

Attachment E

Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Waiver

Evaluation Plan 2014

1. Introduction

This proposed evaluation plan relates to the demonstration period January 1, 2014 through December 31, 2014 for the Prepaid Medicaid Assistance Project Plus (PMAP+) Section 1115 waiver. The State of Minnesota has provided care to eligible individuals under a Section 1115 demonstration waiver for many years. One of the primary components of the waiver has been the MinnesotaCare program, which was created in 1992 to help people who struggled with the high cost of private insurance but earned too much to qualify for Medicaid. This program, which requires payment of a monthly premium and higher cost sharing than Medicaid, has been credited with keeping Minnesota's uninsured rate lower than the national average. During the 2011-2013 demonstration period, the primary purpose of the demonstration was to provide cost-effective and comprehensive health insurance coverage to people with family incomes above Medicaid state plan income levels. In July of 2012, midway through the 2011-2013 demonstration period, there were over 120,000 people covered under the demonstration. On August 1st, 2011, Minnesota received authority to add coverage for a category of adults without children to the MinnesotaCare program. Over 30,000 adults received coverage under the waiver every month. This group was previously covered under state-funded programs. Coverage became available under Minnesota's health insurance exchange, MNsure, in January of 2014. The PMAP+ waiver was amended to reflect the expansion of eligibility in Minnesota's Medicaid program, and to modify the MinnesotaCare program to ease the planned transition to Basic Health Plan authority in 2015.

2. Background on the PMAP+ Section 1115 Waiver

Minnesota has long been known for its low rates of uninsurance, high quality of care, mature managed care environment, and generous publicly funded health care programs.

Enrollees began receiving services from health plans on a prepaid capitated basis under the first Prepaid Medical Assistance Project (PMAP) Section 1115 waiver in July of 1985, almost thirty years ago. The project required that Medical Assistance or MA recipients (other than persons with disabilities) be enrolled with a health plan for a 12-month period. PMAP was initially limited to a few Minnesota counties.

In April 1995, CMS approved a statewide health care reform amendment to the PMAP waiver. This allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the federal poverty guidelines (FPG) into the Medicaid program. An amendment approved in 1999 expanded the program to include parents enrolled in

MinnesotaCare. A subsequent amendment in 2000 allowed for administrative simplification and mandatory enrollment of certain MA populations in managed care.

With promulgation of managed care regulations in 2002, states were able to implement mandatory enrollment in managed care through their Medicaid state plans. Minnesota now provides prepaid managed care coverage to infants, children, pregnant women, parents and adults without children via the state plan. Nevertheless, the PMAP+ 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 population under the MinnesotaCare program and mandatory managed care for certain MA populations, such as American Indians and children with special needs.

In March of 2011, Minnesota included adults without dependent children with family incomes at or below 75 percent FPG in its state plan for the first time under authority granted by the Affordable Care Act. Effective August 1, 2011, Minnesota was also granted authority to cover adults without dependent children with family incomes above 75 and at or below 250 percent of the FPG as an expansion population under the PMAP+ waiver.

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 does not have fee-for-service data for comparison.

In January of 2014, many provisions of the ACA were implemented, and the waiver was changed significantly to reflect the expansion of eligibility in Minnesota's MA program and to reflect legislative intent that the 2014 MinnesotaCare program act as a bridge to 2015, when Minnesota will implement the basic health plan (BHP) option. During 2014, the waiver continued to support Minnesota's longstanding policy of providing affordable and comprehensive health insurance for working families.

3. The PMAP+ § 1115 Waiver January 1, 2014 through December 31, 2014

With the implementation of many aspects of the ACA in 2014, Minnesota expanded eligibility for its Medicaid program, which necessitated some corresponding changes in MinnesotaCare. Minnesota also sought to amend MinnesotaCare at the beginning of the operation of Minnesota's MNsure health care exchange to smooth the transition to Basic Health Plan authority in 2015.

Beginning January 1, 2014, a "bright line" is established between MinnesotaCare and MA. People who are eligible for MA must enroll in MA rather than MinnesotaCare. This ensures that people who are eligible for MA receive the most generous coverage they are entitled to receive.

With more generous eligibility standards for Medical Assistance in 2014, MinnesotaCare coverage is no longer needed for certain groups. For example:

- MinnesotaCare no longer covers adults, parents and 19-20 year-olds with incomes below 133% of the FPL because these groups are enrolled in MA. In 2013, adults, parents and 19-20 year-olds have been eligible for MA if they have family incomes at or below 100% of the Federal Poverty Level or FPL. In 2014, this was expanded to 133% of the FPL.
- Pregnant women and children under age 19 with family incomes at or below 275% of the FPL were enrolled in MinnesotaCare in 2013, but were transitioned to MA in 2014.
- In 2014, MinnesotaCare covers parents, adults and 19-20 year-olds with family incomes up to 200% FPL instead of 250% or 275% FPL to align eligibility standards with requirements for the Basic Health Plan.

In 2014, MinnesotaCare benefits for certain adults were increased to conform to benefits requirements in the Affordable Care Act and to minimize disruption with the transition to a Basic Health Plan in 2015. As before, MinnesotaCare enrollees under age 21 receive the full MA benefit set.

- Benefits: For adults without children, the \$10,000 cap on inpatient hospital services is eliminated.
- Cost-sharing: For adults without children, the 10% co-pay on inpatient hospital services is eliminated.
- Reduced premiums. Premiums are reduced for adult in MinnesotaCare. Enrollees under age 21 pay no premium.

The benefit set offered to MinnesotaCare Children and MA One-Year-Olds under the 2014 waiver 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). The benefit offered to MinnesotaCare Caretaker Adults and MinnesotaCare Adults without Children is identical to the benefits offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (a) through (h) below are excluded.

1. Services included in an individual's education plan;
2. Private duty nursing;
3. Orthodontic services;
4. Non-emergency medical transportation services;
5. Personal Care Services;
6. Targeted case management services (except mental health targeted case management);
7. Nursing facility services; and
8. ICF/MR services.

In 2014, MinnesotaCare eligibility rules were changed to align with requirements in the Affordable Care Act. MinnesotaCare no longer has an asset test. The 4-month and 18-month eligibility waiting periods were eliminated. MinnesotaCare coverage may begin while an

individual is hospitalized. Eligibility for certain special populations (volunteer firefighters, former foster care children) is eliminated. (Former foster care children are covered under MA).

In 2014, MinnesotaCare eligibility was expanded to include groups that are expected to be covered by the Basic Health Plan in 2015 so that these groups would experience fewer coverage transitions.

- MinnesotaCare provides coverage for children under age 19 who are not eligible for MA under MA household composition rules but who have family incomes at or below 200% FPL using different household composition rules.
- MinnesotaCare provides coverage for adults who would not have family incomes at or below 200% FPL using Medicaid income calculation rules, but would have incomes at or below 200% FPL using income calculation rules that will apply under the Basic Health Plan.

Following these changes, the 2014 waiver makes coverage available to 19- and 20-year olds and adults with incomes between 133% and 200% of the federal poverty level, providing a more generous benefit set and lower cost sharing than people at these income levels are likely to be able to purchase with federal tax credits through MNsure.

In addition, the demonstration allows Minnesota to provide coverage to additional groups under a “designated state health program” during the interim year prior to the BHP: children who are barred from Medicaid due to Medicaid income methodologies; and adults and children who would not otherwise qualify for MinnesotaCare using Medicaid income methodologies but would be eligible under Marketplace income methodologies.

Finally, the 2014 demonstration also continues to provide important authorities for Minnesota’s Medicaid program such as streamlining benefit sets for pregnant women, authorization of medical education funding, preserving eligibility methods currently in use for children ages 12 to 23 months, simplifying the definition of a parent or caretaker relative to include people living with child(ren) under age 19, and allowing mandatory enrollment of certain populations in managed care.

4. Evaluation Strategy for the 2014 Waiver

4.1 Demonstration Goals, Hypotheses and Objectives for 2014

The goal of the waiver is to reduce the proportion of uninsured and provide better coverage and better value for those who are participating in the program as compared to people who are not covered under Medicaid expansion. The evaluation will compare coverage levels under MinnesotaCare and coverage available under a qualified health plan purchased through MNsure. The demonstration also seeks to provide comparable access and quality of care to the waiver populations as compared to Medicaid managed care enrollees not eligible under the waiver. The objective is to demonstrate that access, quality of care and enrollee satisfaction is maintained

under the demonstration and is comparable to care provided to Medicaid managed care enrollees not eligible under the waiver.

The goals and hypotheses that will be tested during the evaluation period are summarized below:

4.11 Goal 1: Provide better coverage for insured.

Provide better health insurance coverage to Minnesotans at MinnesotaCare income levels than they might otherwise select through MNsure.

Objective: Increase the proportion of Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance as compared with the Minnesotans at 200-250% FPL with coverage purchased on MNsure.

Measurement:

- Categorize MinnesotaCare waiver benefits, cost-sharing and premiums, and that of plans available through MNsure, to determine comparative levels of coverage comprehensiveness.
- Determine the proportions of people receiving coverage through MNsure with incomes 200-250% FPL who are enrolled in bronze, silver, gold and platinum level plans.
- Determine the proportion of people at incomes of 200-250% FPL enrolled through MNsure who have benefit sets just as or more comprehensive than the benefit set of the waiver group.

Hypothesis: Minnesotans in the waiver group will have more comprehensive coverage and lower cost-sharing than they would likely have otherwise chosen through MNsure assuming their choices would be similar to those Minnesotans purchasing coverage through MNsure with incomes between 200 and 250% FPL.

Data Source: MNsure eligibility data, MNsure coverage data.

4.12 Goal 2: Provide value.

Provide more comprehensive health insurance coverage for Minnesotans at MinnesotaCare income levels at competitive rates, taking into consideration enrollee cost sharing, federal and state expenditures.

Objective: Provide Minnesotans over age 18 at 133-200% FPL with comprehensive health insurance in a cost effective manner.

Measurement:

- Compare MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

- Calculate premiums, cost-sharing and tax credit expenditures for purchase of MinnesotaCare-level coverage via MNsure for people at incomes of 200-250% FPL, by level of coverage (bronze, silver, gold and platinum).

Hypothesis: Combined federal and state per capita spending on the waiver group and average enrollee cost sharing will be equal to or less than spending and cost sharing for Minnesotans at the 200-250 % FPL income level enrolled through MNsure if they choose coverage similar to what the waiver group will receive.

Data Source: MNsure eligibility data; state expenditure data on waiver group; CMS data on cost-sharing settle-ups.

4.13 Goal 3: Improve the quality of care.

The goal of the waiver is to provide comparable access and quality of health care to waiver populations as compared to Minnesota’s other public health care program enrollees in managed care.

Objectives: Improve:

- Utilization of services for children (childhood immunizations, child access to PCP, annual dental visits, well-child visits, medication management for people with asthma and follow-up after hospitalization for mental illness.)
- Utilization of services for adults (diabetes care, depression management, adult preventive visits, cervical cancer screening, dental visits, medication management for people with asthma, initiation and engagement of alcohol and other drug dependence treatment, and follow-up after hospitalization for mental illness.)
- Enrollee satisfaction with the delivery and quality of services (satisfaction survey results)

Measurement: Compare waiver and non-waiver Medicaid enrollees using selected HEDIS 2015 and other performance measures of utilization, preventive and chronic disease care, physical and mental health services, and satisfaction with managed care services to compare, contrast and draw out differences between the populations.

Hypothesis: Providing health care coverage to child and adult populations who would otherwise be uninsured will result in improved outcomes:

Data Source: Encounter data.

5. Evaluation Populations for 2014 Waiver

Waiver evaluation populations will consist of the following subgroups:

Waiver population subgroups:

- MinnesotaCare Children. Children ages 19 and 20 years old with family incomes 133-200% of the FPG and DSHP Children ages 0-18 with family incomes at or below 200% of the FPG.
- MinnesotaCare Caretaker Adults. Parents and adults caring for children with family incomes 133-200% of the FPG.
- MinnesotaCare Adults without Children. Adults age 21 or older without dependent children, and incomes 133-200% of the FPL.
- Medical Assistance One-Year-Olds. Children enrolled in MA ages 12-23 months and family incomes 133-275 percent of the FPG.

Medical Assistance (MA) Comparison Groups:

- MA Children. Children in MA ages 0-20.
- MA Caretaker Adults. Parents or adults caring for children with family incomes at or below 100 percent of the FPG, enrolled in managed care.
- MA Caretaker Adults. Adults caring for children with family incomes at or below 133 percent of the FPG, enrolled in managed care.
- MA Adults without Children. Adults age 21 or older without dependent children, and incomes at or below 133 percent of the FPG.

5.1 Evaluation Plan for the 2014 Waiver

Goals one and two will require examination and contrast of MinnesotaCare and MNsure populations program attributes, MinnesotaCare and MNsure coverage plans and coverage patterns.

For goal three, a comparison and stratification of the selected HEDIS 2015 and other performance measures will be made between the waiver (MA and MinnesotaCare) populations and other public program managed care enrollees to show the ongoing improvement in care for all publicly funded program enrollees. Performance measurement rates for the baseline period (CYs 2011, 2012 and 2013) will be calculated for the targeted populations and compared to CY 2014. In addition, national benchmarks will be obtained from NCQA’s Medicaid Quality Compass to compare performance of Minnesota’s populations with national and other state’s performance.

Overview of Populations, Measures and Years

Waiver Populations	Comparison Populations	Measures	Measurement/Reference Years
2. MinnesotaCare Children 0-20 to 200% FPG (DHS program/eligibility codes: LL/C1, C2, I1, I2.)	2. MA Children0-20	1. Childhood immunizations (2 yrs) 2. Child access to PCP (age groups 12-24 mos; 25 mos-6 yrs; 7-11 yrs; 12-19 yrs) 3. Annual Dental Visit (age groups 2-3 yrs; 4-6 yrs; 7-10 yrs; 11-14 yrs; 15-18 yrs) 4. Well –child visits first 5. 15months 5. Well-child visits 3 to 6 yrs.	MY = CY 2014 RYs = 2011 through 2013

		6. Adolescent well-care visits (12-19 yrs) 7. Medication Management for People with Asthma 8. Follow-up After Hospitalization for Mental Illness	
3. MinnesotaCare Caretaker Adults (DHS program/eligibility codes: FF/A2, M2)	3. MA Caretaker Adults (DHS program/eligibility codes: MA/AA)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness	MYs = CY 2014 RYs = 2011 through 2013
4. MinnesotaCare Adults w/o Children (DHS program/eligibility codes: BB/M5)	4. MA Adults w/o Children (DHS program/eligibility codes: AX)	1. Diabetes A1c screening 2. Diabetes LDL screening 3. Adult access preventive/ambulatory health services 4. Cervical CA screening 5. Medication Management for People with Asthma 6. Follow-up After Hospitalization for Mental Illness 7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	MYs = CY 2014 RYs = 2011 through 2013
1. MA Children 12-24 Mos. 133 to 275 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	1. MA Children 12-24 Mos. less than 133 % FPG (DHS program/eligibility codes: MA/CB and MAXIS financial information)	1. Child access to PCP (age groups 12-24 mos) 2. Well-child visits first 15months	MY = CY 2014 RYs = 2011 through 2013

To demonstrate continued satisfaction with program level care and services, a review of historical and evaluation period adult CAHPS satisfaction information will be done to assess the domains of enrollee experiences.

5.2 Evaluation Metrics for the 2014 Waiver

1. Measures:

Rates and program attributes will be displayed to assist in making comparisons between MinnesotaCare benefits, cost-sharing and premiums to plans available through MNsure.

The selected HEDIS performance measures will be used to evaluate child and adult care for the waiver population compared to Medicaid managed care enrollees. Performance measure data will be extracted from DHS' managed care encounter database in June the following year to allow for a sufficient encounter run-out period.

The table below provides a list of the annual HEDIS 2015 performance measures that will be analyzed in the evaluation.

Children (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 15 months
Well-child visits 3 to 6 yrs.
Adolescent well-care visits (12-19 yrs)
Adults
Adult access preventive/ambulatory health services
Annual Dental Visit
Medication Management for People with Asthma
Follow-up After Hospitalization for Mental Illness
Comprehensive Diabetes Care
Cervical CA screening

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

The performance measures will be evaluated for period-to-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 populations based on the following measures 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 by the diabetes screening, adult preventive visits, and cervical cancer screening measures.
- Enrollee satisfaction analysis and comparison of satisfaction survey results reflecting the enrollee's perspective on agreement with the delivery and quality of health care services. The DHS conducted annual CAHPS satisfaction survey access and quality care provided by MCOs of adults will be the information used.

2. Comparison Metrics between CYs 2011-2013 and CY 2014. The key factor that would limit the comparison metric is subpopulation size. Modification of the planned metrics may be needed based upon the initial data analytical step to determine subpopulation enrollment

characteristics. Public program eligibility changes will also influence metric comparisons and would need to be assessed during the initial data analytical step.

3. Other Quality Performance Measures. As part of the performance measure and stratification evaluation step (June 2015), annual AHRQ ambulatory care sensitive conditions (ACSC) program level measures will be calculated to provide additional insight into the quality of care provided over the calendar years 2011 through 2014.

6. Evaluation Implementation Strategy and Timeline

6.1 Management and Coordination of the 2014 Waiver Evaluation

The DHS Health Care Research and Quality Division will conduct the waiver evaluation and review results over the second half of calendar year 2015, with the final report submitted to CMS by the end of 2015. Below is an overview of evaluation activities and timeline:

- May 2015: DHS will calculate measurement rates for goals one and two.
- June 2015: DHS staff will review and evaluate goal rates and drawn conclusions.
- July – August 2015: DHS will calculate and stratify HEDIS 2015 performance measures.
- Sept – December 2015: HEDIS and CAHPS results will be reviewed and results evaluated.
- September 2015- March 2016: Draft and final waiver report is written, reviewed and approved.
- May 2016: Final report is submitted to CMS.

**2014 Waiver Evaluation Process Steps Timeline
CY 2015**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CAHPS Data Collection		X	X	X	X	X						
CAHPS Data Analysis							X	X				
Goal 1 and 2 Data collection					X							
Goal 1 and 2 Results Analysis						X	X					
Performance Measures Validation						X	X	X				
Performance Measures Calculation & Stratification							X	X	X			
Performance Measure Analysis									X	X	X	X
Draft Report – March												

2016												
Final Report & Approval- May 2016												

6.2 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 the 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. The Quality Strategy and related documents are posted on the Minnesota DHS web site at: www.dhs.state.mn.us/managedcarereporting.

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.

6.3 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. Changes that will result from transitioning from ICD-9 to ICD-10 codes are not expected to have an impact.
- Measures with high rates of utilization 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.

6.4 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.