employed as an indicator of the COVID-19 effect.

Cautious Generalization

We must exercise caution in the interpretation of our findings because of the strong possibility of unmeasured events or policy changes and the difficulty of inferring causality from our observational, quasi- experimental design.

Sections

Please see the following sections for additional information:

1. Independent Evaluator
2. Evaluation Budget
3. Timeline and Major Milestones

Independent Evaluator

Since May 2016, the Minnesota Department of Human Services has had a Professional/Technical Contract with the University of Minnesota to conduct the evaluation of the Alternative Care demonstration waiver. According to Minn. Stat. 16C.06 Subd. 3b(b), the combined length of a contract and amendments cannot exceed five years, unless approved by the Commissioners of the Department of Administration and Minnesota Management and Budget. DHS has approval to continue this contract with the University of Minnesota beginning July 1, 2021.

The contract between DHS and the University details the services to be performed during the contract period, a description of deliverables, such as reports, their due date, and amount to be paid for each deliverable. It also specifies the total payment obligation for all compensation and reimbursements to the University under this contract.

In addition, this contract details information privacy and security obligations in a Data Sharing Agreement and Business Associate Agreement Terms and Conditions. This covers all Protected Health Information and non-public information under the Minnesota Government Data Practices Act that is shared between the state and University. This outlines the protected data to be shared and responsibilities in the case of a breach.

Independent Capacity: This contract is between the State of Minnesota and the Regents of the University of Minnesota, an independent contractor, not an employee of the State of Minnesota. The contract certification form specifies that a contract shall not establish an employment relationship between the state or the agency performing work under the contract. The contractor and agency must not be employees of the state.

Minnesota Professional Technical contracts also certify that the contractors' employees and agents will not be considered employees of the state. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents are in no way the state's obligation or responsibility. By the terms of the contract the University certifies that it has liability insurance. Each party shall be responsible for claims, losses, damages and expenses which are proximately caused by wrongful or negligent acts or omissions of that party or its agents, employees or representatives acting within the scope of their duties. The liability of each party is as set out in chapter 3.736 of the Minnesota Statutes and subject to the limitations therein.

Evaluation Budget

Below are the proposed tasks, staffing, and costs for the evaluation budget. The budget is based on estimated costs incurred by the State of Minnesota in the form of staff time and a contract with an external evaluator who will conduct the analysis.

Evaluation Budget Tasks

Project Management and Consultation: The external evaluator and State of Minnesota will participate in bi-monthly meetings, and additional consultation via email, phone calls, and other methods as needed to support the research and evaluation activities. This includes support to administer the contract and provide subject matter expertise on policies, processes, and data needed to develop, implement, and interpret analytic models. In addition, presentations and summaries are expected to be used for ongoing monitoring of the evaluation. The State of Minnesota expects to dedicate 0.2 FTE of a program evaluation specialist, 0.1 FTE of a research and analysis supervisor, and 0.05 FTE of a research and analysis manager to this work each year.

Contract Deliverables: The external evaluation contract is expected to include annual deliverables, such as implementing an updated evaluation plan, annual analyses, and the interim and summative evaluation reports due Feb. 2024 and July 2026. It also includes the cost of Medicare data as made available to the University by CMS. Projections are estimated based on deliverable costs for the previous five year waiver reporting period.

Annual Costs

The table below reflects annual costs during the waiver reporting period. These include a 3% annual adjustment to account for inflationary cost increases.

| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
|-----------------------------------|-----------------|------------------|-------------------|-------------------|-------------------|-------------------|------------------|
| Project Management & Consultation | \$44,079 | \$ 45,401 | \$ 46,763 | \$48,166 | \$49,611 | \$51,100 | \$52,633 |
| Contract Deliverables | | \$ 45,085 | \$ 54,546 | \$61,800 | \$57,819 | \$59,553 | \$67,474 |
| Total | \$44,079 | \$ 90,486 | \$ 101,309 | \$ 109,967 | \$ 107,430 | \$ 110,653 | \$120,106 |

Timeline and Major Milestones

This demonstration approved period is from February 1, 2020 through January 31, 2025. The table below displays the timeline for the deliverables for the demonstration period including who is responsible.

| Deliverable | Responsible Party (from to) | Date |
|--|------------------------------|---|
| Draft Evaluation Design Plan | State to CMS | Within 120 days after the approval of the demonstration extension (July 30, 2020) |
| Final Evaluation Plan | State to CMS | Within 60 days following receipt of CMS comments on Draft Evaluation Design Plan |
| Annual internal report to DHS from independent evaluator | Independent Evaluator to DHS | June of each year during demonstration |
| Interim Evaluation Report | Independent Evaluator to DHS | June 2023 |
| Final evaluation report | Independent Evaluator to DHS | Within 12 months following the end of the demonstration extension period |
| Draft Summative Evaluation Report | State to CMS | Within 18 months following the end of the demonstration extension period |
| Final Summative Report | State to CMS | Within 60 days of receipt of CMS comments |

Appendix F: DHS Quality Metrics

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

The performance targets for these measures are year over year improvement. DHS strives to improve the measures which are below the 50th percentile by national benchmark to achieve that benchmark and continue to improve. For example, if a measure is already above the 50th percentile, then the goal is to move toward the 75th percentile.

Table 7: List of quality measures used by DHS to evaluate the quality of health care in the Medicaid program.

| Measure Steward | Measure Name | Medicaid Core Sets: Adults and Children | Annual Technical Report | Integrated Health Partnerships | Behavioral Health Homes | CCBHC | Disparities by Payer Type |
|-----------------|---|---|-------------------------|--------------------------------|-------------------------|-------|---------------------------|
| NCQA | Cervical Cancer Screening (CCS) | X | X | X | X | | |
| NCQA | Chlamydia Screening in Women Ages 16-20 and 21-24 (CHL) | X | X | X | | | |
| NCQA | Breast Cancer Screening (BCS) | X | X | X | X | | X |
| NCQA | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | X | | | | | |
| NCQA | Childhood Immunization Status (CIS) | X | X | X | | | X |
| NCQA | Immunizations for Adolescents (IMA) | X | X | X | | | |
| OHSU | Developmental Screening in the First Three Years of Life (DEV) | X | | | | | |
| NCQA | Well-Child Visits in the First 30 Months of Life (W30) | X | X | X | | | |
| NCQA | Child and Adolescent Well-Care Visits (WCV) | X | X | X | X | | |
| NCQA | Adults' Access to Preventive/Ambulatory | | X | | X | | |

| Measure Steward | Measure Name | Medicaid Core Sets: Adults and Children | Annual Technical Report | Integrated Health Partnerships | Behavioral Health Homes | CCBHC | Disparities by Payer Type |
|-----------------|---|---|-------------------------|--------------------------------|-------------------------|-------|---------------------------|
| | Health Services (AAP) | | | | | | |
| NCQA | Colorectal Cancer Screening (COL) | X | X | X | X | | X |
| NCQA | Prenatal and Postpartum Care: Timeliness of Prenatal Care and Postpartum Care (PPC-CH) | X | X | | | | |
| NCQA | Prenatal and Postpartum Care(Age 21 and older): Timeliness of Prenatal Care and Postpartum Care (PPC2-AD) | X | X | | | | |
| CDC | Live Births Weighing Less Than 2,500 Grams (LBW) | X | | | | | |
| OPA | Contraceptive Care – Postpartum Women Ages 15–20 and 21–44 (CCP) | X | | | | | |
| OPA | Contraceptive Care – All Women Ages 15–20 and 21–44 (CCW) | X | | | | | |
| NCQA | Controlling High Blood Pressure (CBP) | X | | | | | X |
| NCQA | Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (GSD) | X | X | | X | | |
| NCQA | Statin Therapy for Patients with Cardiovascular Disease (SPC) | | | X | | | |
| AHRQ | Prevention Quality Indicators (PQI) | X | | X | X | | |
| NCQA | Plan All-Cause Readmissions (PCR) | X | | X | X | X | |
| NCQA | Asthma Medication Ratio: Ages 5–18 and 19–64 (AMR) | X | X | X | X | | |
| NCQA | Ambulatory Care: Emergency Department Visits | X | X | X | X | | |

| Measure Steward | Measure Name | Medicaid Core Sets: Adults and Children | Annual Technical Report | Integrated Health Partnerships | Behavioral Health Homes | CCBHC | Disparities by Payer Type |
|-----------------|---|---|-------------------------|--------------------------------|-------------------------|-------|---------------------------|
| | (AMB) | | | | | | |
| MNCM | Optimal Vascular Care (OVC) | | | | | | X |
| MNCM | Optimal Diabetes Care (ODC) | | | X | | | X |
| MNCM | Optimal Asthma Control (OAC) Children, Adults | | | X | | | X |
| MNCM | Adolescent Mental Health and/or Depression Screening | | | X | X | | X |
| MNCM | Depression Remission at 6 Months Adolescent, Adults | | | X | X | | X |
| NCQA | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) | X | | X | X | X | |
| NCQA | Medical Assistance with Smoking and Tobacco Use Cessation (MSC) | X | | | | | |
| NCQA | Antidepressant Medication Management (AMM) | X | X | X | X | X | |
| NCQA | Follow-Up After Hospitalization for Mental Illness: Age 6–20 and 18 and Older (FUH) | X | X | X | X | X | |
| NCQA | Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who | X | | | | | |
| | Are Using Antipsychotic Medications (SSD) | | | | | | |
| NCQA | Follow-Up After Emergency Department Visit for Substance Use (FUA) | X | | | X | X | |
| NCQA | Follow-Up After Emergency | X | | | X | X | |

| Measure Steward | Measure Name | Medicaid Core Sets: Adults and Children | Annual Technical Report | Integrated Health Partnerships | Behavioral Health Homes | CCBHC | Disparities by Payer Type |
|-----------------|---|---|-------------------------|--------------------------------|-------------------------|-------|---------------------------|
| | Department Visit for Mental Illness (FUM) | | | | | | |
| PQA | Use of Opioids at High Dosage in Persons Without Cancer (OHD) | X | | | | | |
| NCQA | Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) | X | | | | X | |
| PQA | Concurrent Use of Opioids and Benzodiazepines (COB) | X | | | | | |
| CMS | Use of Pharmacotherapy for Opioid Use Disorder (OUD) | X | | | X | X | |
| NCQA | Follow-Up Care for Children Prescribed Attention- Deficit/ Hyperactivity Disorder (ADHD) Medication (ADD) | X | | | | X | |
| NCQA | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | X | | | | | |
| NCQA | Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | X | | | | | |
| AHRQ | Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD) | X | X | | | | |
| AHRQ | Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child | X | X | | | | |

| Measure Steward | Measure Name | Medicaid Core Sets: Adults and Children | Annual Technical Report | Integrated Health Partnerships | Behavioral Health Homes | CCBHC | Disparities by Payer Type |
|-----------------|---|---|-------------------------|--------------------------------|-------------------------|-------|---------------------------|
| | Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) | | | | | | |
| AHRQ | Clinical Group CAHPS | | | X | | | |
| CMS | Hospital CAHPS | | | X | | | |
| MN DHS | Patient Experience of Care Survey; Youth/Family Experience of Care Survey | | | | | X | |
| NCQA | Annual Dental Visits | | X | X | X | | |
| ADA | Sealant Receipt on Permanent 1st Molars | X | | | | | |
| CMS | Percentage of Eligibles Who Received Preventive Dental Services (PDENT) | Form CMS- 416 | | | | | |
| NASDDDS/HSRI | National Core Indicators Survey (NCIDDS) | X | | | | | |
| NCQA | Follow Up after ED Visit for People with Multiple High-Risk Chronic Conditions (FMC) | | | | | | |

Abbreviations Used:

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

NCQA = National Committee for Quality Assurance

OHSU = Oregon Health and Science University

CMS = Centers for Medicare and Medicaid Services MNCM = Minnesota Community Measurement CDC = Center for Disease Control and Prevention OPA = the U.S. Office of Population Affairs

AHRQ = Agency for Healthcare Research & Quality PQA = Pharmacy Quality Alliance

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

NASDDDS = National Association of State Directors of Developmental Disabilities Services

HSRI = Human Services Research Institute

DHS Quality Metric Results for 2023

Table A: Here is the list of child core set measures and results for FFY 2023.

| Child Core Set Measure | Code | 2023 Result | 2022 US Median | 2024 Target |
|---|------|--------------|---------------------------------|---------------------|
| Primary Care Access and Preventive Care | | | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Ages 3-17) | WCC | 7.4 | | NCQA median |
| BMI Percentile | | 1.9 | | |
| Nutrition Counseling | | 1.6 | | |
| Counseling on Physical Activity | | | | |
| Chlamydia Screening in Women Ages 16 to 20 | CHL | 45.9 | NCQA 16-24 55.8 | NCQA average |
| Childhood Immunization Status | CIS | | NCQA | NCQA |
| Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV and PCV) | | 56.0 | 63.2 | average for Combo 3 |
| Combo 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV) | | 50.1 | none | |
| Combo 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, and Influenza) | | 33.6 | 31.9 | |
| Well-Child Visits in the First 30 Months of Life | W30 | | CMS | NCQA |
| 6 or more visits first 15 months | | 48.7 | 57.5 | 56.8 |
| 2 or more visits 15 to 30 months | | 61.0 | 65.1 | 66.7 |
| Immunizations for Adolescents | IMA | | CMS | CMS median for HPV |
| Combo 1: Meningococcal, Tdap | | 76.5 | 75.2 | |
| HPV | | 31.1 | 35.0 | |
| Developmental Screening in the First Three Years of Life | DEV | 50.7 | 34.7 | To be reported |
| Child and Adolescent Well-Care Visits (Ages 3-21) | WCV | 42.0 | 47.6 | NCQA 48.6 |
| 3-11 | | 50.0 | 54.2 | NCQA averages |
| 12-17 | | 41.2 | 49.0 | |
| 18-21 | | 20.9 | 22.5 | |
| Lead Screening in Children | LSC | Not reported | NCQA 59.4 | To be reported |
| Maternal and Perinatal Health | | | | |
| Prenatal and Postpartum Care: Under Age 21 | PPC | | No benchmark for this age range | To be reported |
| Prenatal care | | 58.9 | NCQA: 83.3 (adult rate) | |
| Contraceptive Care – Postpartum Women | CCP | 44.8 | 39.4 for 60-days postpartum | To be reported |
| Ages 15 to 20 | | | | |
| 90 days postpartum rate (non-LARC) | | | | |

| Child Core Set Measure | Code | 2023 Result | 2022 US Median | 2024 Target |
|--|------|--------------|--|--------------------------------|
| Contraceptive Care – All Women Ages 15 to 20 (non-LARC) | CCW | 24.1 | 26.3 | To be reported |
| Care of Acute and Chronic Conditions | | | | |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years | AAB | Not reported | No child benchmark, NCQA 62.2 (adult rate) | To be reported |
| Asthma Medication Ratio: Ages 5 to 18 | AMR | 60.8 | 73.1 | CMS median |
| Ambulatory Care: Emergency Department (ED) Visits | AMB | 34.5 | 31.9 | To be reported |
| Behavioral Health Care | | | | |
| Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (Ages 6 to 12) Initiation Phase Continuation and Maintenance Phase | ADD | 38.5 44.4 | NCQA 43.0 54.1 | NCQA averages |
| Screening for Depression and Follow-Up Plan: Ages 12 to 17 | CDF | Not reported | No benchmark | To be reported |
| Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 Within 7-days of discharge Within 30-days of discharge | FUH | 48.9 75.2 | CMS 47.9 70.4 | Improve rates to next quartile |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics | APM | 34.3 | NCQA 33.2 | NCQA average |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics | APP | 69.9 | NCQA 62.6 | Improve rate |
| Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 Within 7-days of ED visit Within 30-days of ED visit | FUA | 25.4 33.6 | NCQA 13-adult 23.1 35.6 | Improve rates |
| Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 Within 7-days of ED visit Within 30-days of ED visit | FUM | 69.7 83.0 | NCQA 6-17 54.6 72.7 | Improve to next quartile |
| Dental and Oral Health Services | | | | |
| Oral Evaluation, Dental Services | OEV | Not reported | 43.2 | To be reported |
| Topical Fluoride for Children | TFL | Not reported | 19.3 | To be reported |
| Sealant Receipt on Permanent First Molars At least one sealant All four molars sealed | SFM | 48.4 35.4 | 46.4 32.9 | To be reported |

Table B: Here is the list of adult core set measures and results for FFY 2023.

| Adult Core Set Measure | Code | 2023 Result | 2022 US Median | 2024 Target |
|---|--------|----------------------|--|-----------------------------|
| Primary Care Access and Preventive Care | | | | |
| Cervical Cancer Screening | CCS | 51.5 | (CMS – N/A) 2022 NCQA 55.9 | NCQA average |
| Chlamydia Screening in Women Ages 21 to 24 | CHL | 54.3 | (CMS – N/A) 2022 NCQA (Ages 16-24) 55.8 | NCQA average |
| Colorectal Cancer Screening Age 46-49 Age 50-64 Age 65-75 | COL | 22.9 45.0 52.8 | (CMS – N/A) No NCQA Medicaid benchmark 2022 NCQA Medicare (Ages 50-75) 68.6 | Improve rates |
| Breast Cancer Screening Age 50-64 Age 65-74 | BCS | 55.4 53.2 | FFY 2022 CMS (Ages 50-74) 48.8 2022 NCQA (Ages 50-74) 52.4 | Improve to next quartile |
| Maternal and Perinatal Health | | | | |
| Prenatal and Postpartum Care: Age 21 and Older Postpartum Care | PPC | 53.7 | FFY 2022 CMS 75.0 2022 NCQA 77.0 | CMS median |
| Contraceptive Care – Postpartum Women Ages 21 to 44 90 days postpartum rate (non-LARC) 90 days postpartum rate (LARC) | CCP | 38.2 14.7 | No benchmark | |
| Contraceptive Care – All Women Ages 21 to 44 90 days postpartum rate (non-LARC) 90 days postpartum rate (LARC) | CCW | 23.5 5.0 | No benchmark | |
| Care of Acute and Chronic Conditions | | | | |
| Controlling High Blood Pressure | CBP | Not reported | FFY 2022 CMS 57.7 | To be reported |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older | AAB | Not reported | | To be reported |
| Hemoglobin A1c Control for Patients with Diabetes Poor Control HbA1c (>9.0%) | HBD | Not reported | 2022 NCQA 40.3 | To be reported |
| Diabetes Short-Term Complications Admission Rate (Ages 18-64) | PQI 01 | 13.0 | 17.2 | CMS median |

| Adult Core Set Measure | Code | 2023 Result | 2022 US Median | 2024 Target |
|---|-------------|----------------------|---|--------------------------|
| Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate Age 40-64 Age 65 and older | PQI 05 | 17.0 45.2 | No benchmark | |
| Heart Failure Admission Rate (Ages 18-64) | PQI 08 | 18.8 | No benchmark | |
| Asthma in Younger Adults Admission Rate (Ages 18-39) | PQI 15 | 2.1 | No benchmark | |
| Plan All-Cause Readmissions (Lower rates signify better performance.) | PCR | 10.4 | (CMA – N/A) 2022 NCQA (Ages 18-64) 9.8 | Decrease to NCQA average |
| Asthma Medication Ratio: Ages 19 to 64 | AMR | 56.1 | FFY 2022 CMS 57.9 2022 NCQA (Ages 5-64) 65.5 | |
| Use of Opioids at High Dosage in Persons Without Cancer (Ages 18-64) | OHD | 6.7 | FFY 2022 CMS 6.7 | NCQA 6.1 |
| Concurrent Use of Opioids and Benzodiazepines (Ages 18-64) | COB | 14.7 | No benchmark | |
| Behavioral Health Care | | | | |
| Initiation and Engagement of Substance Use Disorder Treatment (Ages 18-64) Initiation Engagement | IET | 39.9 14.8 | FFY 2022 CMS 43.4 15.8 2022 NCQA 45.0 14.9 | NCQA 13+ 45.0 14.9 |
| Medical Assistance with Smoking and Tobacco Use Cessation (Ages 18-64) Advising Smokers and Tobacco Users to Quit Discussing Cessation Strategies Discussing Cessation Medications | MSC | 74.4 48.9 57.9 | CMS – N/A 2022 NCQA 72.8 45.4 51.2 | Improve to next quartile |
| Antidepressant Medication Management (Ages 18-64) Acute Phase Treatment Continuation Phase Treatment | AMM | 74.4 60.3 | CMS – N/A 2022 NCQA 60.9 43.9 | Improve to next quartile |
| Screening for Depression and Follow-Up Plan: Age 18 and Older | CDF | Not reported | | To be reported |

| Adult Core Set Measure | Code | 2023 Result | 2022 US Median | 2024 Target |
|---|-------|--------------|---|---------------------------------------|
| Follow-Up After Hospitalization for Mental Illness: (Ages 18-64) Within 7-days post-discharge Within 30-days post-discharge | FUH | 32.5 58.8 | FFY 2022 CMS 33.9 54.5 2022 NCQA 36.6 57.1 | CMS median NCQA 6+ 36.6 57.1 |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications | SSD | 74.9 | CMS – N/A 2022 NCQA 79.0 | NCQA average |
| Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | HPCMI | Not reported | FFY 2022 CMS 41.2 | To be reported |
| Follow-Up After Emergency Department Visit for Mental Illness (Ages 18-64 and Older) Within 7-days of ED visit Within 30-days of ED visit | FUM | 52.0 65.9 | FFY 2022 CMS 38.9 52.5 2022 NCQA 41.5 55.2 | Improve to next quartile |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Ages 18 and Older) | SAA | 79.9 | CMS – N/A 2022 NCQA 59.8 | Improve to next quartile |

Table C: Here is the list of behavioral health home core set measures and results for FFY 2023.

| Behavioral Health Home Core Set Measure | Code | 2023 Result | 2024 Target |
|---|------|----------------------|----------------|
| Initiation and Engagement of Substance Use Disorder Treatment Initiation of treatment Engagement of treatment | IET | 49.1 22.1 | Improve rates |
| Controlling High Blood Pressure | CBP | Not reported | To be reported |
| Colorectal Cancer Screening Age 46-49 Age 50-64 Age 65-75 | COL | 33.7 57.0 66.1 | Improve rates |
| Screening for Depression and Follow-Up Plan | CDF | Not reported | To be reported |
| Follow-Up After Hospitalization for Mental Illness Within 7-days of post-discharge Within 30-days of post-discharge | FUH | 46.2 70.6 | Improve rates |
| Plan All-Cause Readmissions | PCR | 10.1 | Improve rate |
| Use of Pharmacotherapy for Opioid Use Disorder | OUD | 52.9 | Improve rate |

| Behavioral Health Home Core Set Measure | Code | 2023 Result | 2024 Target |
|---|-------------|----------------------------|--------------------------|
| Follow-Up After Emergency Department Visit for Substance Use Within 7-days of ED visit Within 30-days of ED visit | FUA | 44.0 62.7 | Improve rates |
| Follow-Up After Emergency Department Visit for Mental Illness Within 7-days of ED visit Within 30-days of ED visit | FUM | 65.7 76.3 | Improve rates |
| Preventive Quality Indicator Chronic Conditions Composite (Hospitalizations per 100,000 enrollee months) | PQI 92 | 185.6 | Improve rate |
| Utilization Measures | | | |
| Admission to a Facility from the Community | AIF | Not reported | To be reported |
| Ambulatory Care: Emergency Department (ED) Visits | AMB | 59.3 | Improve rate |
| Inpatient Utilization (average length of stay in days) Inpatient Mental and behavioral disorders Surgery Medicine | IU | 165.4 146 6.4 9.5 | Decrease length of stays |

Appendix G: State Directed Payments

As of early 2024, the state agency has the following state directed payments (SDPs):

1. Behavioral Health Homes;
2. Certified Community Behavioral Health Clinics;
3. Dental Services;
4. Long-Acting Reversible Contraceptives;
5. Managed Long Term Services and Supports;
6. Medical Transportation;
7. Certain Mental Health Services;
8. Certain SUD Programs;
9. A safety net hospital for enrollees in a large metro county in the state (Hennepin County Medical Center);
10. Integrated Health Partnerships program, an ACO-type payment arrangement.

A brief discussion of each follows, covering its type (according to the types described in 42 CFR §438.6(c), its origin in state law, and its quality measures in reference to **Error! Reference source not found.** or as required by Minnesota law or a CMS-approved waiver.

Behavioral Health Homes

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates

Behavioral Health Homes (BHHs) are a result of Minnesota Statutes §256B.0757 and 42 USC 1396w-4. BHHs provide a model of care focused on integration of primary care, mental health services, and social services and supports for adults diagnosed with mental illness or children diagnosed with emotional disturbance. Care coordination is a critical component that occurs when the BHH services team acts as the central point of contact in the compilation, implementation and monitoring of the individualized health action plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports.

Payment is by a FFS-based minimum fee schedule for a care engagement rate and a continuing care encounter rate. MCOs are required to pay the same rates and method as the FFS system. The quality measures are described in the BHH services certification process (an online application and a site visit), and followed up by recertification. For continued certification under this section, BHHs must meet process, outcome, and quality standards developed and specified by DHS. See also page **Error! Bookmark not defined.** for a discussion of matching these quality measures to the state’s quality goals.

Certified Community Behavioral Health Clinics

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates

Certified Community Behavioral Health Clinics (CCBHCs) are a result of MS §245.735 and Section 223 of Public Law Number 113-93. CCBHCs provide a set of services designed to integrate primary care, behavioral health, and substance use disorder services (SUDs), social/community services for children with emotional disturbance, and services for adults with mental illness.

Payment is by a FFS-based minimum fee schedule for an encounter rate known as a daily bundled rate.

In addition to the daily bundled rate, CCBHCs may earn a Quality Incentive Program payment for performance described on the DHS web site at https://mn.gov/dhs/assets/Updated%20SPA%20Clinic%20Benchmarks%20CY22_tcm1053-571270.pdf CCBHCs must meet targets and minimum thresholds on six measures to qualify for a bonus payment.

The quality measures for CCBHC are federally required, designed to ensure improved access to care and high-quality services. There are 22 federally required quality measures, including two annual consumer experience of care surveys (adult and children/family). DHS has also expanded the federal Mental Health Statistics and Improvement Program (MHSIP) surveys. See also page **Error! Bookmark not defined.** for a discussion of matching these quality measures to the state’s quality goals.

The federally required measures are:

| Measure Name | Measure Acronym |
|--|-----------------|
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | SAA-BH |
| Antidepressant Medication Management | AMM-BH |
| Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment | SRA-BH-C |
| Depression Remission at Twelve Months | DEP-REM-12 |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications | SSD |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence | FUA |
| Follow-Up After Emergency Department Visit for Mental Illness | FUM |
| Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) | FUH-BH-A |
| Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) | FUH-BH-C |
| Follow-up care for children prescribed ADHD medication | ADD-BH |
| Housing Status | HOU |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | IET-BH |
| Major Depressive Disorder: Suicide Risk Assessment | SRA-A |
| Patient Experience of Care Survey Adult | PEC |
| Patient Experience of Care Survey Youth/Family | Y/FEC |
| Plan All-Cause Readmission Rate | PCR-BH |
| Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention | TSC |
| Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up | BMI-SF |
| Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling | ASC |
| Screening for Clinical Depression and Follow-Up Plan | CDF-BH |
| Time to Initial Evaluation | I-EVAL |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | WCC-BH |

In addition, Minnesota-specific impact measures are:

| Measure |
|---|
| Track proportion of encounters and persons served by peer services in CCBHCs |
| Track persons served by telemedicine for allowable services in CCBHCs |
| Compare percentage of Persons of Color and Latinos/Hispanics receiving CCBHC services to their percentage of Medicaid population in the CCBHC service areas |
| Compare percentage of Non-Primary English speakers receiving CCBHC services versus their percentage of Medicaid population in the CCBHC service area |
| Track the mean number of days between initial contact and evaluation of new clients |
| Track percentage of all clients receiving 2 or more services within 2 months after initial assessment |
| Track percentage of clients who are Persons of Color and Latinos/Hispanics receiving 2 or more services within 2 months after initial assessment |
| Track percentage of non-primary English speaking clients receiving 2 or more services within 2 months after initial assessment |

Dental Services

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates.

The Minnesota Legislature in 2021 required a rate increase for dental services, including FFS and managed care, intended to increase the utilization of dental care across the Medicaid population. This rate increase excludes dental services provided as part of an encounter or per diem payment structure.

Payment is by a FFS-based minimum fee schedule and codified in are a result of MS §256B.76, subd. 2, l and was expressed as a 98% fee increase. At the same time, the dental benefit was changed from a defined list of covered dental procedures to medically necessary dental care.

The quality measures for dental care are Annual Dental Visits (NCQA); Sealant Receipt on Permanent 1st Molars (ADA); and Percentage of Eligibles Who Received Preventive Dental Services (CMS). THE results are reported in the Medicaid Core Sets for adults and children.

Long-Acting Reversible Contraceptives

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates.

The Minnesota Legislature in 2023 required that MCOs pay for long-acting reversible contraceptive procedures (e.g., insertion of an IUD) separately from a delivery fee, immediately postpartum in the inpatient setting. Payment is by a FFS-based minimum fee schedule codified in Minnesota Statutes §256.969 and is required to be paid on the same basis and at the same rate as outpatient drugs. Quality is measured for this SDP by determining the percentage of enrollees at risk of unintended pregnancy who were provided a long-acting reversible method of contraception.

Managed Long Term Services and Supports

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates.

The MCO contract as of 2019 required MCOs to make payment at no less than the FFS-established rates

for long term services and supports, including Elderly Waiver (EW) services, Community First Services and Supports (CFSS), and nursing facility services. Quality measures for EW and CFSS are outlined in the relevant waivers described above under HCBS waivers, **Error! Bookmark not defined.** Quality measures for nursing facility care are described above **Error! Bookmark not defined.**

Medical Transportation

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates.

The MCO contract as of 2024 requires MCOs to pay a fuel adjustment when the cost of fuel exceeds a threshold of \$3.00 per gallon, as does the FFS program, for nonemergency medical transportation and ambulance services. The MCO must adjust the rate paid per mile for NEMT by one percent (1%) up or down for every increase or decrease of ten (10) cents for the price of gasoline. Quality is measured for this SDP by the NCQA measure Adults' Access to Preventive/Ambulatory Health Services (AAP).

Certain Mental Health Services

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates.

The MCO contract as of 2024 requires MCOs to pay mental health providers other than adult day treatment services and early intensive developmental and behavioral intervention [autism] services with a 3% increase over the previous year-end rates, which increase is also paid by the FFS program. This payment level is not required for providers who are paid on an encounter or cost basis, nor those whose payment is set by another SDP such as CCBHCs.

Quality is measured for this SDP by behavioral health measures in **Error! Reference source not found.** above, including Antidepressant Medication Management (AMM); Follow-Up After Hospitalization for Mental Illness: Age 6–20, and 18 and Older (FUH); Follow-Up After Emergency Department Visit for Mental Illness (FUM); Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA); Follow-Up Care for Children Prescribed ADHD Medication (ADD); Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP); and the CAHPS surveys.

Certain SUD Programs

SDP: 42 CFR 438.6(c)(1)(iii)(A) – minimum fee schedule based on state plan rates.

The MCO contract as of 2024 requires MCOs to pay rates at least equal to the FFS program rates for SUD programs that have special components including being culturally specific or culturally responsive, and disability responsive, and for SUD programs that serve parents with their children. Services of SUD programs under the state's 1115 waiver are also paid at least as much as the FFS program.

Quality is measured for this SDP by behavioral health measures in **Error! Reference source not found.** above, including Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET); Follow-Up After Emergency Department Visit for Substance Use (FUA); Use of Opioids at High Dosage in Persons Without Cancer (OHD); Use of Pharmacotherapy for Opioid Use Disorder (OUD); and the CAHPS surveys.

A Safety Net Hospital for Enrollees in a Large Metro County in the State (Hennepin County Medical Center)

SDP: 42 CFR 438.6(c)(1)(iii)(B) – minimum fee schedule based on rates other than state plan rates.

This SDP, which began in 2022, requires MCOs to pay a safety net hospital and its clinics by a fee schedule set on the average commercial rate of that health system. This provider class serves medically needy enrollees with high levels of social and clinical risk and limited English proficiency, among whom are a high proportion of adults with serious chronic conditions and individuals of color. The geographic area served includes the census tracts of the most concentrated areas of deep poverty in the state.

In order to receive the payment the provider must provide services at the same or better access than the preceding year (with allowances for the pandemic year of 2020). Access will be measured by availability of services to include behavioral health, emergent care, preventive care, outpatient care, hospitalization, transportation, interpreter services, and pharmaceutical services, as shown in the encounter data received by the state agency from MCOs.

The quality measures for this SDP are:

Primary Care

In year 1, improve performance on the following measures:

- Childhood Immunization Status (CIS) Combo 10: 31.7 in 2019
- Breast Cancer Screening (BCS): 61.2% in 2019

In year 2, improve performance on year 1 measures and on additional measures such as the following measure:

- Well-Child Visits in the First 30 Months of Life (W30) Since W30 is new for 2020 dates of service we do not have 2019 results available. We will be able to share the 2020 baseline results after we have finished our quality assurance review and shared these results with HCMC for their review. We do have 2019 results for W15 (Well-Child Visits in the First 15 Months of Life), which is now a sub-measures of W30: 53.6%.
- Asthma Medication Ratio: 57.3% in 2019

In year 3, improve performance on year 1 and 2 measures and on the following measures:

- Child and Adolescent Well Care Visits (WCV) . Like W30, this measure is new for 2020 dates of services and we do not have 2019 results available. We will be able to share those 2020 baseline results after we have finished our quality assurance review and shared these results with HCMC for their review.
- Cervical Cancer Screening (CCS) 61.0% in 2019
- Colorectal Cancer Screening (COL) 50.8% in 2019

Behavioral health measures:

- Follow-Up After Hospitalization for Mental Illness (FUH)– 30 days: 47.9% in 2019

In year 2, improve performance on year 1 measures and on the following measures:

- Follow-Up After Hospitalization for Mental Illness (FUH)– 7 days: 18.4% in 2019

In year 3, improve performance on year 1 and 2 measures and the following measures:

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET):
Initiation of AOD Treatment (14 days): 33.6% in 2019
Engagement of AOD Treatment (34 days): 11.4% in 2019

Improve racial equity and close disparity gaps:

- Year 1: Breast Cancer Screening (BCS): 61.2% in 2019
- Year 2: Well-Child Visits in the First 30 Months of Life (W30) no 2019 data available.
- Year 3: Colorectal Cancer Screening (COL) 50.8% in 2019.

Integrated Health Partnerships Program

SDP: 42 CFR 438.6(c)(1)(i) – a value-based purchasing model.

The Integrated Health Partnership (IHP) is a Medicaid service delivery reform demonstration based on an integrated care model. The goal of the demonstration is to improve the health of the target population by delivering care of higher quality and lower cost through innovative approaches to both care and payment. In this effort, DHS negotiates a payment arrangement directly with health care provider organizations and partnerships that are already delivering services to Medicaid enrollees. The IHP providers within each IHP work together to coordinate their efforts and achieve a demonstrable level of savings when compared to predicted cost targets developed by the state.

Providers that demonstrate savings across their population, while maintaining or improving quality of care, may receive a portion of the savings. Providers with higher costs over time may be required to pay back a portion of the higher cost to the state.

The IHP model began in 2013 with seven IHP organizations, and has grown to 25 IHPs, which are large or small provider organizations delivering the breadth of care. On an overall basis across all IHPs, the state has realized savings of more than \$400 million, serving more than 460,000 patients, and reducing ER visits and inpatient stays by 7% and 14% respectively. See <https://mn.gov/dhs/integrated-health-partnerships/> for further information.

Providers in the Integrated Health Partnership program receive a base payment for services like other Medicaid providers from either FFS or MCO depending on which program the enrollee is in. In addition, the state calculates a target payment amount that is based on past utilization and cost data for the population served by the IHP. If an IHP is able to deliver services at a lower cost than the calculated target, shared savings payment may be made to the IHP which distributes the payment to its providers. Lower costs may be the result of better coordination, greater efficiency, or reduced utilization of medical services, such as by reducing inpatient admissions.

Each IHP negotiates a payment arrangement with the state agency that outlines the quality measures and parameters to meet in order to earn the shared savings payment. Most measures are common across all IHPs (see discussion beginning **Error! Bookmark not defined.**) but IHPs additionally develop measures and/or quality improvement projects that address issues more specific to the population served.