Attachment D

Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) §1115 Waiver Evaluation Design

For Demonstration Extension Period of July 1, 2011 through June 30, 2014

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Section One **Information About the Demonstration**

1.1 Demonstration Name and Effective Dates

This evaluation plan relates to the renewal period July 1, 2011 through June 30, 2014, for the Prepaid Medical Assistance Plus (PMAP+) §1115 Demonstration.

1.2 Brief Description and History of the Demonstration

Enrollees began receiving services from health plans under the first Prepaid Medical Assistance (PMAP) Section 1115 demonstration in July of 1985. This waiver allowed Minnesota's Medicaid Program (Medical Assistance or MA) to purchase coverage from health plans on a prepaid capitated basis. The project required that nondisabled MA recipients be enrolled with a health plan, and remain enrolled with that plan for a 12-month period. PMAP was originally limited to a few Minnesota counties.

In April 1995, HCFA approved a statewide health care reform amendment to the PMAP waiver. Generally, this amendment, known as Phase 1, allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the FPG into the Medicaid Program. An amendment approved in February 1999 expanded the program to include parents enrolled in MinnesotaCare.

In March 1997, the State proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that CMS authorize a second phase of provisions that had been enacted by the Minnesota Legislature. On August 22, 2000, HCFA approved most aspects of Minnesota's Phase 2 amendment request, known as the PMAP+ waiver. Some important components of this waiver amendment allowed for administrative simplification and mandatory enrollment of certain MA populations in managed care.

With promulgation of the BBA Managed Care regulations in 2002, states were able to implement through their State Plans many of the provisions that were previously only permitted under a §1115 waiver. Minnesota has taken advantage of this option, and now provides prepaid managed care coverage to infants, children, pregnant women and parents via the state plan. Minnesota has also obtained a separate §1915(b) waiver for coverage of its senior population, which was previously covered under the PMAP+ waiver. Nevertheless, the PMAP+ §1115 waiver remains necessary to implement several important components of Minnesota's publicly funded health care programs, including providing Medicaid services with federal financial participation to expansion populations

under the MinnesotaCare program and mandatory managed care for certain MA populations, such as Native Americans and children with special needs.

As the scope of the demonstration authority has evolved over time, so has the evaluation design. Similarly, as mandatory managed care has been implemented statewide for almost all of Minnesota's recipients without disabilities, Minnesota has little access to useful fee for service data for comparison.

A brief overview of current PMAP+ waiver authorities:

MinnesotaCare Authorities

The waiver provides Minnesota the flexibility to implement the MinnesotaCare managed care program with components that differ from traditional Medicaid, including:
- higher premiums and copays than would be allowed under traditional Medicaid
- prospective enrollment
- enrollees must not have access to health insurance for four months prior to enrollment
- a less rich benefit set for adult caretaker enrollees;
- a simplified income methodology
- a broader definition of family
- mandatory enrollment of all children in a family

Medical Assistance Authorities

The waiver also allows Minnesota to deviate from standard Medicaid rules in the state Medical Assistance program, including:
- streamlined MA eligibility and benefit set for pregnant women up to 275% FPG
- elimination of 6 month income reviews for medically needy MA recipients with unvarying, unearned income
- payment of managed care GME via MERC
- mandatory managed care enrollment for exempt groups not covered by the state plan (i.e. American Indians, duals under 65 who are not using a disabled basis of eligibility, and children receiving title V, adoption assistance or foster care)

1.3 Population Groups Impacted by the Demonstration

The PMAP+ demonstration allows Minnesota to receive federal financial participation to provide coverage to the following eligibility groups

i. MA One Year Olds. This group includes infants age 12 through 23 months of age, with family incomes at or below 275% of the FPL. State plan income methodologies and eligibility rules apply.

ii. MinnesotaCare Children. This group includes children under 21 years of age with family incomes at or below 275% of the FPL. MinnesotaCare income methodologies and eligibility rules apply.

iii. MinnesotaCare Pregnant Women. This group includes pregnant women with family incomes at or below 275% of the FPL. MinnesotaCare income methodologies and eligibility rules apply.

iv. iv. MinnesotaCare Caretaker Adults. This group includes parents and other caretaker relatives with family incomes at or below 275% of the FPL. MinnesotaCare income methodologies and eligibility rules apply.

The benefit offered to MinnesotaCare Children, MinnesotaCare Pregnant Women, and MA One Year Olds is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid state plan, including all services that meet the definition of early and periodic screening, diagnostic, and treatment (EPSDT) found in section 1905(r) of the Act. The benefit offered to MinnesotaCare Caretaker Adults is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (a) through (h) below are excluded, inpatient hospital services are limited for certain participants as described in (i) below, and chiropractic services are covered as described in (j) below.[1]

a) Services included in an individual's education plan;
b) Private duty nursing;
c) Orthodontic services;
d) Non- emergency medical transportation services;
e) Personal Care Services;
f) Targeted case management services (except mental health targeted case management);
g) Nursing facility services; and
h) ICF/MR services.
i) Inpatient Hospital Limit. MinnesotaCare Caretaker Adults (except pregnant women) with income above 215 percent of the FPL are subject to a $10,000 annual limit on inpatient hospitalization.
(j) Chiropractic services covered under MinnesotaCare include medically necessary exams.[2]

1.4 Purposes, Aims, Objectives, and Goals of the Demonstration

The goal of the demonstration is to provide comparable access and quality of prevention and chronic disease care to child and adult waiver populations as compared to Minnesota's other managed care public program enrollees. The waiver hypothesis is that providing health care coverage to child and adult waiver populations who would otherwise be uninsured will result in the following outcomes:

[1] MINNESOTA LAWS 2009, Chapter 79, Article 5, Section 54. Effective January 1, 2010 or upon Federal approval, whichever is later.

[2] Ibid.

1. Improved utilization of preventative and chronic disease care services for children (childhood immunizations, child access to PCP, annual dental visits, and well-child visits)
2. Improved health and utilization of preventative and chronic disease care services for adults (diabetes screenings, adult preventive visits, cervical cancer screening)
3. Improved utilization of postpartum care services for pregnant women (postpartum care services)
4. Enrollee satisfaction with the delivery and quality of services for all populations (satisfaction survey results)

The quantifiable target goal for the first three outcomes will be to provide comparable access and quality of prevention and chronic disease care to child and adult waiver populations as compared to Minnesota's other managed care public program enrollees. This will be demonstrated by the waiver evaluation set of HEDIS performance measures calculated from MCO submitted encounter data. The quantifiable target goal for the fourth outcome will be to demonstrate continued satisfaction of waiver and non-waiver populations. Satisfaction survey results will be calculated from responses to the annual satisfaction (CAHPS) survey. See section 2.4 for a description of the analysis plan.

1.5 Observations from the Previous Waiver Period

As indicated in the evaluation design plan for the current PMAP+ waiver period, DHS has completed the data collection and interim review of the 20 waiver evaluation HEDIS performance measures for the PMAP and MinnesotaCare programs. The PMAP and MinnesotaCare program rates for calendar years 2005 through 2008 have been calculated and are discussed in this update. The November 2010 update will present the final evaluation year's performance measurement results for the waiver and comparison populations based on HEDIS 2010 technical specifications. Please refer to Attachment C for a copy of the March 2010 interim report. The final evaluation report submitted April 2, 2011 will provide conclusions on the evaluation for calendar years 2008 and 2009.

1.6 Summary of the Evaluation Requirements in the Demonstration Special Terms and Conditions

Paragraph 57 of the Special Terms and Conditions includes the following requirements regarding the evaluation design for the demonstration:

1. A discussion of the demonstration goals and objectives, as well as the specific hypotheses that are being tested.
2. A discussion of the outcome measures that will be used to evaluate the impact of the demonstration during this extension period,

3. A discussion of the data sources and sampling methodology for assessing the outcomes.
4. A detailed analysis plan that describes how the effects of the demonstration will be isolated from other initiatives occurring in the State.

Section Two **Evaluation Design**

2.1 Management and Coordination of the Evaluation

The Minnesota Department of Human Services (DHS) will conduct the PMAP+ §1115 Waiver evaluation. The evaluation will be conducted by DHS staff from the Performance Measurement and Quality Improvement Division. Health care coverage analysis will be completed by DHS staff from the Health Care Eligibility and Access Division. Below is an overview of the evaluation and activities and timeline:

- March 2013 - DHS provides HEDIS measure results for the comparison population's three baseline years (2008 through 2010) in the PMAP+ waiver quarterly progress report to CMS. As CMS is aware, HEDIS based measures are annually calculated each June and more frequent reporting is inefficient utilization of State resources.
- June through August 2013 - Calendar years 2008 through 2012 HEDIS rates are calculated and performance measure validation process completed
- September through December 2013, an analysis of the rates is conducted
- November 2013 - DHS provides HEDIS measure results for measurement years (2011 and 2012) in the PMAP+ waiver annual progress report to CMS.
- January through March 2014 - The draft and final waiver report is written, reviewed and approved
- April 1, 2014 - Final report is submitted to CMS.

A subset of HEDIS 2013 performance measures are expected to demonstrate the continuation of the ongoing quality of care and services provided by the contracted managed care organizations as seen in previous waiver periods.

As the state Medicaid agency, the Minnesota Department of Human Services will conduct the evaluation. This is preferable to contracting with an outside vendor because the complex design of the evaluation, the utilization of encounter data, the five to six months necessary to complete the competitive procurement required by the state to contract with a qualified organization, and the time needed to educate the new vendor makes outsourcing of this project impractical.

2.2 Performance Measures

The selected HEDIS 2013 performance measures will evaluate the childhood prevention, adult chronic disease care management and care provided to pregnant women for the waiver population compared to all PMAP and MinnesotaCare enrollees.[3] Performance measure data will be extracted from DHS' managed care encounter data base during June 2013 to allow for a sufficient encounter run-out period.

Evaluation populations will consist of three subgroups:

- Children age 0 to 19 years in MinnesotaCare with income at or below 275% FPG.
- Parents (caretakers) with income at or below 275% FPG with children enrolled in MinnesotaCare or Medical Assistance.
- Pregnant women enrolled in MinnesotaCare with income at or below 275% FPG.

The table below provides a list of the annual HEDIS 2013 performance measures that will be analyzed in the evaluation.

Childhood Prevention (0-19 yrs.)
Childhood immunizations (2 yrs)
Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs)
Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs)
Well –child visits first 15months
Well-child visits 3 to 6 yrs.
Adolescent well-care visits (12-19 yrs)
Adult Chronic Care Management (Parents of children)
Diabetes A1c screening
Diabetes LDL screening
Adult access preventive/ambulatory health services
Cervical CA screening
Pregnant Women Care
Postpartum Care

The quality of managed care organization (MCO) encounters is essential to the validity of the evaluation. DHS contracts with MetaStar Inc., a NCQA certified HEDIS auditor. MetaStar annually validates DHS produced performance measures are accurate and consistent with HEDIS Technical Specifications and 42 CFR 438.358(b)(2). An annual audit consistent with federal protocol is conducted to ensure MCO-submitted encounter data are accurate and DHS produced performance measures follow HEDIS specifications.[4]

[3] For the Childhood immunization performance measure a statewide immunization registry will be used to augment DHS managed care encounters.
[4] The final evaluation report will include an attachment of MetaStar's validation report.

The waiver hypothesis subcomponents will be evaluated for evidence of historical and measurement period changes:

- Utilization of preventative and chronic disease care services for children - Analysis of trends/comparisons over the baseline/measurement period performance of the child waiver population and non-waiver child population. Measures of this hypothesis component will be the childhood immunizations, child access to PCP, annual dental visits, and well-child visits.
- Improved health and utilization of preventative and chronic disease care services for adults - Analysis of trends/comparisons over the baseline measurement period performance of the adult caretaker waiver population and non-waiver adult caretaker population. Measures of this hypothesis component will be the diabetes screening, adult preventive visits, and cervical cancer screening.
- Improved utilization of postpartum care services for pregnant women - Analysis of trends/comparisons over the baseline measurement period performance of the pregnant women waiver population and pregnant women non-waiver population. The measure of this hypothesis component will be the postpartum care.
- Satisfaction - analysis and comparison of satisfaction and disenrollment surveys reflecting the enrollee's perspective on agreement with the delivery and quality of health care services. Measures of this hypothesis component will be the results of the annual CAHPS satisfaction survey and the monthly disenrollment surveys.

The overall goal of the CAHPS project is to conduct an annual consumer satisfaction survey of access and quality of care provided by MCOs to Minnesota's publicly funded health care program enrollees. The CAHPS® 4.0 Adult Medicaid Core Questionnaire Module plus optional CAHPS® questions and supplemental DHS questions are incorporated with the core module to create the survey instrument. The survey is conducted using a four-wave mail plus telephone data collection method. The CAHPS vendor works toward the goal of collecting 300 completed questionnaires/interviews in each of 28 cells defined by DHS, for a total of 8,400 completed interviews. Data collection will be completed between January 2013 and April 2013.

For the past ten years, DHS has been conducting monthly surveys of enrollees who voluntarily change from one MCO to another. The one-page survey with a brief explanation of the purpose and the survey questions is mailed to the head of each household. The initial mailing is made early in the month that the change became effective. Three weeks later, a second survey is mailed to non-respondent households. The survey instrument is in English, with interpreter services available by telephone. The survey is composed of a set of questions that form four composites: I changed my health plan because; I was dissatisfied with my health plan because; I was dissatisfied with my health plan's medical provider because; and I was dissatisfied with my health plan's dental provider because. Each composite includes specific statements relating to the topic. It is expected the survey results will be integrated with other MCO quality information to guide improvement of care and services. DHS uses this information and other quality indicators to monitor the performance of MCOs, ensure the health of enrollee and that

purchased services meet the needs of public program enrollees. DHS' expectation is that statewide change rates will vary over time, but remain below a 5% threshold.

2.3 Integration of the Quality Improvement Strategy

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

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

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

2.4 Plan for Analysis

A simple and straightforward comparison of the selected HEDIS 2013 performance measures will be made between the waiver populations and other public program managed care enrollees demonstrating the ongoing improvement in care for all publicly funded program enrollees. Performance measurement rates for the baseline period (CYs 2008 through 2010) will be calculated for the targeted populations and compared to the first two calendar years (CYs 2011 and 2012) of the waiver period. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass data to compare performance of Minnesota's waiver and the entire public programs populations (PMAP and MinnesotaCare population's) performance measurement rates.

To demonstrate continued satisfaction with program level care and services a review of historical and evaluation period satisfaction information will be undertaken with two surveys. 1) CAHPS program level composite responses will be used to assess the domains of enrollee experiences. 2) The DHS conducted "Voluntary Changes in MCO Enrollment Survey" or disenrollment survey will be reviewed and assessed as an indicator of ongoing enrollee satisfaction.

Performance measurement rates will be presented in a series of tables to analyze and compare performance similar to the table below:

Childhood Prevention	**Waiver Population**	**PMAP**	**MinnesotaCare**	**National Medicaid**
Child Immunizations				
CY 2005				
CY 2006				
CY 2007				
CY 2008				
CY 2009				

2.5 Limitations and Opportunities

The following limitations may impact the results of this evaluation:

- Unexpected consequences due to changes in state law regarding public programs.
- Future changes to HEDIS Technical Specifications influence future coding or data reporting that would bias this type of longitudinal analysis. If these types of changes occur the biases and potential consequences will be reported in the final report limitation section.
- Measures with high rates may show only small changes or remain stable over time.
- The HEDIS Technical Specification criteria of continuous enrollment, while reducing the population included in the measure offers a simple methodological adjustment that allows a straightforward comparison. The HEDIS methodology is

critical for the evaluation's longitudinal design, providing the opportunity to retrospectively identify factors that may seem insignificant, but became important with the passage of time. These types of relationships will be considered during the analysis to provide a deeper understanding of the motivational forces behind the complex relationships of how enrollees utilize and value prevention and chronic health care services.

2.6 Conclusion, Best Practices, and Recommendations

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

Section Three **Reporting Schedule**

A separate final written report summarizing the results of the demonstration evaluation activities set out above shall be produced and submitted to CMS by April 1, 2014, ninety days prior to the end of the waiver period. This report will be separate from the quarterly and annual PMAP+ waiver reports required by the special terms and conditions which include information about demonstration enrollment, expenditures, grievances and appeals, and implementation activities.