

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

Extension Request

Project No. 11-W-00039/5

June 2020

Table of Contents

Section I – Background	1
Section II – PMAP+ Waiver Extension.....	2
Section III - Waivers and Expenditure Authorities	3
Section IV - Delivery System	4
Section V - Quality Assurance and Monitoring	4
Section VI - PMAP+ Evaluation Activities.....	6
Section VII – Demonstration Financing and Budget Neutrality	6
Section VIII – Public Notice and Comment Process.....	7
Section IX – Demonstration Administration	9

Attachments

Attachment A	Annual Technical Report
Attachment B	PMAP+ Waiver Interim Evaluation Report 2014-2018
Attachment C	PMAP+ Waiver Evaluation Plan for 2021-2025
Attachment D	Historical and Projected Expenditures
Attachment E	State Register Notice - Public Comment
Attachment F	Tribal Letter May 26, 2020
Attachment G	Public Comment <i>(if any)</i>

Section I – Background

The PMAP+ Section 1115 Waiver has been in place for over 30 years, primarily as the federal authority for the MinnesotaCare program, which provided comprehensive health care coverage through Medicaid funding for people with incomes in excess of the standards in the Medical Assistance program. The longstanding goal of the demonstration had been to provide MinnesotaCare enrollees with comparable access to high-quality preventive and chronic disease care. Evaluation of the waiver showed a high level of access to quality preventive and chronic disease care at rates similar to Minnesota Medicaid experience and in most instances exceeding national Medicaid benchmarks.

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

The PMAP+ waiver also provided the State with longstanding federal authority to enroll certain populations eligible for Medical Assistance into managed care who otherwise would have been exempt from managed care under the Social Security Act. In December of 2014, CMS notified the Department of Human Services (DHS) that it would need to transition this portion of its PMAP+ waiver authority to a section 1915(b) waiver. Therefore, on October 30, 2015, DHS submitted a request to transfer this authority to its Minnesota Senior Care Plus section 1915(b) waiver.

The amendment to the MSC+ 1915(b) waiver sought to continue federal waiver authority to require the following groups to enroll in managed care:

- American Indians, as defined in 25 U.S.C. 1603(c), who otherwise would not be mandatorily enrolled in managed care;
- Children under age 21 who are in state-subsidized foster care or other out-of-home placement; and
- Children under age 21 who are receiving foster care under Title IV-E.

CMS approved the amendment to the MSC+ waiver on December 22, 2015 with an effective date of January 1, 2016.

The PMAP+ waiver continues to be necessary to continue certain elements of Minnesota's Medical Assistance program. On February 11, 2016, CMS approved DHS's request to renew the PMAP+ waiver for the period of January 1, 2016 through December 31, 2020.

The current waiver provides continued federal authority to:

- Cover children as “infants” under Medical Assistance who are 12 to 23 months old with income eligibility above 275 percent and at or below 283 percent of the federal poverty level (FPL) (referred to herein as “MA One Year Olds”);
- Waive the federal requirement to 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;
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility; and
- Fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

Section II – PMAP+ Waiver Extension

The purpose of the extension of this waiver is to continue these longstanding authorities for Minnesota’s Medicaid program including preserving eligibility methods currently in use for children ages 12 to 23 months and simplifying the definition of a parent or caretaker adult to include people living with child(ren) under age 19. This waiver request also seeks continued federal authority to provide full Medical Assistance benefits for pregnant women during the period of presumptive eligibility and to fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

MA One-Year-Olds

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

Caretaker Adults with 18-Year-Old

The PMAP+ waiver provides 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.

MERC

Through expenditure authority granted under the PMAP+ waiver, payments made through the Medical Education and Research Costs (MERC) Trust Fund through sponsoring institutions to medical care providers are eligible for federal financial participation.

Section III - Waivers and Expenditure Authorities

The state is requesting approval of the same waiver and expenditure authorities as those approved under the current demonstration. These are as follows:

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, expenditures made by the state for the items identified below (which are not otherwise included as expenditures under section 1903) will be regarded as expenditures under the state's title XIX plan for the period of this extension.

The following expenditure authorities enable Minnesota to operate its section 1115 demonstration:

- 1.** Expenditures for Medicaid coverage for children from ages 12 months through 23 months, who would not otherwise be eligible for Medicaid, with income above 275 percent and at or below 283 percent of the federal poverty level (FPL).
- 2.** Expenditures for Medicaid coverage for pregnant women described in section 1902(a)(47) of the Act, to the extent that services are provided during a hospital presumptive eligibility period, that are in addition to ambulatory prenatal care services.
- 3.** Expenditures for payments made directly to medical education institutions or medical providers and restricted for use to fund graduate medical education (GME) of the recipient institution or entity through the Medical Education and Research Costs (MERC) trust fund. In each demonstration year, payments made under this provision are limited to the amount claimed for federal financial participation (FFP) under this demonstration as MERC expenditures for

state fiscal year (SFY) 2009. Except as specifically authorized in the STCs, the state may not include GME as a component of capitation or as a basis for other direct payment under the State plan. This expenditure authority will be subject to changes in federal law or regulation that may restrict the availability of federal financial participation for GME expenditures.

Requirements Not Applicable to the Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the list below, shall apply to the expenditure authorities.

1. Managed Care Payment

**Section 1903(m)(2)(A)(ii)
Section 1902(a)(4)**

To the extent necessary to allow the state to make payments directly to providers, outside of the capitation rate, for GME and other medical education through the MERC trust fund.

Title XIX Waivers

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are in effect to enable Minnesota to carry out the PMAP+ demonstration.

Redeterminations for Caretaker Adults Section 1902(a)(17)

To the extent necessary to enable the state to not perform a redetermination of the basis of eligibility for caretaker adults with income at or below 133 percent of FPL because they assume responsibility for and live with a child age 18 who is not a full time student in secondary school.

Section IV - Delivery System

Minnesota currently utilizes both fee-for-service and managed care delivery systems under the Medicaid State plan. Coverage for a large portion of enrollees in Medical Assistance is purchased on a prepaid capitated basis. Managed care enrollment is mandatory for Medicaid State plan groups that are not otherwise exempt from mandatory managed care. The remaining recipients received services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities. DHS contracts with MCOs in each of Minnesota's 87 counties.

Section V - Quality Assurance and Monitoring

To ensure that the level of care provided by each MCO meets acceptable standards, the state monitors the quality of care provided by each MCO through an ongoing review of each MCO's quality improvement system, grievance procedures, service delivery plan, and summary of health utilization information.

Quality Strategy

In accordance with 42 C.F.R. §438.202(a), the state's quality strategy was developed to monitor and oversee the quality of PMAP and other publicly funded managed care programs in Minnesota.

This quality strategy assesses the quality and appropriateness of care and services provided by MCOs for all enrollees in managed care. It incorporates elements of current MCO contract requirements, state health maintenance organization (HMO) licensing requirements (Minnesota Statutes, Chapters 62D, 62M, 62Q), and federal Medicaid managed care regulations (42 C.F.R. §438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) are at the core of DHS's quality strategy. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with managed care requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance with these requirements and standards. The outcomes of these quality improvement activities are included in the Annual Technical Report (ATR).

MCO Internal Quality Improvement System

MCOs are required to have an internal quality improvement system that meets state and federal standards set forth in the contract between the MCO and DHS. These standards are consistent with those required under state HMO licensure requirements. The Minnesota Department of Health conducts triennial audits of the HMO licensing requirements.

External Review Process

Each year the state Medicaid agency must conduct an external quality review of managed care services. The purpose of the external quality review is to produce the Annual Technical Report (ATR) that includes:

- 1) Determination of compliance with federal and state requirements,
- 2) Validation of performance measures, and performance improvement projects, and
- 3) An assessment of the quality, access, and timeliness of health care services provided under managed care.

Where there is a finding that a requirement is not met, the MCO is expected to take corrective action to come into compliance with the requirement. The external quality review organization (EQRO) conducts an overall review of Minnesota's managed care system. The review organization's charge is to identify areas of strength and weakness and to make recommendations for change. Where the technical report describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's ATR. A copy of the 20XX Annual Technical Report produced by the external quality review organization is provided at Attachment A.

DHS also conducts annual surveys of enrollees who switch between MCOs during the calendar year. Survey results are summarized and sent to CMS in accordance with the physician incentive plan (PIP) regulation. The survey results are published annually and are available on the DHS website at [Managed Care Reporting](#).

Consumer Satisfaction

DHS sponsors an annual satisfaction survey of public program managed care enrollees using the Consumer Assessment of Health Plans Survey (CAHPS®) instrument and methodology to assess and compare the satisfaction of enrollees with services and care provided by MCOs. DHS contracts with a certified CAHPS vendor to administer and analyze the survey. Survey results are published on the DHS website at [Managed Care Reporting](#).

Update on Comprehensive Quality Strategy

Minnesota's Comprehensive Quality Strategy is an overarching and dynamic continuous quality improvement strategy integrating processes across Minnesota's Medicaid program. The Comprehensive Quality Strategy includes measures and processes related to the programs affected by the PMAP+ waiver. Minnesota's Comprehensive Quality Strategy can be found on the DHS website at [Quality Outcome and Performance Measures](#).

Section VI - PMAP+ Evaluation Activities

Please refer to Attachment B for an interim report of evaluation activities and findings to date.

A copy of the evaluation plan for the proposed extension period of January 1, 2021 through December 31, 2025 is found at Attachment C.

Section VII – Demonstration Financing and Budget Neutrality

The budget neutrality spreadsheet at Attachment D provides financial data demonstrating the state's historical and projected expenditures for the requested period of the extension.

Per paragraph 31.d) of the PMAP+ waiver special terms and conditions, the allocated expenditures for the Caretaker Adults with 18 year olds population are estimates of the allocated costs. The state used the following formula to estimate allocated costs for this group: $0.83\% * \text{expenditures for MA Caretaker Adults} = \text{estimated allocated expenditures}$. This percentage is based on the percentage of MA Caretaker Adults with youngest or only child age 18 as compared to all MA Caretaker Adults.

The historical data for the Caretaker Adults with 18 year olds population in the spreadsheet at Attachment D of this extension request is based on actual data for this population which shows the allocation ratio increasing over time:

	Total MA Caretaker Member Months	Youngest Child 18 Years Old Member Months	Allocation Ratio
SFY 2015	1,639,662	20,093	1.23%
SFY 2016	1,561,521	21,101	1.35%
SFY 2017	1,624,918	24,678	1.52%
SFY 2018	1,696,062	29,447	1.74%
SFY 2019	1,654,069	29,236	1.77%
January 2020	130,721	2,286	1.75%

The allocation ratio estimate of 0.83% was based on January 2014 data and was calculated as the number of MA Caretakers with youngest (or only) child 18 years old divided by the total number of MA Caretakers. Based on January 2020 data the state has calculated an updated allocation ratio of 1.75 percent. This is the recommended allocation ratio for the PMAP+ waiver extension period.

Section VIII – Public Notice and Comment Process

Public Notice

A notice requesting public comment on the proposed PMAP+ §1115 waiver extension request was published in the Minnesota State Register on May 26, 2020. This notice announced a 30-day comment period from May 26, 2020 to June 25 2020 on the PMAP+ waiver extension request. The notice informed the public on how to access an electronic copy of the waiver request. Instructions on how to submit written comments were provided. In addition, the notice included information about two teleconferences scheduled to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The date and time for the two teleconferences, along with information about how to arrange to speak at either conference, was provided. Finally, the notice provided a link to the PMAP+ Waiver web page for complete information on the PMAP+ waiver request including the public notice process, the public input process, planned teleconferences and a copy of waiver application. A copy of the Minnesota State Register Notice published on May 26, 2020 is provided as Attachment E.

The DHS public web site at [PMAP+ Waiver](#) provides the public with information about the PMAP+ waiver extension request. The web site is updated on a regular basis and includes information about the public notice process, opportunities for public input, planned hearings and a copy of the waiver application. The main page of the DHS public website includes a “Public Participation” link to help people quickly identify what comment periods are open. This page contained a link to the PMAP+ waiver web page during the public comment period. After the comment period, it will be updated to alert web visitors of the upcoming federal comment period on the PMAP+ extension request and to provide the link to the federal website when it is available. A copy of the final draft of the waiver request that includes modifications following the public input process will be posted on the PMAP+ waiver web page.

Teleconferences

In lieu of in-person public hearings, two teleconferences were held to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The first teleconference was held on June 1, 2020. **Public testimony/attendance**. The second teleconference was held on June 3, 2020. **Public testimony/attendance**.

Use of electronic mailing list or similar mechanism to notify the public.

The State used an electronic mailing list or similar mechanism to notify the public. On May 26, 2020 an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the State's intent to submit the PMAP+ waiver extension request and directing them to the PMAP+ waiver web page. A second email will be sent to provide notice that the final submitted version of the waiver is on the web site and to alert stakeholders that a federal comment period on the PMAP+ extension request is expected soon.

Tribal consultation

In Minnesota, there are seven Anishinaabe (Chippewa or Ojibwe) reservations and four Dakota (Sioux) communities. The seven Anishinaabe reservations include Grand Portage located in the northeast corner of the state, Bois Forte located in extreme northern Minnesota, Red Lake located in extreme northern Minnesota west of Bois Forte, White Earth located in northwestern Minnesota; Leech Lake located in the north central portion of the state; Fond du Lac located in northeastern Minnesota west of the city of Duluth; and Mille Lacs located in the central part of the state, south of Brainerd. The four Dakota Communities include: Shakopee Mdewakanton Sioux located south of the Twin Cities near Prior Lake; Prairie Island located near Red Wing; Lower Sioux located near Redwood Falls; and Upper Sioux whose lands are near the city of Granite Falls. While these 11 tribal groups frequently collaborate on issues of mutual benefit, each operates independently as a separate and sovereign entity – a state within a state or nation within a nation. Recognizing American Indian tribes as sovereign nations, each with distinct and independent governing structures, is critical to the work of DHS. DHS has a designated staff person in the Medicaid Director's office who acts as a liaison to the Tribes

The Tribal Health Directors Work Group was formed to address the need for a regular forum for formal consultation between tribes and state staff. Work group attendees include Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, and the state consultation liaison. The Native American Consultant from CMS and state agency staff attend as necessary depending on the topics covered at each meeting. The state liaison attends all Tribal Health Directors Work Group meetings and provides updates on state and federal activities. The liaison will often arrange for appropriate DHS policy staff to attend the meeting to receive input from Tribes and to answer questions.

On May 26, 2020 a letter was sent to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic informing them of the State's intent to submit a request to extend the PMAP+ waiver. The letter also informed Tribes of the public input process and

provided a link to the PMAP+ waiver web page. Please refer to Attachment F for a copy of the May 26, 2020 letter.

Comments received by the state during the 30-day public notice period.

DHS received **XX written comments** from stakeholders regarding the proposed PMAP+ waiver extension during the comment period from May 26, 2020 to June 25, 2020. Copies of the **XX** comments are included at Attachment G.

State's responses to submitted comments (and whether or how the state incorporated them into the final application)

DHS response to comments at Attachment G.

Post Award Public Forums

DHS held a public forum on June 27, 2019 to provide the public with an opportunity to comment on the progress of the PMAP+ demonstration. A notice was published on the DHS Public Participation web site on May 28, 2019 informing the public of the date, time and location of the forum. There were no members of the public in attendance at the forum. The next public forum is planned for the summer of 2020.

Section IX – Demonstration Administration

Contact

Jan Kooistra, Federal Relations
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

(651) 431-2188

Jan.kooistra@state.mn.us

Minnesota Department of Human Services
2017 External Quality Review Annual Technical Report
Issued April 29, 2019

An independent external quality review of Minnesota publicly funded managed care programs in accordance with the Balanced Budget Act of 1997 (Subpart E, 42 Code of Federal Regulations Section 438.364)



Better healthcare,
realized.

Corporate Headquarters

1979 Marcus Avenue

Lake Success, NY 11042-1002

(516) 326-7767

[IPRO Website](#)

**2017 External Quality Review
Annual Technical Report**

Issued: April 29, 2019

Prepared by:

IPRO

1979 Marcus Avenue

Lake Success, NY 11042-1002

[IPRO Website](#)

For More Information:

Mark Foresman, PhD, Supervisor, Quality Improvement

Health Care Research and Quality

Department of Human Services

P.O. Box 64986

St. Paul, MN 55164-0986

Telephone: (651) 431-6324

Fax: (651) 431-7422

E-mail: [Mark Foresman E-mail](#)



For accessible formats of this publication and additional equal access to human services, write to [Minnesota State Department of Human Services Quality Improvement E-mail](#), call 651-461-2610 or use your preferred relay service. (ADA-1 [9-15])

**This document may be reproduced without restriction.
IPRO reviewed and confirmed this document is 508-compliant.**

HEDIS[®] and Quality Compass[®] are registered trademarks of the National Committee for Quality Assurance (NCQA). NCQA HEDIS[®] Compliance Audit[™] is a trademark of the NCQA. NCQA[™] is a trademark of the National Committee for Quality Assurance.

TABLE OF CONTENTS

List of Figures	ii
List of Tables	iii
Acronyms Used in This Report	v
Executive Summary.....	1
Chapter 1: Introduction	2
Chapter 2: Summary of DHS Activities.....	8
2017 Health Care Disparities Report	8
State Targeted Response to the Opioid Crisis	9
Chapter 3: Evaluation of MCO Strengths and Opportunities	11
A. Evaluation Process.....	11
B. MCO Evaluations.....	17
Blue Plus.....	18
HealthPartners.....	31
Hennepin Health.....	43
Itasca Medical Care (IMCare).....	55
Medica	66
PrimeWest Health.....	75
South Country Health Alliance.....	89
UCare	102
C. Common Strengths and Opportunities across MHCP.....	116
Chapter 4: Follow-Up to 2016 ATR Recommendations	119
Chapter 5: MCO Feedback on 2017 ATR.....	162
Chapter 6: EQRO Recommendations to DHS.....	172

LIST OF FIGURES

Figure 1: MHCP Enrollment by MCO – December 2017	5
Figure 2: MHCP Enrollment Trends by MCO – December 2015, December 2016 and December 2017	6
Figure 3: Enrollment by Population Type – December 2017	7
Figure 4: Blue Plus 2018 HEDIS Measure Matrix	25
Figure 5: HealthPartners 2018 HEDIS Measure Matrix.....	38
Figure 6: Hennepin Health 2018 HEDIS Measure Matrix.....	50
Figure 7: IMCare 2018 HEDIS Measure Matrix	62
Figure 8: Medica 2018 HEDIS Measure Matrix.....	71
Figure 9: PrimeWest 2018 HEDIS Measure Matrix	84
Figure 10: SCHA 2018 HEDIS Measure Matrix	97
Figure 11: UCare 2018 HEDIS Measure Matrix.....	111

LIST OF TABLES

Table 1: MCO 2017 Participation by Program	3
Table 2: Blue Plus Enrollment as of December 2017	18
Table 3: Blue Plus Rates for the 2015-2017 PIP	19
Table 4: Blue Plus 2017 Financial Withhold	20
Table 5: Blue Plus HEDIS Performance – Reporting Years 2016, 2017 and 2018	22
Table 6: Blue Plus CAHPS Performance – 2016, 2017 and 2018	27
Table 7: HealthPartners Enrollment as of December 2017	31
Table 8: HealthPartners Performance Rates for the 2015-2017 PIP	32
Table 9: HealthPartners 2017 Financial Withhold	33
Table 10: HealthPartners HEDIS Performance – Reporting Years 2016, 2017 and 2018	35
Table 11: HealthPartners CAHPS Performance – 2016, 2017 and 2018	39
Table 12: Hennepin Health Enrollment as of December 2017	43
Table 13: Hennepin Health Performance Rates for the 2015-2017 PIP	44
Table 14: Hennepin Health 2017 Financial Withhold	45
Table 15: Hennepin Health HEDIS Performance – Reporting Years 2016, 2017 and 2018	47
Table 16: Hennepin Health CAHPS Performance – 2016, 2017 and 2018	51
Table 17: IMCare Enrollment as of December 2017	55
Table 18: IMCare Performance Rates for the 2015-2017 PIP	56
Table 19: IMCare 2017 Financial Withhold	57
Table 20: IMCare HEDIS Performance – Reporting Years 2016, 2017 and 2018	59
Table 21: IMCare CAHPS Performance – 2016, 2017 and 2018	63
Table 22: Medica Enrollment as of December 2017	66

Table 23: Medica 2017 Financial Withhold.....	67
Table 24: Medica HEDIS Performance – Reporting Years 2016, 2017 and 2018.....	70
Table 25: Medica CAHPS Performance – 2016, 2017 and 2018	72
Table 26: PrimeWest Enrollment as of December 2017.....	75
Table 27: PrimeWest Rates for the 2015-2017 PIP.....	76
Table 28: PrimeWest 2017 Financial Withhold.....	77
Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2016, 2017 and 2018	80
Table 30: PrimeWest CAHPS Performance – 2016, 2017 and 2018	85
Table 31: SCHA Enrollment as of December 2017	89
Table 32: SCHA Performance Rates for the 2015-2017 PIP	90
Table 33: SCHA 2017 Financial Withhold.....	91
Table 34: SCHA HEDIS Performance – Reporting Years 2016, 2017 and 2018.....	93
Table 35: SCHA CAHPS Performance – 2016, 2017 and 2018.....	98
Table 36: UCare Enrollment as of December 2017.....	102
Table 37: UCare Performance Rates for the 2015-2017 PIP.....	103
Table 38: UCare 2017 Financial Withhold.....	104
Table 39: UCare HEDIS Performance – Reporting Years 2016, 2017 and 2018.....	107
Table 40: UCare CAHPS Performance – 2016, 2017 and 2018	112
Table 41: MHCP HEDIS Performance – Reporting Years 2016, 2017 and 2018.....	117
Table 42: MHCP CAHPS Performance – 2016, 2017 and 2018	118

ACRONYMS USED IN THIS REPORT

AACAP:	American Academy of Child and Adolescent Psychiatry
AAFP:	American Academy of Family Physicians
AAP:	American Academy of Pediatrics
ACA:	Affordable Care Act
ACCF:	American College of Cardiology Foundation
ACIP:	Advisory Committee on Immunization Practices
ACOG:	American Congress of Obstetricians and Gynecologists
ACPM:	American College of Preventive Medicine
ADA:	American Diabetes Association
AHA:	American Heart Association
AHRQ:	Agency for Healthcare Research and Quality
APA:	American Psychiatric Association
ATR:	Annual Technical Report
BBA:	Balanced Budget Act (of 1997)
BOC:	Board of Commissioners
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
CBP:	County-Based Purchasing
CDC:	Centers for Disease Control and Prevention
CFR:	Code of Federal Regulation
CHW:	Community Health Worker
CMS:	Centers for Medicare and Medicaid Services
COPD:	Chronic Obstructive Pulmonary Disease
C&TC:	Child and Teen Checkups
DHS:	Department of Human Services
ED:	Emergency Department
EQR:	External Quality Review
EQRO:	External Quality Review Organization
ER:	Emergency Room
F&C-MA:	Families and Children Medical Assistance
GOLD:	Global Initiative for Chronic Obstructive Lung Disease
HEDIS®:	Healthcare Effectiveness Data and Information Set
HMO:	Health Maintenance Organization
HRSA:	Health Resources and Services Administration
ICHHS:	Itasca County Health and Human Services

ICSI:	Institute for Clinical Systems Improvement
IMCare:	Itasca Medical Care
JACC:	Journal of the American College of Cardiology
JAMA:	Journal of the American Medical Association
JNC 8:	Eighth Joint National Committee
JPB:	Joint Powers Board
MA:	Medical Assistance
MCO:	Managed Care Organization
MDH:	Minnesota Department of Health
MNCare:	MinnesotaCare
MNCM:	MN Community Measurement
MHCP:	Minnesota Health Care Programs
MSHO:	Minnesota Senior Health Options
MSC+:	Minnesota Senior Care Plus
MTM:	Medication Therapy Management
MY:	Measurement Year
NCQA:	National Committee for Quality Assurance
NHLBI:	National Heart, Lung and Blood Institute
NIH:	National Institutes of Health
OB/GYN:	Obstetrician/Gynecologist
PCP:	Primary Care Practitioner/Provider
PIP:	Performance Improvement Project
QA:	Quality Assurance
QAE:	Quality Assurance Examination
QC®	Quality Compass®
QI:	Quality Improvement
SNBC:	Special Needs Basic Care
SNP:	Special Needs Plan
STR:	State Targeted Response
SWA:	Statewide Average
TCA:	Triennial Compliance Assessment
UR:	Utilization Review
URI:	Upper Respiratory Infection
USDHHS:	United States Department of Health and Human Services
USPSTF:	United States Preventive Services Task Force
VBP:	Value-Based Program

EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an external quality review organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCO). In order to comply with these requirements, the Department of Human Services (DHS) contracted with IPRO to assess and report the impact of its Minnesota Health Care Programs (MHCP) and each of the participating MCOs on the accessibility, timeliness and quality of services. In accordance with Federal requirements, as set forth in the Balanced Budget Act (BBA) of 1997, this report summarizes the results of the 2017 EQR.

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as state requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: the validation of performance measures, the validation of performance improvement projects (PIP), and compliance monitoring. Results of the most current Healthcare Effectiveness Data and Information Set (HEDIS®)¹ reporting period and Consumer Assessment of Healthcare Providers and Systems (CAHPS)² survey are presented. IPRO's assessment also included a review of the PIPs that were in progress during the measurement year, the most current Quality Assurance Examination (QAE) and Triennial Compliance Assessment (TCA) findings, and MCO achievements under the Financial Withhold Program.

In 2017, MHCP performance in the area of access to care was strong, while performance in the areas of quality of care and timeliness of care demonstrated opportunities for improvement. MHCP members reported high satisfaction with personal doctors and specialists seen most often, and high dissatisfaction with MCO customer service and getting care.

Collectively, the MCOs continued to demonstrate strong performance in access to preventive and ambulatory care for adults and demonstrated notable performance in access to primary care for adolescents aged 12-19 years. Related HEDIS rates met or exceeded the 75th percentile benchmark. MHCP demonstrated opportunities for improvement in regard to the quality of childhood immunizations and one aspect of diabetes care, the timeliness of child and adolescent well-care visits and women's preventive screenings for cancer and chlamydia, and access to dental care. Related HEDIS rates were below the 50th percentile benchmark. MHCP CAHPS performance indicated that members were highly satisfied with provider communication and personal doctors, including specialists. Satisfaction with getting needed care and customer service were identified as opportunities for improvement.

¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

² CAHPS is a product of the U.S. Agency for Healthcare Research and Quality (AHRQ).

CHAPTER 1: INTRODUCTION

DHS purchases medical care coverage through contracts with eight MCOs that receive a fixed, prospective monthly payment for each enrollee. The Minnesota Department of Health (MDH) licenses five of the entities as health maintenance organizations (HMOs): Blue Plus, HealthPartners, Medica, Hennepin Health, and UCare. These HMOs are non-profit corporations or government entities that provide comprehensive health maintenance services, or arrange for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee. The remaining three entities – Itasca Medical Care (IMCare), PrimeWest Health, and South Country Health Alliance (SCHA) – are licensed as county-based purchasing (CBP) organizations. CBP organizations are health plans operated by a county or group of counties, which purchase health care services for certain residents enrolled in the Medical Assistance and MinnesotaCare programs.³

Minnesota’s publicly funded managed care programs include:

- **Families & Children Medical Assistance (F&C-MA):** A state-administered program for low-income people who are blind or disabled, low-income families with children, and children who are in need.
- **MinnesotaCare (MNCare):** A state-funded program for working families and people who do not have access to affordable health care coverage and meet certain income, asset, and residency requirements.
- **Minnesota Senior Health Options (MSHO):** A DHS program that combines Medicare and Medicaid financing and acute and long-term care service delivery systems for persons over 65 years of age who are dually eligible for both Medicare and Medicaid.
- **Minnesota Senior Care Plus (MSC+):** A federal- and state-funded mandatory program for individuals age 65 years and older who qualify for Medical Assistance (Medicaid).
- **Special Needs Basic Care (SNBC):** A voluntary program for individuals, ages 18 – 64 years, who are certified disabled and qualify for the Medical Assistance (Medicaid) program.

³ [Minnesota Department of Health - Health Plan Information](#)

Table 1: MCO 2017 Participation by Program

MCO	Managed Care Program				
	F&C-MA	MNCare	MSHO	MSC+	SNBC
Blue Plus	•	•	•	•	
HealthPartners	•	•	•	•	•
Hennepin Health	•	•			•
IMCare	•	•	•	•	
Medica			•	•	•
PrimeWest Health	•	•	•	•	•
SCHA	•	•	•	•	•
UCare	•	•	•	•	•

The DHS-MCO contract specifies the relationships between the purchaser and the MCOs and explicitly states compliance requirements for finances, service delivery, and quality of care terms and conditions. DHS and the MCOs meet throughout the year to ensure ongoing communication between the purchaser and the MCOs and to discuss contract issues.

DHS contracts with IPRO to serve as its EQRO. As part of this agreement, IPRO performs an independent analysis of MCO performance relative to quality, access, and timeliness of health care services. This report is the result of IPRO’s 2017 evaluation and review.

The purpose of the 2017 ATR is to present the results of the quality evaluations performed in accordance with the BBA,⁴ review the strengths and weaknesses of each MCO, provide recommendations for improvement, and provide technical assistance to the MCOs. This report provides insight into the performance of the MCOs on key indicators of health care quality for enrollees in publicly funded programs.

Forming the foundation for improving care for the populations served by DHS is the Quality Strategy. CMS requires that each state Medicaid agency has a written strategy for evaluating the quality of care of its publicly funded managed care programs. The DHS quality strategy operationalizes the theories and precepts influencing the purchase of managed health care services for publicly funded programs. The strategy is designed to assess the quality and appropriateness of care and service provided by MCOs for all managed care contracts, programs, and enrollees. It is aimed at achieving seven essential outcomes:

1. Purchasing quality health care services
2. Protecting the health care interests of managed care enrollees through monitoring
3. Assisting in the development of affordable health care

⁴ Subpart E, 42 Code of Federal Regulations (CFR), Section 438.364

4. Reviewing and realigning DHS policy and procedures that act as unintended barriers to the effective and efficient delivery of health care services
5. Focusing on health care prevention and chronic disease improvements consistent with enrollee demographics and cultural needs
6. Improving the health care delivery system's capacity to deliver desired medical care outcomes through process standardization, improvement, and innovation
7. Strengthening the relationship between the patients and health care providers

Purchasing quality health care services is the primary outcome of the DHS quality strategy. To achieve this outcome, there must be measurement of improvement in enrollee health status and satisfaction. DHS's Quality Strategy is framed on the key standards in Subpart D of the Medicaid Managed Care Regulation (*Quality Assessment and Performance Improvement*): Access, Structure and Operations, and Measurement and Improvement.

To facilitate and promote achievement of the quality strategy goals, DHS conducts yearly activities, including three (3) mandatory EQR-related activities for each contracted MCO pursuant to the BBA, Code of Federal Regulation (CFR) 438.358. IPRO, as the EQRO, provides analysis of the results. Mandatory EQR activities for each contracted MCO include the following:

- **Validation of Performance Measures:** DHS contracts with MetaStar, a certified HEDIS vendor, to evaluate the DHS information system's ability to collect, analyze, integrate, and report data. The evaluation includes extensive examinations of DHS's ability to monitor data for accuracy and completeness.
- **Validation of Performance Improvement Projects (PIPs):** DHS validates that each MCO develops its proposed PIPs in a manner designed to achieve significant improvement that is sustainable over time and consistent with Federal protocols.
- **Review MCO Compliance with Federal and State Standards Established by DHS:** DHS uses MDH QAE and TCA audits to determine whether MCOs meet requirements relating to access to care, structure and operations, and quality measurement and improvement.

Minnesota Health Care Programs help people who live in Minnesota pay for all, or some, medical bills. The programs are generally for people who cannot get or afford health insurance elsewhere. Some people who already have insurance may also be eligible for help. To obtain coverage, there are rules about income, assets, insurance coverage, and other factors. Some rules vary for different people; for example, the income limit depends on age, living situation, and pregnancy or disability status.

Within the State of Minnesota, publicly funded medical assistance is available for:

- Pregnant women
- Families and children
- Adults with disabilities
- Children with disabilities
- People 65 years or older

- Adults without children

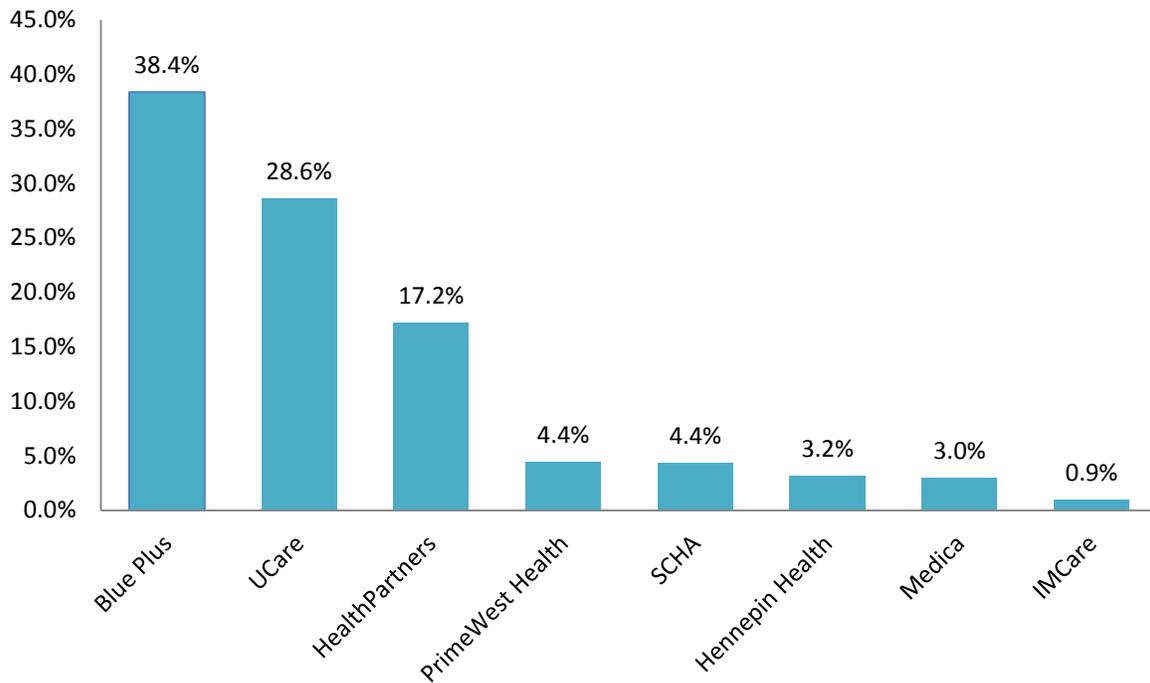
Coverage is also available for the following people who meet certain eligibility criteria:

- People who need nursing home care or home care
- Employed persons with disabilities
- People who want only family planning coverage
- People who have breast or cervical cancer and have been screened by the Sage Program⁵

As of December 2017, total enrollment for MHCP was 958,284; a 6.52% increase since December 2016.⁶

Figure 1 displays December 2017 MHCP enrollment by MCO while **Figure 2** trends MHCP enrollment for December 2015, December 2016 and December 2017.

Figure 1: MHCP Enrollment by MCO – December 2017



⁵ Please visit the Minnesota Department of Health SAGE Screening Program.

[Minnesota Department of Health Breast and Cervical Cancer Screening – Sage Program Website](#)

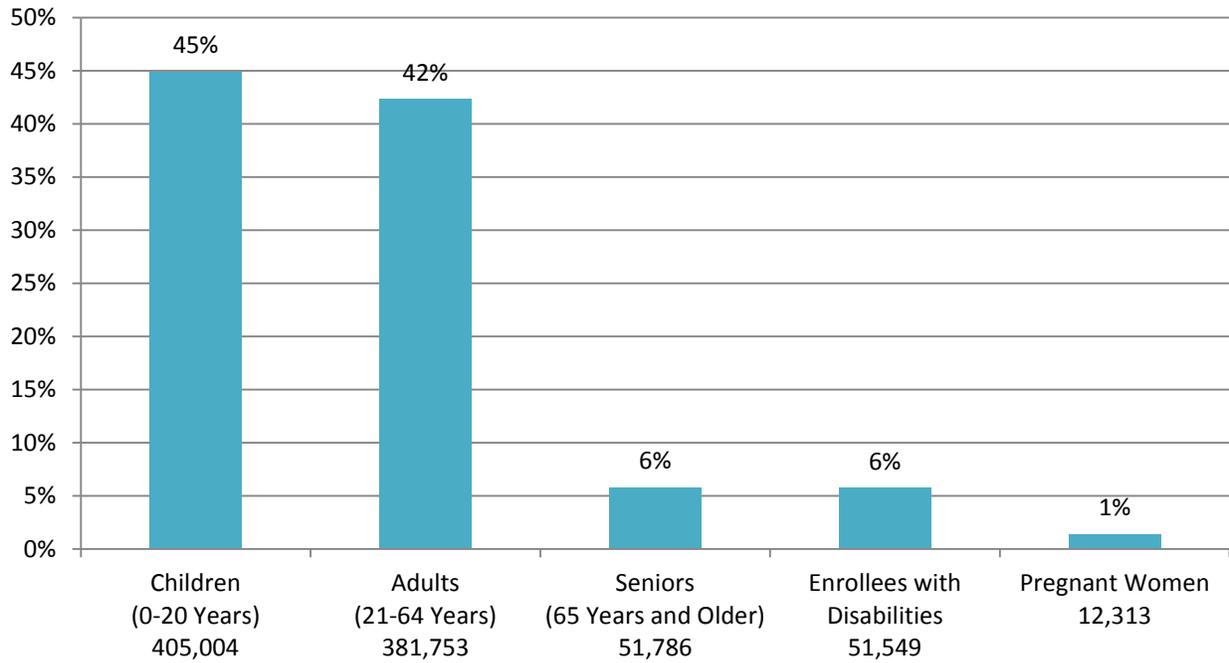
⁶ Enrollment data presented in Chapters 1 and 3 of this report derive from the [DHS MHCP Enrollment Totals December 2017 Report](#).

Figure 2: MHCP Enrollment Trends by MCO – December 2015, December 2016 and December 2017



As displayed in **Figure 3**, children are the largest population served by MHCP, accounting for 45% of the total enrollment. The overall December 2017 population breakdown is similar to that observed in December 2016.

Figure 3: Enrollment by Population Type – December 2017



CHAPTER 2: SUMMARY OF DHS ACTIVITIES

2017 Health Care Disparities Report

In 2018, DHS contributed to the production of the MN Community Measurement[®] *2017 Health Care Disparities Report for Minnesota Health Care Programs*. The report provides health care performance rates for patients who received care under MHCP in 2017.

Two (2) of the ten (10) comparable MHCP statewide measures improved since last year: Controlling High Blood Pressure and Colorectal Cancer Screening. These improvements were statistically significant.

The following eight (8) measures declined since last year: Appropriate Treatment for Children with Upper Respiratory Infection (URI), Breast Cancer Screening, Chlamydia Screening in Women, Depression Remission at Six Months, Optima Asthma Control – Adults, Optimal Asthma Control – Children, Optimal Diabetes Care and Optimal Vascular Care; of these, only Chlamydia Screening in Women did not have a significant decline.

This report also explores the difference in performance rates between patients enrolled in MHCP and patients enrolled in managed care programs of other purchasers (private, employer-based health care insurance, or Medicare managed care programs) at a statewide and medical group level. The report reveals that the largest gaps between MHCP and other purchaser patients occurred for four (4) measures: Childhood Immunization Status – Combo 10, Colorectal Cancer Screening, Breast Cancer Screening and Optimal Vascular Care. Statewide gaps in performance between MHCP and other purchasers have narrowed over time for Chlamydia Screening in Women, Controlling High Blood Pressure, Optimal Asthma Control – Children Ages 5-17 and Adults Ages 18-50, Optimal Diabetes Care and Colorectal Cancer Screening.

Another topic in this report focuses on the differences between racial and ethnic groups within the MHCP population for five (5) HEDIS measures.

- The American Indian or Alaskan Native racial group had rates significantly below the statewide averages for Childhood Immunization Status (Combo 10), Controlling High Blood Pressure and Breast Cancer Screening.
- The Asian group had rates significantly above the MHCP statewide average for these three (3) measures: Appropriate Treatment for Children with URI, Childhood Immunization Status and Chlamydia Screen in Women.
- The Black or African American group had three (3) measures with rates below the statewide average: Childhood Immunization, Controlling High Blood Pressure and Breast Cancer Screening; and two (2) measures that were above the statewide average: Appropriate Testing for Children with URI and Chlamydia Screening in Women.
- The multiracial group had rates above the statewide average for Chlamydia Screening in Women.

- The White group had above average rates for Breast Cancer Screening and had below average rates for these three (3) measures: Appropriate Treatment for Children with URI, Controlling High Blood Pressure and Chlamydia Screening for Women.

A final element of the report is regional analysis for the MHCP population.

- The Northwest region has the lowest rate for these four (4) measures, all of which are significantly below the MHCP statewide rate: Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Care (children ages 5-17), and Optimal Asthma Care (adults ages 18-50). This region does not have the highest screening rate for any measure.
- The Northeast region had the highest rate for two (2) measures: Depression Remission at Six Months and Colorectal Cancer Screening, and these rates were significantly above the MHCP statewide rate. This region did not have the lowest rate for any measure.
- The Metro region had the highest rate for three measures: Optimal Vascular Care, Optimal Asthma Control – Children Ages 5-17, and Optimal Asthma Control – Adults Ages 18-50). The rates for Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control – Children Ages 5-17 and Optimal Asthma Control – Adults Ages 18-50 were significantly above the MHCP statewide rate. This region had the lowest rate for Colorectal Cancer Screening which was significantly below the MHCP statewide rate.
- The Southern region had the lowest rate for one measure, Depression Remission at Six Months, which was significantly below the MHCP statewide rate. The rates for the Optimal Asthma Control – Adults Ages 18-50 and Colorectal Cancer Screening measures were significantly above the MHCP statewide rate. This region had the highest rate for one measure: Optimal Diabetes Care.

The full report, as well as key findings, can be accessed [here](#).

State Targeted Response to the Opioid Crisis⁷

In 2017, Minnesota received a two-year grant from the Substance Abuse and Mental Health Services Administration. The State Targeted Response (STR) to the Opioid Crisis Grant program expands access to evidence-based prevention, treatment, and recovery support services, reduces unmet treatment needs, and helps to prevent opioid overdose deaths. The grant expires on July 1, 2019.

DHS has awarded grants to forty (40) state agencies, tribes and counties from the STR grant. The STR grants focus on:

- Supporting communities most impacted in order to offer elective, culturally relevant services
- Building on existing, proven efforts
- Offering new and innovative approaches

⁷ [Minnesota State Targeted Response to the Opioid Crisis](#)

Overarching themes for grant activities include:

- Naloxone distribution
- Integrated care for high-risk pregnancies
- Community health worker mother's recovery training
- Care Coordination
- Parent child assistance program
- Rule 25 assessments
- Detox
- Office-based opioid treatment
- Improve access to treatment: fast-tracker
- Recently released from incarceration
- Peer recovery
- Extension from community healthcare outcomes (ECHO) hubs
- Prevention
- Innovation grants:
 - Strategies to decrease burden of opioid
 - Strategies to decrease the burden of opioid misuse, abuse and overdose and address public awareness, provider education, and access to treatment
 - Syringe exchange program
 - Business plan that innovatively provides pretreatment, treatment, and post-treatment options
 - Better identify and treat Neonatal Abstinence Syndrome
 - Medication assisted treatment training program

CHAPTER 3: EVALUATION OF MCO STRENGTHS AND OPPORTUNITIES

A. Evaluation Process

In order to assess the impact of MHCP on access, timeliness, and quality of health care services, IPRO reviewed pertinent MCO-specific information from a variety of sources including accreditation survey findings, member satisfaction surveys, performance measures, and state compliance monitoring reports. Specifically, IPRO considered the following elements during the 2017 External Quality Review:

- HEDIS 2018
- 2018 CAHPS 5.0H Adult Medicaid Survey
- Performance Improvement Projects
- Minnesota Department of Health Quality Assurance Examination and Triennial Compliance Assessment
- 2017 Financial Withhold
- MCO Annual Quality Assurance Work Plan for 2017
- MCO Evaluation of the 2017 Quality Assessment and Performance Improvement Program
- MCO Clinical Practice Guidelines

HEDIS Performance

HEDIS allows for the standardized measurement of care received. All of the performance measures reported herein are derived from HEDIS or CAHPS. For these measures, statewide averages and national Medicaid benchmarks have been provided. HEDIS benchmarks originate from the National Committee for Quality Assurance (NCQA) *Quality Compass*⁸ 2018 for Medicaid and represent the performance of all MCOs (excluding PPOs and EPOs) that reported HEDIS data to the NCQA for HEDIS 2018 (Measurement Year (MY) 2017). *Note: The NCQA Quality Compass 2018 did not include benchmarks for the Medication Management for People with Asthma – 50% (5-64 Years) measure.*

Included in this report is a combination of DHS-produced (administrative) and MCO-produced (hybrid) HEDIS rates in the ATR. Administrative rates were calculated using encounter data and were audited by DHS's NCQA-certified HEDIS auditor, MetaStar. Hybrid rates were calculated using a mix of claims data and data abstracted from medical records, and were also validated by NCQA-certified HEDIS auditors. HEDIS rates produced by the MCOs were reported to the NCQA.

To better identify MCO strengths and opportunities in this area, DHS continues to incorporate the measure matrix into the ATR. The measure matrix allows for the comparison of MCO performance year-over-year, as well as the comparison of MCO performance to the statewide average. It is a color-coded tool that visually indicates when an MCO's performance rates are notable or whether there is cause for action. For these year-over-year comparisons, the significance of the difference between two

⁸ Quality Compass[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

As seen below, boxes in the top row indicate that there was a statistically significant positive change in the rate from 2016, boxes in the middle row indicate no change from 2016, while those in the bottom row indicate a statistically significant negative change in the rate. Similarly, boxes in the right column indicate that the rate for the measure is higher than the statewide average, with those in the middle column being the same as the statewide average, and those in the left column indicating a rate that is lower than the statewide average.

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C	B	A	
	D	C	B	
	F	D	C	

The color of each box depends on its location in both the columns and rows and represents the recommended action:

 The green box (or “A” box) indicates notable performance. The MCO’s HEDIS 2018 rate is statistically significantly above the 2018 statewide average and trends up from HEDIS 2017.

 The light green boxes (or “B” boxes) indicate a potential opportunity for improvement, but no immediate action is required. The MCO’s HEDIS 2018 rate is not different than the 2018 statewide average and is statistically above the HEDIS 2017 rate or that the MCO’s HEDIS 2018 rate is statistically significantly above the 2018 statewide average but there is no change from HEDIS 2017.

 The yellow boxes (or “C” boxes) indicate that the MCO should evaluate the measure for opportunities for improvement. The MCO’s HEDIS 2018 rate is statistically significantly below the 2018 statewide average and trends up from HEDIS 2017 or that the MCO’s HEDIS 2018 rate is not different than the 2018 statewide average and there is no change from HEDIS 2017 or that the MCO’s HEDIS 2018 rate is statistically significantly above the 2018 statewide average but trends down from HEDIS 2017.

 The orange boxes (or “D” boxes) indicate poor performance and action based on the results of a root cause analysis. The MCO’s HEDIS 2018 rate is statistically significantly below the 2018 statewide average and there is no change from HEDIS 2017 or that the MCO’s HEDIS 2018 rate is not different than the 2018 statewide average and trends down from HEDIS 2017.

 The red box (or “F” box) indicates poor performance and action based on the results of a root cause analysis. The MCO’s HEDIS 2018 rate is statistically significantly below the 2018 statewide average and trends down from HEDIS 2017.

HEDIS measures selected for inclusion in the measure matrix cover four (4) overarching areas of care: oral care, chronic conditions, women’s health, and child and adolescent care. Measures selected for these categories include:

- Oral Care
 - HEDIS *Annual Dental Visit*
- Chronic Conditions
 - HEDIS *Comprehensive Diabetes Care: HbA1c Test*
 - HEDIS *Comprehensive Diabetes Care: Eye Exam*
 - HEDIS *Controlling High Blood Pressure*
 - HEDIS *Medication Management for People with Asthma*
- Women’s Health
 - HEDIS *Breast Cancer Screening*
 - HEDIS *Cervical Cancer Screening*
 - HEDIS *Chlamydia Screening in Women*

- Child and Adolescent Care
 - HEDIS *Adolescent Well-Care Visits*
 - HEDIS *Childhood Immunization Status: Combo 3*
 - HEDIS *Well-Child Visits in the First 15 Months of Life (6+ Visits)*
 - HEDIS *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*

CAHPS Performance

CAHPS allows for the standardized measurement of member satisfaction with care received. All of the performance measures reported herein are derived from HEDIS or CAHPS. For these measures, statewide averages and national Medicaid benchmarks have been provided. CAHPS benchmarks originate from the Agency for Healthcare Research and Quality’s (AHRQ) CAHPS Database and represent the performance of all health plans that reported CAHPS data to the AHRQ for the 2018 Adult Medicaid Survey 5.0 (MY 2017). *Note: The CAHPS Database did not include benchmarks for the Shared Decision Making composite measure.*

In 2017, DHS contracted with DataStat to conduct the 2018 CAHPS 5.0H Adult Medicaid Survey on behalf of the participating MCOs who offer F&C-MA, MNCare, MSC+ and SNBC. In the CAHPS tables that follow, scores for the following composite measures were calculated using responses of “yes” or “always”: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making*; while scores for the following rating measures were calculated using responses of “9” or “10”: *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Rating of Health Plan*. MCO scores that were determined to be significantly higher than the statewide averages are indicated by ▲, while MCO scores that were significantly lower than the statewide averages are indicated by ▼. DataStat utilized difference-of-means tests to determine statistical significance. Scores that were significantly higher than the statewide averages were considered strengths, and scores that were significantly lower than the statewide averages were considered opportunities for improvement.

Performance Improvement Projects

MCOs are contractually required to conduct PIPs and to report annually on their progress. These PIPs use targeted interventions and ongoing measurements to significantly improve care quality. Ideally, these improvements in care are sustained over time. 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 measurement process includes a baseline, generally a three-year average of the measurement selected, and explicit and precisely defined goals. PIPs are considered completed when the goal has been reached and two more consecutive measurements sustain the improvement. PIPs reported in this ATR were validated by the DHS Quality Improvement Team to ensure MCO compliance with Federal protocols. DHS’s assessments of the PIPs were considered during IPRO’s evaluation of the MCO.

Starting with the 2015-2017 PIPs, the DHS PIP reporting requirements were modified to resemble the Medicare format. PIPs run for three (3) years and follow BBA guidelines for PIP protocols. MCO progress is monitored through the annual submission of interim reports. As DHS has identified disparities in care for enrollees with mental health conditions, DHS selected the following overarching PIP topic for 2015-2017 period, *Reduction of Race and Ethnic Disparities in the Management of Depression*.

During this cycle, Blue Plus, Hennepin Health, HealthPartners, Medica and UCare collaborated on the conduct of their PIPs, while IMCare, PrimeWest and SCHA conducted separate PIPs. Descriptions of MCO-specific topics, goals, and baseline and final measurement rates are reported in Section B: MCO Evaluations. Please note that reported PIP status is as of December 31, 2017.

Quality Assurance Examination and Triennial Compliance Assessment

Federal regulations require DHS to conduct triennial, on-site contract compliance validation assessments of each contracted MCO. DHS uses MDH Quality Assurance examinations (MDH-QA) and Triennial Compliance Assessment (TCA) audits to determine whether MCOs meet requirements relating to access to care, structure and operations, and quality measurement and improvement.

While the Quality Assurance examinations and Triennial Compliance Assessments are conducted every three (3) years, the process is staggered and is conducted at different times for each MCO. A summary of recommendations, mandatory improvements and deficiencies from the *most recent* exam is presented for each MCO and was considered during IPRO's evaluation of the MCO. Recommendations are areas where, although compliant with law, opportunities for improvement were identified. The MCO submits a Corrective Action Plan (CAP) to correct 'not-met' determinations, if necessary. If the MCO fails to submit a CAP within 30 days, and/or address contractual obligation compliance failures, then financial penalties will be assessed. Deficiencies are violations of law.

2017 Financial Withhold

The overall purpose of the financial withhold is to emphasize and focus MCO and health care provider improvement efforts in the areas of prevention or early detection and screening of essential health care services. Specifically, the DHS-MCO contract allows DHS to withhold a percentage of the capitation payments due to the MCO, only to be returned if the MCO meets performance targets determined by the state. MCO performance in the 2017 financial withhold is displayed in the following subsection of this report and was considered during IPRO's evaluation.

MCO Annual Quality Assurance Work Plan for 2017

Each MCO submits an annual written work plan that details proposed quality assurance and performance improvement projects for the year. At a minimum, the work plan must present a detailed description of the proposed quality evaluation activities, including proposed focused studies, and their respective timetables for completion. Summaries of all MCO Annual Quality Assurance Work Plans follow; however, these reports were not evaluated as part of the EQR process.

MCO Evaluation of the 2017 Quality Assessment and Performance Improvement Program

Each MCO conducts an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations, and current NCQA *Health Plan Accreditation* standards and requirements. The evaluation reviews the impact and effectiveness of the MCO's quality assessment and performance improvement program, including performance on standard measures and performance improvement projects. Summaries of all MCO annual quality assessment and performance improvement program evaluation reports follow; however, these reports were not evaluated as part of the EQR process.

MCO Clinical Practice Guidelines

MCOs are required to adopt, disseminate, and apply practice guidelines consistent with current NCQA *Health Plan Accreditation Requirements – Practice Guidelines (QI 9)*. Adopted guidelines should be:

- Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Reflective of the needs of the MCO's enrollees
- Adopted in consultation with contracting health care professionals
- Reviewed and updated periodically as appropriate
- Disseminated to all affected providers and, upon request, to enrollees and potential enrollees
- Applied to decisions for utilization management, enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines

Summaries of all MCO clinical practice guidelines follow; however, this information was not evaluated as part of the EQR process.

MCO Quality Improvement Program Websites

Each MCO submits annual quality program updates to demonstrate how their quality improvement programs identify, monitor and work to improve service and clinical quality issues related to MHCP enrollees. These updates are publicly presented on each MCO's corresponding website and highlight what the MCO considers to be significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement. Additionally, the MCOs' most recent quality assurance work plan and evaluation of the quality assessment and performance improvement program can be accessed on these websites. While the websites are evaluated by DHS for content and accessibility, the results of the evaluations were not considered as part of the EQR process. (*MCO quality improvement program website URLs can be accessed [here](#).*)

B. MCO Evaluations

This section presents MCO-specific performance, as well as strengths, opportunities for improvement, and recommendations identified by IPRO during the external quality review process.

In regard to the HEDIS performance measures, please note the following:

- As the MCOs were not required to report HEDIS for the MSC+ program, there are no hybrid performance measures presented for the MSC+ program in this section of the report. However, a total of three (3) DHS administrative measures are presented.
- For the F&C-MA program, a total of six (6) MCO-produced rates are presented, while fourteen (14) DHS-produced rates are presented.
- For the MNCare program, a total of five (5) MCO-produced rates are presented, while twelve (12) DHS-produced rates are presented.
- For the MSHO program, a total of two (2) MCO-produced rates are presented, while two (2) DHS-produced rates are presented.
- For the SNBC program, a total of four (4) MCO-produced rates are presented, while seven (7) DHS-produced rates are presented. *(Counts will vary if the MCO produced SNP and Non-SNP rates.)*

SPACE INTENTIONALLY LEFT BLANK

BLUE PLUS

Corporate Profile

Blue Plus, a wholly owned subsidiary of Blue Cross and Blue Shield of Minnesota, is a licensed HMO. Blue Plus contracts with DHS to deliver and administer F&C-MA, MNCare, MSC+ and MSHO. Blue Plus has provided managed care coverage for MHCP since 1993. In November of 2017, Blue Plus was awarded the Commendable level of accreditation by NCQA under the Health Plan Accreditation status for its Medicaid lines of business for the 2017-2018 NCQA rating period. As of December 2017, enrollment totaled 367,956, accounting for 38% of the entire MHCP population. **Table 2** displays Blue Plus's enrollment as of December 2017.

Table 2: Blue Plus Enrollment as of December 2017

Program	Enrollment (as of December 2017)
F&C-MA	323,636
MNCare	32,347
MSC+	3,744
MSHO	8,229
Total Enrollment	367,956

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE on November 16, 2015 through November 20, 2015. The examination period covered April 1, 2013 to September 30, 2015, while the file review period covered September 1, 2014 to August 31, 2015. The MCO received a total of three (3) recommendations, two (2) mandatory improvements, and two (2) deficiencies for the QAE. The MCO submitted a corrective action plan (CAP) addressing these deficiencies and mandatory improvements. During this period, the TCA was also completed. The MCO achieved full compliance on the TCA.

The 2017 mid-cycle review determined that the MCO was compliant in executing its CAP for the QAE.

Performance Improvement Project

The following PIP was in progress:

- **Reducing Race and Ethnic Disparities in the Management of Depression (2015-2017)** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP was to reduce, by 4 percentage points, the disparity between non-Hispanic White and non-White F&C-MA and MNCare members as indicated by the HEDIS *Antidepressant Medication Management – Continuation Phase* measure. **Table 3** displays the MCO's performance rates for this PIP.

Table 3: Blue Plus Rates for the 2015-2017 PIP

HEDIS Year	Non Hispanic White	Non White	Disparity
2014	39.99%	31.93%	-8.06%
2015	41.59%	28.46%	-13.13%
2016	39.61%	27.77%	-11.84%
2017	43.12%	27.01%	-16.11%
Net Change	+3.13	-4.92	+8.05

Member-focused interventions included:

- Member outreach via mail to members from racial and ethnic minority groups who recently filled new prescriptions for antidepressant medication. This mailing included a letter and a “tip sheet” on depression and antidepressants. Targeted members were identified bi-weekly via pharmacy claims data.
- Telephonic outreach targeted African American and Hispanic/Latino members who were identified for the mailing intervention.

Provider-focused interventions included:

- In collaboration with the other MCOs listed above, development of provider training opportunities on cultural competency, depression, and its treatment. The MCOs conducted trainings in partnership with other organizations, such as the National Alliance on Mental Illness Minnesota (NAMI-MN), and promoted them to various health care providers.
- An electronic provider toolkit was developed in Year 1 of the PIP, which focused on the following topics: best practices in depression care, integration of behavioral health into the primary care setting, cultural awareness and treating depression, shared decision making for depression treatment, mental health resources for providers, patients and caregivers, health plan resources, and resources for seniors.

Community-focused interventions included:

- Community events to increase awareness and reduce stigma associated with mental health conditions.
- Working with organizations, such as NAMI-MN, religious groups, targeted clinics, and other community organizations, to identify channels for promoting awareness.
- Sharing depression resources at local health fairs.
- Promoting culturally specific community events related to depression and mental health.

MCO-focused interventions included:

- In collaboration with other MCOs, development of common messaging for member and provider resources to ensure members and providers received the same information with the same terminology.

2017 Financial Withhold

Blue Plus achieved 37.65 points (of 105 points) for the F&C-MA and MNCare programs, and achieved 75.74 points (of 90 points) for the MSHO and MSC+ programs. **Table 4** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by Blue Plus.

Table 4: Blue Plus 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare	-	-
Annual Dental Visit: Age 2-64 Years	15	0
Well-Child Visits in the First 15 Months of Life	15	0
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	4.74
Hospital Admission Rate	15	2.91
Hospital 30-Day Readmission Rate	15	0
Total	105	37.65
MSHO and MSC+	-	-
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0.74
Total	90	75.74

Annual Quality Assurance Work Plan for 2017

Blue Plus submitted an annual quality assurance work plan, compliant with Minnesota Administrative Rule 4685.1130, which outlines performance improvement projects and focused studies conducted by the MCO throughout the year. The MCO conducted improvement activities across multiple facets of care and services, and work plans were presented consistently across projects. Blue Plus established quarterly milestones for each project, while tracking overall improvement on a yearly basis. Each project provides a list of personnel responsible for the project, a description of the activities, the measure(s) used to evaluate the project, planned milestones, benefits of the project for Blue Plus members, the members each project touches, updates of measurements, and an evaluation of the project. The quality assurance work plan is clear and consistent across projects.

Evaluation of the 2017 Annual Quality Assessment and Performance Improvement Program

The goal of Blue Plus' quality improvement (QI) program is to emphasize health improvement and the clinical process of care in order to achieve high quality of care for members. The QI program is designed to monitor aspects of clinical care and services, as well as organizational services, provided to members. The program identifies opportunities for enhancing existing programs and developing new programs. The scope of the QI program for 2017 included activities in the following areas: provider quality, population health improvement, health promotion/wellness, patient safety, behavioral health, quality of

services, oversight of NCQA delegated relationships, and quality infrastructure. Blue Plus is dedicated to the principles of continuous quality improvement.

Blue Plus' health economics team experienced some reporting delays due to limited resources during 2017. Additionally, Blue Plus leveraged internal resources to meet the NCQA requirements for appointment access and accuracy of the provider directory, rather than a survey vendor, which impacted response rates due to an inability to deploy survey follow-up protocols. Blue Plus collaborates with a variety of partners in order to deliver high quality care for its members. The QI program appears to be effective in terms of improving quality of care and services for its members.

MCO Clinical Practice Guidelines

Blue Plus recognizes the following sources for clinical practice guidelines:

- U.S. Preventive Services Task Force (USPSTF)
 - Preventive services for adults
 - Preventive services for children and adolescents
 - Routine prenatal care
- Health Resources and Services Administration (HRSA)
- Institute for Clinical Systems Improvement (ICSI)
 - Treatment of individuals with major depressive disorder
- American Psychiatric Association (APA)
 - Treatment of individuals with major depressive disorder
- American Academy of Pediatrics (AAP)
 - Diagnosis, evaluation, and treatment of ADHD in children and adolescents
- American Diabetes Association (ADA)
 - Prevention and management of diabetes
- National Heart, Lung and Blood Institute (NHLBI)
 - Diagnosis and management of asthma
- American Heart Association (AHA)
 - Management of heart failure
- National Osteoporosis Foundation (NOF)
 - Prevention and treatment of osteoporosis
- Advisory Committee on Immunization Practices (ACIP) for the Centers for Disease Control and Prevention (CDC)
- Eighth Joint National Committee (JNC 8)
 - Management of High Blood Pressure

HEDIS and CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 5** and **Table 6**, respectively. The results of the MCO's Measure Matrix analysis are presented in **Figure 4**.

Table 5: Blue Plus HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	Blue Plus HEDIS 2016	Blue Plus HEDIS 2017	Blue Plus HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	39.4%	36.8%	41.6%	10 th	42.4%
Adult BMI Assessment ¹	90.7%	90.3%	92.5%	75 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	86.0%	87.1%	84.1%	75 th	83.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	88.7%	88.9%	87.7%	50 th	87.2%
Annual Dental Visit ²	Unavailable	Unavailable	46.5%	10 th	47.1%
Breast Cancer Screening (50-64 Years) ²	58.9%	62.2%	60.7%	50 th	63.1%
Cervical Cancer Screening (24-64 Years) ²	58.0%	60.2%	58.3%	33.33 rd	58.9%
Childhood Immunization Status: Combo 3 (2 Years) ¹	74.7%	75.5%	71.8%	50 th	73.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	97.5%	97.3%	96.8%	66.67 th	96.6%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	90.4%	90.4%	90.4%	66.67 th	90.2%
Children and Adolescents' Access to PCPs (7-11 Years) ²	92.8%	92.4%	92.5%	66.67 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	93.3%	93.2%	93.1%	75 th	93.1%
Chlamydia Screening in Women (16-24 Years) ²	50.2%	53.5%	51.0%	25 th	52.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	71.5%	65.6%	67.6%	75 th	65.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	93.8%	96.0%	91.2%	75 th	90.9%
Controlling High Blood Pressure ¹	68.6%	66.9%	66.9%	75 th	67.0%
Medication Management for People With Asthma – 50% (5-64 Years) ²	55.0%	63.5%	64.6%	No Benchmark	63.9%
Medication Management for People With Asthma – 75% (5-64 Years) ²	33.2%	40.2%	40.4%	66.67 th	41.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	63.5%	67.7%	61.4%	10 th	63.8%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	62.4%	63.8%	63.7%	33.33 rd	63.6%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 5: Blue Plus HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	Blue Plus HEDIS 2016	Blue Plus HEDIS 2017	Blue Plus HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MNCare	-	-	-	-	-
Adolescent Well-Care Visit (12-21 Years) ¹	26.9%	23.4%	23.1%	<10 th	28.9%
Adult BMI Assessment ¹	90.0%	90.5%	94.2%	75 th	91.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	80.2%	83.4%	82.2%	66.67 th	82.1%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	87.0%	89.3%	88.5%	66.67 th	88.0%
Annual Dental Visit ²	Unavailable	Unavailable	38.8%	10 th	39.2%
Breast Cancer Screening (50-64 Years) ²	66.9%	68.7%	69.8%	90 th	70.2%
Cervical Cancer Screening (24-64 Years) ²	50.3%	53.7%	55.3%	25 th	56.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	93.5%	10 th	96.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	98.2%	92.6%	90.9%	75 th	90.2%
Children and Adolescents' Access to PCPs (12-19 Years) ²	97.1%	90.2%	90.4%	50 th	89.6%
Chlamydia Screening in Women (16-24 Years) ²	51.6%	52.3%	49.3%	10 th	51.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	69.5%	62.8%	74.2%	95 th	70.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	94.5%	95.9%	94.4%	95 th	94.6%
Controlling High Blood Pressure ¹	69.3%	74.2%	73.0%	90 th	72.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	70.3%	82.3%	63.9%	No Benchmark	71.7%
Medication Management for People With Asthma – 75% (5-64 Years) ²	41.8%	53.2%	41.2%	66.67 th	49.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	58.1%	66.7%	63.5%	10 th	59.7%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 5: Blue Plus HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	Blue Plus HEDIS 2016	Blue Plus HEDIS 2017	Blue Plus HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.8%	98.2%	98.4%	95 th	98.3%
Breast Cancer Screening (65-74 Years) ²	67.4%	67.5%	64.0%	66.67 th	61.1%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	80.1%	81.0%	77.9%	95 th	79.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	96.5%	94.9%	95.1%	95 th	95.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.6%	93.1%	90.2%	66.67 th	93.3%
Breast Cancer Screening (65-74 Years) ²	55.3%	56.0%	55.3%	33.33 rd	41.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	87.8%	89.3%	86.2%	33.33 rd	76.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 4: Blue Plus 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> Comprehensive Diabetes Care – Eye Exam (MNCare) 	A
	D <ul style="list-style-type: none"> Adolescent Well-Care Visit (MNCare) 	C <ul style="list-style-type: none"> Annual Dental Visit (MNCare) Adolescent Well-Care Visit (F&C-MA) Breast Cancer Screening (F&C-MA, MNCare, MSHO) Controlling High Blood Pressure (F&C-MA, MNCare) Cervical Cancer Screening (MNCare) Comprehensive Diabetes Care – Eye Exam (F&C-MA, MSHO) Comprehensive Diabetes Care – HbA1c Testing (MNCare, MSHO) Chlamydia Screening in Women (MNCare) Childhood Immunization Status – Combo 3 (F&C-MA) Medication Management for People with Asthma-50% (F&C-MA, MNCare) Medication Management for People with Asthma-75% (F&C-MA, MNCare) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA, MNCare) 	B <ul style="list-style-type: none"> Breast Cancer Screening (MSC+) Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	
	F <ul style="list-style-type: none"> Annual Dental Visit (F&C-MA) Chlamydia Screening in Women (F&C-MA) Well-Child Visits in the First 15 Months of Life (F&C-MA) 	D <ul style="list-style-type: none"> Cervical Cancer Screening (F&C-MA) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA) 	C	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 6: Blue Plus CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	Blue Plus CAHPS 2016	Blue Plus CAHPS 2017	Blue Plus CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Getting Needed Care*	53%	50%	56%	50 th	54%
Getting Care Quickly*	62%	58%	59%	25 th	58%
How Well Doctors Communicate*	78%	85%	83%	90 th	81%
Customer Service*	74%	62%	64%	25 th	67%
Shared Decision Making*	86% [▲]	82%	85%	Benchmark Unavailable	82%
Rating of All Health Care**	60% [▲]	56%	63% [▲]	90 th	54%
Rating of Personal Doctor**	72%	72%	73%	90 th	71%
Rating of Specialist Seen Most Often**	67%	75% [▲]	71%	75 th	70%
Rating of Health Plan**	62% [▲]	58%	66% [▲]	90 th	60%
MNCare					
Getting Needed Care*	53%	57%	51%	10 th	54%
Getting Care Quickly*	53%	61%	60%	50 th	61%
How Well Doctors Communicate*	78%	75%	81%	90 th	81%
Customer Service*	59%	56%	64%	25 th	67%
Shared Decision Making*	82%	85%	82%	Benchmark Unavailable	84%
Rating of All Health Care**	54%	51%	50%	25 th	54%
Rating of Personal Doctor**	69%	68%	66%	50 th	70%
Rating of Specialist Seen Most Often**	72%	71%	69%	75 th	68%
Rating of Health Plan**	50%	46% [▼]	55%	25 th	55%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Table 6: Blue Plus CAHPS Performance – 2016, 2017 and 2018 (Continued)

CAHPS Measures	Blue Plus CAHPS 2016	Blue Plus CAHPS 2017	Blue Plus CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
MSC+					
Getting Needed Care*	59%	60%	56%	50 th	56%
Getting Care Quickly*	66%	65%	66%	90 th	62%
How Well Doctors Communicate*	78%	77%	76%	50 th	77%
Customer Service*	63%	65%	71%	75 th	66%
Shared Decision Making*	76%	80%	74%	Benchmark Unavailable	77%
Rating of All Health Care**	63%	65%	65%	90 th	60%
Rating of Personal Doctor**	79%	77%	80%	90 th	75%
Rating of Specialist Seen Most Often**	72%	78%	77%	90 th	71%
Rating of Health Plan**	69%	72% [▲]	68%	90 th	66%

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Strengths

- **NCQA Accreditation Survey** – Blue Plus maintained its NCQA commendable accreditation level for the F&C-MA, MNCare and MSHO programs.
- **CAHPS (Member Satisfaction)** – Blue Plus performed well in regard to the following areas of member satisfaction:
 - F&C-MA
 - *Rating of All Health Care*
 - *Rating of Health Plan*
- **TCA** – Blue Plus was fully compliant with contractual standards reviewed for the TCA.

Opportunities for Improvement

- **Financial Withhold** – Blue Plus did not achieve full points for the F&C-MA, MNCare, MSHO and MSC+ programs. This was also noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age 2-64 Years
 - Well-Child Visits in the First 15 Months of Life
 - Emergency Department Utilization Rate
 - Hospital Admission Rate
 - Hospital 30-Day Readmission Rate
 - MSHO and MSC+
 - Annual Dental Visit: Age 65+ Years
- **HEDIS (Quality of Care)** – Blue Plus demonstrates an opportunity for improvement in the following areas of care:
 - F&C-MA
 - *Annual Dental Visit*
 - *Chlamydia Screening in Women*
 - *Well-Child Visits in the First 15 Months of Life*
 - *Cervical Cancer Screening*
 - *Comprehensive Diabetes Care – HbA1c Testing*
 - MNCare
 - *Adolescent Well-Child Visit*

Recommendations

- **Financial Withhold** –
 - In regard to ED utilization, hospital admissions and readmissions, Blue Plus should continue with the improvement strategy described in the MCO’s response to the previous year’s recommendation. Blue Plus should leverage the successes of its health connectors, value-based programs (VBPs) and health coaches to encourage members to utilize the health care system appropriately.

- Blue Plus indicates that there are significant barriers to improving access to dental services across the state. As such, Blue Plus should consider utilizing a mobile dental service in remote areas of the state, as well as consider organizing a series of local dental fairs in which members can receive dental care. The MCO should also encourage primary care providers to remind members to receive dental care.
- **HEDIS (Quality of Care) –**
 - In regard to child and adolescent well-care visits, Blue Plus should evaluate the effectiveness of its current improvement strategy. Blue Plus should consider identifying barriers to care within identified sub-populations and developing targeted interventions that address the specific needs of those sub-populations.
 - As Blue Plus has demonstrated improvement in regard to diabetic eye exams, the MCO should consider adding HbA1c testing to the initiatives described in its response to the previous year’s recommendation.
 - In regard to women’s health, Blue Plus should consider using the reach of the Minnesota Chlamydia Partnership to educate members on the importance of other preventive screenings. Blue Plus should continue with its plan to expanding its Clinical Consultants’ outreach and education to non-VBP network providers.

HEALTHPARTNERS

Corporate Profile

HealthPartners became a managed care entity in 1992. HealthPartners provides services to enrollees in the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. As of December 2017, enrollment totaled 164,535, accounting for 17% of the entire MHCP population. **Table 7** displays HealthPartners' enrollment as of December 2017.

Table 7: HealthPartners Enrollment as of December 2017

Program	Enrollment (as of December 2017)
F&C-MA	131,974
MNCare	22,759
MSC+	2,161
MSHO	3,041
SNBC	4,600
Total Enrollment	164,535

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit between May 11, 2015 and May 15, 2015. The evaluation period covered April 1, 2012 to March 31, 2015, while the file review period covered April 1, 2014 to March 31, 2015. While it was determined that the MCO was fully compliant with contractual standards reviewed for the TCA, the MCO received six (6) recommendations, one (1) mandatory improvement, and one (1) deficiency for the QAE.

The 2016 mid-cycle review determined that the MCO was compliant in executing its CAP for the QAE.

Performance Improvement Project

The following PIP is was in progress:

- ***Reducing Race Disparities in the Management of Depression (2015-2017)*** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP was to reduce, by 20 percentage points, the disparity between White and non-White F&C-MA and MNCare members as indicated by the HEDIS *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure. **Table 8** displays the MCO's rates for this PIP.

Table 8: HealthPartners Performance Rates for the 2015-2017 PIP

HEDIS Year	White	Non White	Disparity
2015	43.36%	24.65%	-18.71%
2016	44.82%	24.19%	-20.63%
2017	43.46%	24.49%	-18.97%
Change	0.10	-0.16	+0.26

Member-focused interventions included:

- Upon notification that a member has filled a new prescription for an antidepressant, the Behavioral Health team completed an outreach call, which included member education about the medication and information about the MCO's Medication Therapy Management (MTM) program. Interpreters were available for these calls.
- Members received a refill reminder letter when medication refills were due. If the medication was not filled, the members received a more specific letter, as well as a phone call. The provider also received a letter. HealthPartners assessed the need to translate these letters into different languages.

Provider-focused interventions included:

- In collaboration with the other MCOs listed above, development of provider training opportunities on cultural competency, depression, and its treatment. These trainings were available to a variety of health care providers and disciplines. HealthPartners Behavioral Health staff participated in cultural awareness activities and education to enhance their skills with outreach to different populations.
- MCO collaboration development of an electronic provider toolkit with resources for providers working with culturally diverse patients. The toolkit included a shared decision making tool aimed at patient education.
- Behavioral Health staff participated in the HealthPartners Medical Group to discuss and create process changes to impact depression management in primary care.

Community-focused interventions included:

- A community event to create awareness during Minority Mental Health Month in July.
- Identifying communication channels to promote awareness of depression in minority communities.
- Sharing depression resources at local health fairs.
- Presenting cultural issues on mental health to health care organizations, church groups, community groups, etc.
- Promoting events and issues related to depression and mental health to our members.
- Joint development of posters or other educational materials for the community.

MCO-focused interventions included:

- In collaboration with the MCOs listed above, development of common messaging for member and provider resources to ensure members and providers received the same information with the same terminology.

2017 Financial Withhold

HealthPartners achieved 65.86 points (of 105 points) for the F&C-MA and MNCare programs, achieved 75 points (of 90 points) for the MSHO and MSC+ programs and achieved 45 points (of 45 points) for the SNBC program. **Table 9** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by HealthPartners.

Table 9: HealthPartners 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare	-	-
Annual Dental Visit: Age 2-64 Years	15	0
Well-Child Visits in the First 15 Months of Life	15	15
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	0
Hospital 30-Day Readmission Rate	15	5.86
Total	105	65.86
MSHO and MSC+	-	-
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0
Total	90	75
SNBC	-	-
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	Not Applicable	Not Applicable
Total	45	45

Notes: In regard to SNBC Annual Dental Visit performance measure, the baseline rate is not applicable, because the SNBC adult enrollment started at the beginning of calendar year 2016. This measure was eliminated from the total point calculation.

Annual Quality Assurance Work Plan for 2017

HealthPartners' annual QA work plan was compliant with Minnesota Administrative Rule 4685.1130. The MCO's work plan clearly defines activities for a wide variety of topics, and categorizes each activity under a general focus area. For each activity, the work plan defines the key priority areas and action plans, goals and measures of success, responsible staff, planned due dates, and outcomes. The MCO continued to track results for each activity on a quarterly basis throughout the year. Additionally, the MCO lists the specific populations and product lines each activity targets.

Evaluation of the 2017 Annual Quality Assessment and Performance Improvement Program

HealthPartners' QI Program is designed to achieve improvements in health and well-being through partnerships with members, patients, and the community. The Program is built on the Triple Aim values of health, experience, and affordability. The MCO integrates Quality Improvement and Utilization Management functions in order to ensure quality and experience are considered. MCO medical and executive leadership are actively involved in the Program. The Board of Directors has final authority and ultimate responsibility for the quality of care and services, and oversees the QI Program. The Board's Quality Committee provides oversight through review of QI progress reports from various committees. The MCO also evaluates the adequacy of its resources at least annually in order to ensure the MCO has enough resources for the Program and that resources are sufficiently utilized.

During 2017, the MCO had active improvement initiative on a variety of topics to address quality of care, member satisfaction and experience, and cost-savings. The MCO made several improvements as demonstrated by improvements in performance measures, increased rates for indicators of member satisfaction, and evidence of decreases in cost for members, providers, and the MCO. The MCO also outlined barriers faced during implementation of elements of the QI Program in order to inform areas of focus for the QI Program for the next year.

MCO Clinical Practice Guidelines

HealthPartners recognizes the following source for clinical practice guidelines:

- ISCI
 - Common preventive services
 - Chronic diseases
 - Acute conditions

HEDIS AND CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 10** and **Table 11**, respectively, while **Figure 5** displays the HEDIS Measure Matrix.

Table 10: HealthPartners HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	Health Partners HEDIS 2016	Health Partners HEDIS 2017	Health Partners HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	42.6%	46.2%	43.1%	10 th	42.4%
Adult BMI Assessment ¹	93.4%	94.9%	95.6%	90 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	83.5%	85.2%	84.0%	75 th	83.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	86.8%	88.8%	87.8%	50 th	87.2%
Annual Dental Visit ²	Unavailable	Unavailable	48.4%	25 th	47.1%
Breast Cancer Screening (50-64 Years) ²	63.6%	65.6%	64.9%	75 th	63.1%
Cervical Cancer Screening (24-64 Years) ²	61.2%	63.2%	62.8%	50 th	58.9%
Childhood Immunization Status: Combo 3 (2 Years) ¹	76.9%	75.4%	78.1%	75 th	73.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	97.5%	97.7%	96.7%	66.67 th	96.6%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	90.4%	90.8%	91.8%	75 th	90.2%
Children and Adolescents' Access to PCPs (7-11 Years) ²	92.8%	92.0%	92.8%	66.67 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	93.3%	92.3%	93.5%	75 th	93.1%
Chlamydia Screening in Women (16-24 Years) ²	62.7%	68.9%	68.1%	75 th	52.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	62.8%	65.0%	68.8%	90 th	65.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	92.7%	94.5%	93.1%	90 th	90.9%
Controlling High Blood Pressure ¹	73.5%	72.3%	67.2%	75 th	67.0%
Medication Management for People With Asthma – 50% (5-64 Years) ²	52.5%	54.4%	56.0%	No Benchmark	63.9%
Medication Management for People With Asthma – 75% (5-64 Years) ²	28.6%	31.5%	35.6%	33.33 rd	41.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	64.3%	65.8%	72.4%	75 th	63.8%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	66.7%	66.6%	68.0%	25 th	63.6%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 10: HealthPartners HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	Health Partners HEDIS 2016	Health Partners HEDIS 2017	Health Partners HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	26.3%	30.7%	24.3%	<10 th	28.9%
Adult BMI Assessment ¹	92.7%	93.7%	94.2%	75 th	91.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	80.5%	80.9%	81.6%	66.67 th	82.1%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	87.0%	87.2%	86.8%	50 th	88.0%
Annual Dental Visit ²	Unavailable	Unavailable	39.0%	10 th	39.2%
Breast Cancer Screening (50-64 Years) ²	71.0%	70.6%	71.3%	90 th	70.2%
Cervical Cancer Screening (24-64 Years) ²	56.2%	53.5%	57.1%	33.33 rd	56.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	96.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	86.7%	97.5%	90.5%	75 th	90.2%
Children and Adolescents' Access to PCPs (12-19 Years) ²	88.9%	Small Sample	90.1%	50 th	89.6%
Chlamydia Screening in Women (16-24 Years) ²	61.4%	63.3%	60.1%	50 th	51.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	71.6%	67.0%	69.0%	90 th	70.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	97.5%	96.7%	95.3%	95 th	94.6%
Controlling High Blood Pressure ¹	77.9%	73.5%	75.9%	95 th	72.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	57.1%	70.0%	68.5%	No Benchmark	71.7%
Medication Management for People With Asthma – 75% (5-64 Years) ²	34.5%	40.0%	41.1%	66.67 th	49.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	71.1%	69.4%	51.5%	<10 th	59.7%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 10: HealthPartners HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	Health Partners HEDIS 2016	Health Partners HEDIS 2017	Health Partners HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MSHO	-	-	-	-	-
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.1%	98.3%	98.1%	95 th	98.3%
Breast Cancer Screening (65-74 Years) ²	70.8%	62.4%	61.2%	50 th	61.1%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	79.6%	79.2%	80.5%	95 th	79.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	97.1%	95.5%	95.4%	95 th	95.2%
MSC+	-	-	-	-	-
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	92.8%	90.9%	91.0%	66.67 th	93.3%
Breast Cancer Screening (65-74 Years) ²	41.8%	36.6%	34.4%	<10 th	41.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	64.7%	67.5%	57.5%	<10 th	76.9%
SNBC	-	-	-	-	-
Adult BMI Assessment ¹ (Non-SNP)	No Data	Small Sample	100%	95 th	92.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	No Data	No Data	94.3%	95 th	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	No Data	Small Sample	96.4%	95 th	96.4%
Breast Cancer Screening (50-64 Years) ²	No Data	No Data	Small Sample	Not Applicable	51.0%
Cervical Cancer Screening (24-64 Years) ²	No Data	No Data	41.7%	<10 th	46.4%
Chlamydia Screening in Women (16-24 Years) ²	No Data	No Data	48.0%	10 th	45.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	No Data	No Data	70.8%	90 th	71.4%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	No Data	No Data	92.0%	75 th	92.5%
Controlling High Blood Pressure ¹ (Non-SNP)	No Data	Small Sample	80.1%	95 th	72.9%
Medication Management for People With Asthma – 50% (19-64 Years) ²	No Data	No Data	Small Sample	Not Applicable	69.4%
Medication Management for People With Asthma – 75% (19-64 Years) ²	No Data	No Data	Small Sample	Not Applicable	48.2%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 5: HealthPartners 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B	A
	D	<ul style="list-style-type: none"> Breast Cancer Screening (MSC+) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA) 	C	B
	F	<ul style="list-style-type: none"> Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	D	C

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 11: HealthPartners CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	HealthPartners CAHPS 2016	HealthPartners CAHPS 2017	HealthPartners CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Getting Needed Care*	56%	53%	54%	25 th	54%
Getting Care Quickly*	60%	60%	63%	75 th	58%
How Well Doctors Communicate*	78%	83%	84%	90 th	81%
Customer Service*	73%	78%▲	67%	25 th	67%
Shared Decision Making*	76%	77%▼	81%	Benchmark Unavailable	82%
Rating of All Health Care**	57%	61%▲	62%▲	90 th	54%
Rating of Personal Doctor**	71%	72%	75%	90 th	71%
Rating of Specialist Seen Most Often**	59%	60%	74%	90 th	70%
Rating of Health Plan**	59%	64%▲	62%	75 th	60%
MNCare					
Getting Needed Care*	56%	52%	58%	50 th	54%
Getting Care Quickly*	51%	60%	58%	25 th	61%
How Well Doctors Communicate*	81%	82%	87%	90 th	81%
Customer Service*	68%	67%	74%▲	90 th	67%
Shared Decision Making*	82%	81%	83%	Benchmark Unavailable	84%
Rating of All Health Care**	56%	56%	54%	50 th	54%
Rating of Personal Doctor**	68%	73%	71%	90 th	70%
Rating of Specialist Seen Most Often**	66%	67%	68%	50 th	68%
Rating of Health Plan**	50%	50%	57%	25 th	55%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Table 11: HealthPartners CAHPS Performance – 2016, 2017 and 2018 (Continued)

CAHPS Measures	HealthPartners CAHPS 2016	HealthPartners CAHPS 2017	HealthPartners CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Averages
MSC+	-	-	-	-	-
Getting Needed Care *	59%	63%	56%	50 th	56%
Getting Care Quickly *	66%	67%	56%▼	25 th	62%
How Well Doctors Communicate *	77%	77%	77%	75 th	77%
Customer Service *	69%	71%	63%	10 th	66%
Shared Decision Making *	75%	75%	75%	Benchmark Unavailable	77%
Rating of All Health Care **	59%	58%	59%	90 th	60%
Rating of Personal Doctor **	82%▲	74%	75%	90 th	75%
Rating of Specialist Seen Most Often **	65%	74%	66%	50 th	71%
Rating of Health Plan **	73%▲	68%	68%	90 th	66%
SNBC	-	-	-	-	-
Getting Needed Care *	No Data	51%	54%	25 th	55%
Getting Care Quickly *		60%	64%▲	90 th	60%
How Well Doctors Communicate *		69%▼	79%	90 th	78%
Customer Service *		67%	71%	75 th	69%
Shared Decision Making *		78%	80%	Benchmark Unavailable	80%
Rating of All Health Care **		50%	53%	25 th	54%
Rating of Personal Doctor **		62%▼	69%	75 th	72%
Rating of Specialist Seen Most Often **		64%	63%	25 th	67%
Rating of Health Plan **		52%	64%	90 th	62%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Strengths

- **TCA** – HealthPartners was fully compliant with contractual standards reviewed for the TCA.
- **Financial Withhold** – HealthPartners earned all possible points for the SNBC program.
- **HEDIS (Quality of Care)** – HealthPartners performed well in the following areas of care:
 - F&C-MA
 - *Well-Child Visits in the First 15 Months of Life*
- **CAHPS (Member Satisfaction)** – HealthPartners performed well in regard to the following areas of member satisfaction:
 - F&C-MA
 - *Rating of All Health Care*
 - MNCare
 - *Customer Service*
 - MSC+
 - *Getting Care Quickly*
 - SNBC
 - *Getting Care Quickly*

Opportunities for Improvement

- **QAE** – HealthPartners was not fully compliant with the contractual standards reviewed for the QAE. HealthPartners received one (1) deficiency, one (1) mandatory improvement and six (6) recommendations.
- **Financial Withhold** – HealthPartners did not achieve full points for the F&C-MA, MNCare, MSHO and MSC+ programs. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age 2-64 Years
 - Hospital Admission Rate
 - Hospital 30-Day Admission Rate
 - MSHO and MSC+
 - Annual Dental Visits: Age group 65 years and older
- **HEDIS (Quality of Care)** – HealthPartners demonstrates an opportunity for improvement in the following area of care:
 - MSC+
 - *Comprehensive Diabetes Care – HbA1c Testing*
 - *Breast Cancer Screening*
 - F&C-MA
 - *Medication Management for People with Asthma – 50%*
 - *Medication Management for People with Asthma – 75%*
 - MNCare
 - *Annual Dental Visit*
 - *Adolescent Well-Care Visit*

Recommendations

- **Financial Withhold** – As HealthPartners continues to struggle with increasing annual dental visits and decreasing hospital admissions, the MCO should continue to identify additional ways to positively impact these areas of care. As the use of community health (CHW) workers has proven to be an effective intervention in reducing admissions and readmissions, HealthPartners should consider additional ways that CHWs can be integrated into the system to reach more members and to support other areas of care. For the less managed, low-risk population, HealthPartners should identify the drivers of readmissions for this population and develop targeted interventions that address these drivers. HealthPartners should evaluate the effectiveness of the placement of the full-time employee within the hospital setting and determine whether or not other hospitals would benefit from this intervention. In regard to dental, the HealthPartners Patient Dental Call Center should expand telephonic outreach to all age groups. HealthPartners should also run gaps in care reports within multiple times a year and use these reports to drive outreach.
- **HEDIS (Quality of Care)** – HealthPartners should identify providers with large Medicaid panels and implement the same interventions provided to contracted clinic providers. Specifically, the Health Plan should ensure that providers who provide care for a large number of members also receive gaps in care reports, receive support from the Quality Consultants, participate in the Quality Connections Forum and participate in incentive programs. HealthPartners should consider including dental care into the member incentive program.

HENNEPIN HEALTH

Corporate Profile

Hennepin Health was a Medicaid Expansion demonstration project contracted with DHS for single adults without children ages 19-64 in Hennepin County, which ran from January 1, 2012 through December 31, 2015. Metropolitan Health Plan (MHP) managed the Hennepin Health program under its HMO license. MHP has been a licensed HMO since 1983 and has provided medical assistance benefits to public program enrollees since 1984. The Hennepin Health service model combines a social service approach with behavioral health and medical services. Effective January 1, 2016, DHS awarded MHP/Hennepin Health an F&C-MA/MNCare contract; thus, changing from a Medicaid Expansion demonstration project to offering benefits to the F&C-MA and MNCare populations. Hennepin Health's F&C-MA and MNCare programs continue to combine a social service approach with behavioral health and medical services. When MHP changed its name to Hennepin Health in September 2016, the F&C-MA/MNCare program was renamed Hennepin Health – PMAP/MNCare. Cornerstone, Hennepin Health's SNBC program, was renamed Hennepin Health – SNBC. As of December 2017, enrollment totaled 30,307, accounting for 3% of the entire MHCP population. **Table 12** displays Hennepin Health's enrollment as of December 2017.

Table 12: Hennepin Health Enrollment as of December 2017

Program	Enrollment (as of December 2017)
F&C-MA	25,966
MNCare	2,349
SNBC	1,992
Total Enrollment	30,307

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE on February 27, 2017 through March 2, 2017. The examination period covered June 1, 2014 to December 31, 2016, while the file review period covered January 1, 2016 to November 30, 2016. The MCO received a total of six (6) recommendations, four (4) mandatory improvements, and six (6) deficiencies for the QAE, and nineteen (19) "Not Mets" for the TCA.

Performance Improvement Project

The following PIP was in progress:

- ***The Reduction of Racial Disparities in the Management of Depression (2015-2017)*** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP was to reduce, by 20 percentage points, the rate of disparity between Black and White members and between Native American and White members as indicated by the HEDIS *Antidepressant Medication Management – Effective*

Continuation Phase Treatment measure. **Table 13** displays the MCO's performance rates for this PIP.

Table 13: Hennepin Health Performance Rates for the 2015-2017 PIP

HEDIS Year	White	Black	Native American	White Black Disparity	White Native American Disparity
2014	46.47%	40.54%	35.89%	-5.93%	-10.58%
2015	42.66%	38.98%	17.39%	-3.68%	-25.27%
2016	47.46%	26.71%	25.00%	-20.75%	-22.46%
2017	44.14%	23.91%	28.57%	-20.23%	-15.57%
Change	-2.33	-16.63	-7.32	+14.30	+4.99

Provider-focused interventions included:

- In collaboration with the MCOs listed above, training for providers in a variety of disciplines in partnership with other organizations, such as NAMI-MN and MDH.
- Development of resources, including a toolkit for providers, which included a shared decision making tool, brochures, talking points, and a list of pharmacies that can print medication labels in multiple languages and that have language lines available for non-English speaking members.

Member-focused interventions included:

- Telephonic outreach conducted by care coordinators to members newly diagnosed with depression to address specific treatment barriers and teach strategies for managing side effects.
- Follow-up calls by nursing staff to educate and remind members of the importance of treating depression, the benefits of antidepressant therapy, and side effects.

2017 Financial Withhold

Hennepin Health achieved 90 points (of 90 points) for the F&C-MA and MNCare programs, and achieved 45 points (of 60 points) for the SNBC program. **Table 14** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by Hennepin Health.

Table 14: Hennepin Health 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-64 Years	Not Applicable	Not Applicable
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	15	15
Total	90	90
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Report	15	15
Maintaining a Local or Regional Stakeholders Group as Required in Section 7.4	15	15
Annual Dental Visit: Age 19-64 Years	15	0
Total	60	45

Notes: In regard to the F&C-MA and MN Care Annual Dental Visit performance measure, the baseline rate is not applicable, because the F&C-MA children and teen enrollment started at the beginning of calendar year 2017.

Annual Quality Assurance Work Plan for 2017

Hennepin Health’s annual quality assurance (QA) work plan was compliant with Minnesota Administrative Rule 4685.1130. The work plan clearly lays out each area the MCO is working on, listing the activities for that area under each. For each activity under the areas of focus, the goals and objectives, outcome measures, actions and tasks to be completed, the timeline and/or the expected completion date, responsible staff, and project status are clearly and concisely displayed. Additionally, the MCO has nine key strategic goals for the QA activities, including growing enrollment, financial stability, improving customer service, improving operational infrastructure, improving member relationships with care teams, improving connections with programs outside of health care, improving the “triple aim” outcomes for members, participating in defining future state and national accountable care models, and increasing awareness of the MCO among partners. The MCO also defined several “quality connections”, which include areas such as reducing cost, efficiency, safety, accessibility, and accountability, among others. Each activity corresponds to at least one of these goals and quality connections.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

Hennepin Health’s QI program is designed to provide high quality, culturally competent, comprehensive health services for each member. The goals of the QI program include: improving member health, making continuous and sustained improvement in performance measures; ensuring the health care delivered meets community quality, accessibility, and appropriateness standards; ensuring members

have access to appropriate care; achieving and maintaining member satisfaction; and addressing racial disparities in appropriate quality improvement activities.

Through the QI program, the MCO encourages providers to discuss all options with their patients in order to build collaborative relationships between providers and members. Full participation in medical treatment, preventive health maintenance services, education, provision of treatment in non-restrictive environments, appropriate and efficient application of resources, delivery of medically necessary care, and the avoidance of unnecessary treatment are promoted through the QI program.

MCO Clinical Practice Guidelines

Hennepin Health recognizes the following source for clinical practice guidelines:

- USPSTF
 - Preventive Screenings
 - Children and Asthma
 - Immunization for Adults and Children
 - Maternal and Child Health Measures
 - Screening for Depression in Adults
 - Recommendation for Alcohol Misuse
- MN Community Measurement (MNCM)
 - D5 Goals for Diabetes Mellitus
- ADA
 - Diabetes Management
- ICSI
 - Diagnosis and Management of Asthma
 - Immunization Update and Preventive Services for Children and Adolescents
 - Routine Prenatal Care
 - Depression, Major, in Adults in Primary Care
 - Health Lifestyles
- AHRQ
 - Evidence-Based Psychotherapies
- APA
 - Depression
- American Academy of Child and Adolescent Psychiatry (AACAP)

HEDIS AND CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 15** and **Table 16**, respectively, while **Figure 6** displays the HEDIS Measure Matrix.

Table 15: Hennepin Health HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	Hennepin Health HEDIS 2016	Hennepin Health HEDIS 2017	Hennepin Health HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	No Data	No Data	42.7%	10 th	42.4%
Adult BMI Assessment ¹	Not Reported	93.9%	96.4%	95 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	63.1%	73.0%	67.0%	10 th	83.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	78.9%	86.7%	80.8%	10 th	87.2%
Annual Dental Visit ²	No Data	No Data	29.6%	<10 th	47.1%
Breast Cancer Screening (50-64 Years) ²	68.5%	48.1%	52.9%	25 th	63.1%
Cervical Cancer Screening (24-64 Years) ²	41.9%	50.4%	44.3%	<10 th	58.9%
Childhood Immunization Status: Combo 3 (2 Years) ¹	No Data	No Data	53.3%	<10 th	73.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	No Data	No Data	85.1%	<10 th	96.6%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	No Data	No Data	83.8%	10 th	90.2%
Children and Adolescents' Access to PCPs (7-11 Years) ²	No Data	No Data	Small Sample	Not Applicable	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	No Data	No Data	Small Sample	Not Applicable	93.1%
Chlamydia Screening in Women (16-24 Years) ²	66.3%	78.0%	70.4%	75 th	52.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	Not Reported	64.7%	52.0%	25 th	65.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	Not Reported	92.7%	87.7%	33.33 rd	90.9%
Controlling High Blood Pressure ¹	Not Reported	62.4%	69.8%	75 th	67.0%
Medication Management for People With Asthma – 50% (19-64 Years) ²	63.9%	73.3%	66.7%	No Benchmark	63.9%
Medication Management for People With Asthma – 75% (19-64 Years) ²	30.6%	30.0%	39.4%	50 th	41.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	No Data	No Data	34.4%	<10 th	63.8%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	No Data	No Data	56.0%	<10 th	63.6%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 15: Hennepin Health HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	Hennepin Health HEDIS 2016	Hennepin Health HEDIS 2017	Hennepin Health HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	No Data	No Data	Small Sample	Not Applicable	28.9%
Adult BMI Assessment ¹			98.0%	95 th	91.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²			78.9%	50 th	82.1%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²			94.3%	95 th	88.0%
Annual Dental Visit ²			30.3%	<10 th	39.2%
Breast Cancer Screening (50-64 Years) ²			Small Sample	Not Applicable	70.2%
Cervical Cancer Screening (24-64 Years) ²			44.9%	<10 th	56.0%
Chlamydia Screening in Women (16-24 Years) ²			Small Sample	Not Applicable	51.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹			Small Sample	Not Applicable	70.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹			Small Sample	Not Applicable	94.6%
Controlling High Blood Pressure ¹			61.3%	50 th	72.5%
Medication Management for People With Asthma – 50% (19-64 Years) ²			No Data	Not Applicable	71.7%
Medication Management for People With Asthma – 75% (19-64 Years) ²			Unavailable	Not Applicable	49.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 15: Hennepin Health HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	Hennepin Health HEDIS 2016	Hennepin Health HEDIS 2017	Hennepin Health HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
SNBC					
Adult BMI Assessment ¹ (Non-SNP)	84.9%	92.5%	93.7%	75 th	92.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	90.8%	88.4%	88.6%	95 th	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	94.1%	94.5%	94.2%	95 th	96.4%
Breast Cancer Screening (50-64 Years) ²	55.8%	51.5%	42.6%	<10 th	51.0%
Cervical Cancer Screening (24-64 Years) ²	50.1%	48.5%	46.5%	<10 th	46.4%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	45.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	62.5%	61.7%	63.5%	66.67 th	71.4%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	86.9%	92.5%	93.4%	90 th	92.5%
Controlling High Blood Pressure ¹ (Non-SNP)	60.2%	64.7%	72.4%	90 th	72.9%
Medication Management for People With Asthma – 50% (19-64 Years) ²	59.4%	Small Sample	Small Sample	Not Applicable	69.4%
Medication Management for People With Asthma – 75% (19-64 Years) ²	28.1%	Small Sample	Small Sample	Not Applicable	48.2%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 6: Hennepin Health 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> Controlling High Blood Pressure (F&C-MA) 	A
	D <ul style="list-style-type: none"> Annual Dental Visit (MNCare) Breast Cancer Screening (F&C-MA) Cervical Cancer Screening (MNCare) Comprehensive Diabetes Care – Eye Exam (SNBC) 	C <ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA) Controlling High Blood Pressure (SNBC) Cervical Cancer Screening (SNBC) Comprehensive Diabetes Care – HbA1c Testing (SNBC) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA) 	B <ul style="list-style-type: none"> Chlamydia Screening in Women (F&C-MA) 	
	F <ul style="list-style-type: none"> Annual Dental Visit (F&C-MA) Breast Cancer Screening (SNBC) Cervical Cancer Screening (F&C-MA) Comprehensive Diabetes Care – Eye Exam (F&C-MA) 	D <ul style="list-style-type: none"> Comprehensive Diabetes Care – HbA1c Testing (F&C-MA) 	C	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 16: Hennepin Health CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	Hennepin Health CAHPS 2016	Hennepin Health CAHPS 2017	Hennepin Health CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA	-	-	-	-	-
Getting Needed Care*	53%	61%	53%	25 th	54%
Getting Care Quickly*	57%	61%	52%▼	10 th	58%
How Well Doctors Communicate*	79%	82%	77%	75 th	81%
Customer Service*	62%	69%	58%	<10 th	67%
Shared Decision Making*	84%	81%	77%▼	Benchmark Unavailable	82%
Rating of All Health Care**	45%	55%	40%▼	<10 th	54%
Rating of Personal Doctor**	65%	66%	66%	50 th	71%
Rating of Specialist Seen Most Often**	53%	70%	62%	10 th	70%
Rating of Health Plan**	40%	56%	44%▼	<10 th	60%
MNCare	-	-	-	-	-
Getting Needed Care*	-	-	50%	10 th	54%
Getting Care Quickly*	-	-	61%	50 th	61%
How Well Doctors Communicate*	-	-	76%	50 th	81%
Customer Service*	-	-	64%	25 th	67%
Shared Decision Making*	No Data	No Data	84%	Benchmark Unavailable	84%
Rating of All Health Care**	-	-	52%	25 th	54%
Rating of Personal Doctor**	-	-	69%	75 th	70%
Rating of Specialist Seen Most Often**	-	-	66%	50 th	68%
Rating of Health Plan**	-	-	54%	25 th	55%

▼ Rate is significantly lower than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Table 16: Hennepin Health CAHPS Performance – 2016, 2017 and 2018 (Continued)

CAHPS Measures	Hennepin Health CAHPS 2016	Hennepin Health CAHPS 2017	Hennepin Health CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average		
SNBC	-	-	-	-	-		
Getting Needed Care*	-	-	54%	25 th	55%		
Getting Care Quickly*			58%	25 th	60%		
How Well Doctors Communicate*			80%	90 th	78%		
Customer Service*			68%	50 th	69%		
Shared Decision Making**			No Data	No Data	79%	Benchmark Unavailable	80%
Rating of All Health Care**			-	-	53%	25 th	54%
Rating of Personal Doctor**			-	-	72%	90 th	72%
Rating of Specialist Seen Most Often**			-	-	61%	10 th	67%
Rating of Health Plan**			-	-	57%	25 th	62%

Strengths

- **Financial Withhold** – Hennepin Health earned all possible points for the F&C-MA and MNCare programs.

Opportunities for Improvement

- **QAE** – Hennepin Health was not fully compliant with the contractual standards reviewed for the QAE. Hennepin Health received six (6) deficiencies, four (4) mandatory improvement and six (6) recommendations.
- **TCA** – Hennepin Health was not fully compliant with the contractual standards reviewed for the TCA. Hennepin Health received nineteen (19) “not met” determinations.
- **HEDIS (Quality of Care)** – Hennepin Health demonstrates an opportunity for improvement in the following areas of care:
 - F&C-MA
 - *Annual Dental Visit*
 - *Cervical Cancer Screening*
 - *Comprehensive Diabetes Care – Eye Exam*
 - *Breast Cancer Screening*
 - *Comprehensive Diabetes Care – HbA1c Testing*
 - SNBC
 - *Breast Cancer Screening*
 - *Comprehensive Diabetes Care – Eye Exam*
 - MNCare
 - *Annual Dental Visit*
 - *Cervical Cancer Screening*
- **CAHPS (Member Satisfaction)** – Hennepin Health demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the statewide average for the following measure:
 - F&C-MA
 - *Getting Care Quickly*
 - *Shared Decision Making*
 - *Rating of All Health Care*
 - *Rating of Health Plan*

Recommendations

- **HEDIS (Quality of Care)** –
 - Hennepin Health should identify non-traditional methods for communicating with members.
 - Despite not finding a resource to establish a mobile mammogram center, Hennepin Health should consider other options for mobilizing care, especially since a large majority of their membership lack a health home.
 - Hennepin Health should reconsider the use of monetary incentives for members.

- **CAHPS (Member Satisfaction)** – Hennepin health should conduct thorough root cause analyses for the measures listed above and implement target interventions to address identified barriers. Hennepin Health should also utilize complaints and grievances to identify and address trends that may impact the member-health plan experience.

ITASCA MEDICAL CARE (IMCARE)

Corporate Profile

Itasca County Health and Human Services (ICHHS) administers IMCare, a CBP organization. Itasca County contracts with DHS to provide medical benefits through the IMCare program to the F&C-MA, MNCare, MSHO, and MSC+ populations. As of December 2017, enrollment totaled 8,922 accounting for 1% of the entire MHCP population. **Table 17** displays IMCare’s enrollment as of December 2017.

Table 17: IMCare Enrollment as of December 2017

Program	Enrollment (as of December 2017)
F&C-MA	7,556
MNCare	681
MSC+	227
MSHO	458
Total Enrollment	8,922

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA on September 28, 2015 through October 2, 2015. The examination period covered August 1, 2012 to July 31, 2015, while the file review period covered August 1, 2014 to July 31, 2015. The MCO received a total of two (2) recommendations for the QAE and received one (1) “not met” for the TCA. The MCO submitted a corrective action plan (CAP) addressing these TCA “not met” finding and QAE recommendations.

The 2017 mid-cycle review determined that the MCO was compliant in executing its CAP for the TCA and QAE.

Performance Improvement Project

The following PIP was in progress:

- ***Elimination of Race and Ethnic Disparities in the Management of Depression (2015-2017)*** – The goal of this project was to improve, by 8 percentage points, the HEDIS *Antidepressant Medication Management – Effective Acute Phase Treatment (AMM)* measure rate for F&C-MA and MNCare members who identified as a race other than White, and meet the HEDIS specifications for the *AMM* measure (*note: denominator was four (4)*). **Table 18** displays the MCO’s rates for this PIP.

Table 18: IMCare Performance Rates for the 2015-2017 PIP

HEDIS Year	All
2014	0.0%
2015	25.0%
2017	35.0%
Net Change	+35.0

Member-focused interventions included:

- General member education regarding depression, medications, common side effects, and the importance of medication adherence was included in the member newsletter each year. Resources for accessing this information in another language were also available.
- IMCare identified currently eligible members of the study population monthly, in order to account for the allowable gap in treatment in the NCQA specifications for the HEDIS *AMM* measure, via prescription fill data. Members identified as not filling prescriptions received a reminder phone call concerning the importance of adherence and to address any barriers. Members could also be referred to case management during these phone calls.

Provider-focused interventions included:

- General network provider education via the provider newsletter, including information about: the design/goals of this PIP, practice guidelines, the provider's role in the promotion of medication adherence, resources the provider can access for identified language barriers, and the Minnesota Mental Health Community Foundation online resource for connecting with community referral resources.

Pharmacy-focused interventions included:

- General network pharmacy education via provider update each year.
- Encouraging pharmacies to assess patients for language barriers, and to offer printed prescription labels and instructions in the patient's primary language.

2017 Financial Withhold

IMCare achieved 75.15 points (of 105 points) for the F&C-MA and MNCare programs and achieved 82.62 points (of 90 points) for the MSHO and MSC+ programs. **Table 19** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by IMCare.

Table 19: IMCare 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-64 Years	15	5
Well-Child Visits in the First 15 Months of Life	15	15
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	10.15
Hospital 30-Day Readmission Rate	Not Applicable	Not Applicable
Total	105	75.15
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	7.62
Total	90	82.62

Note: In regard to the F&C-MA and MNCare Hospital 30-Day Readmission Rate performance measure, the sample size was too small to report and therefore the measure was eliminated from the point calculation.

Annual Quality Assurance Work Plan for 2017

IMCare submitted an annual QA work plan compliant with Minnesota Administrative Rule 4685.1130. The MCO's QA work plan covers multiple areas, including credentialing, accessibility, case management and care coordination, utilization of services, and many others. The MCO also included several focused studies for topics including prenatal care, emergency department utilization, and use of controlled substances. The QA work plan clearly defines each activity and lays out a structured format for reporting objectives and goals, tasks to be completed, outcome measures, data sources, responsible staff, project/task timelines, and project/task status. The work plan also reports progress and results for each activity.

Evaluation of the 2017 Annual Quality Assessment and Performance Improvement Program

IMCare's QI program is designed to support the mission, vision, and values of Itasca County and IMCare through ongoing improvement, evaluation, and monitoring of patient safety and delivery of services to enrollees. The QI program is enhanced by partnerships between the MCO and providers, community organizations, and delegated entities. Goals and objectives of the program are based on information from survey results, utilization and claims data, HEDIS data, QAEs, and TCAs. Accountability for managing and improving the quality of care for enrollees falls to the ICHHS Board of Commissioners (BOC), which delegates the day-to-day operations for the program to the IMCare Director. The IMCare Director, in conjunction with the Medical Director, Pharmacy Director, Quality Director, and Contract Compliance Officer, reports quality program activities to the BOC, as well as the Provider Advisory

Subcommittee (PAC) and the Quality Improvement/Utilization Management Subcommittee (QI/UM). The BOC review and approves QI and UM program descriptions, work plans, and program evaluations.

IMCare demonstrated improvement across many of its quality improvement initiatives. The MCO focused on education for staff, providers, and members, and developed an internal quality workgroup intended to enhance staff knowledge of ongoing initiatives and opportunities for improvement while promoting an arena for the exchange of ideas and solutions. The MCO also made improvements to its Service Advisory Committee to make it more enrollee-centered. The Committee was renamed the Stakeholder Advisory Committee and includes enrollees, or individuals who are in a capacity to represent them.

MCO Clinical Practice Guidelines

IMCare recognizes the following sources for clinical practice guidelines:

- AAFP
 - Preventive services
- ICSI
 - Depression, Adult in Primary Care
- UpToDate
 - Establishing and Maintaining a Therapeutic Relationship in Psychiatric Practice
 - Guidelines for Adolescent Preventive Services
 - Initial Prenatal Assessment and First Trimester Prenatal Care
 - Overview of Hypertension in Adults
 - Overview of Medical Care in Adults with Diabetes Mellitus
 - Prenatal Care (Second and Third Trimesters)
 - Preventive Care In Adults: Recommendations
 - Screening Tests in Children and Adolescents'

HEDIS AND CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 20** and **Table 21**, respectively, while **Figure 7** displays the HEDIS Measure Matrix.

Table 20: IMCare HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	IMCare HEDIS 2016	IMCare HEDIS 2017	IMCare HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	29.4%	31.9%	39.2%	10 th	42.4%
Adult BMI Assessment ¹	90.5%	89.3%	92.2%	66.67 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	84.4%	88.2%	83.8%	75 th	83.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	87.8%	90.5%	88.1%	50 th	87.2%
Annual Dental Visit ²	No Data	No Data	56.8%	50 th	47.1%
Breast Cancer Screening (50-64 Years) ²	45.7%	59.0%	52.6%	25 th	63.1%
Cervical Cancer Screening (24-64 Years) ²	53.3%	53.3%	53.3%	10 th	58.9%
Childhood Immunization Status: Combo 3 (2 Years) ¹	68.9%	62.5%	74.8%	75 th	73.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	96.0%	97.7%	96.5%	50 th	96.6%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	89.4%	89.1%	88.7%	50 th	90.2%
Children and Adolescents' Access to PCPs (7-11 Years) ²	93.8%	92.0%	89.2%	33.33 rd	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	92.9%	91.3%	91.7%	66.67 th	93.1%
Chlamydia Screening in Women (16-24 Years) ²	42.5%	43.3%	42.5%	<10 th	52.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	65.6%	54.4%	61.2%	50 th	65.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	93.1%	91.2%	90.5%	75 th	90.9%
Controlling High Blood Pressure ¹	59.0%	86.1%	67.4%	75 th	67.0%
Medication Management for People With Asthma – 50% (5-64 Years) ²	62.5%	67.4%	60.0%	No Benchmark	63.9%
Medication Management for People With Asthma – 75% (5-64 Years) ²	35.0%	37.2%	40.0%	66.67 th	41.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	56.3%	61.1%	59.7%	25 th	63.8%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	66.2%	65.7%	60.9%	<10 th	63.6%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 20: IMCare HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	IMCare HEDIS 2016	IMCare HEDIS 2017	IMCare HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	Small Sample	23.3%	Small Sample	Not Applicable	28.9%
Adult BMI Assessment ¹	91.7%	90.5%	91.9%	66.67 th	91.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	80.9%	87.2%	81.4%	66.67 th	82.1%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	88.0%	89.0%	90.4%	75 th	88.0%
Annual Dental Visit ²	No Data	No Data	55.3%	33.33 rd	39.2%
Breast Cancer Screening (50-64 Years) ²	68.7%	60.8%	68.3%	75 th	70.2%
Cervical Cancer Screening (24-64 Years) ²	54.2%	49.8%	52.2%	10 th	56.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	96.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	89.6%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	51.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	64.3%	61.5%	65.0%	75 th	70.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	90.5%	100.0%	95.0%	95 th	94.6%
Controlling High Blood Pressure ¹	64.8%	89.8%	67.4%	75 th	72.5%
Medication Management for People With Asthma – 50% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	71.7%
Medication Management for People With Asthma – 75% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	49.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 20: IMCare HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	IMCare HEDIS 2016	IMCare HEDIS 2017	IMCare HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.2%	96.6%	98.2%	95 th	98.3%
Breast Cancer Screening (65-74 Years) ²	58.7%	64.5%	60.6%	50 th	61.1%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	58.0%	69.4%	77.8%	95 th	79.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	94.0%	95.9%	94.4%	95 th	95.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	88.2%	90.4%	89.9%	50 th	93.3%
Breast Cancer Screening (65-74 Years) ²	29.7%	30.3%	31.6%	<10 th	41.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	67.6%	77.8%	91.7%	75 th	76.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 7: IMCare 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Childhood Immunization Status – Combo 3 (F&C-MA) 	A
	D <ul style="list-style-type: none"> ▪ Breast Cancer Screening (F&C-MA) ▪ Cervical Cancer Screening (F&C-MA) ▪ Chlamydia Screening in Women (F&C-MA) 	C <ul style="list-style-type: none"> ▪ Breast Cancer Screening (MSC+, MSHO, MNCare) ▪ Cervical Cancer Screening (MNCare) ▪ Comprehensive Diabetes Care – Eye Exam (F&C-MA, MSHO, MNCare) ▪ Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSHO, MNCare) ▪ Medication Management for People with Asthma-50% (F&C-MA) ▪ Medication Management for People with Asthma-75% (F&C-MA) ▪ Well-Child Visits in the First 15 Months of Life (F&C-MA) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	B <ul style="list-style-type: none"> ▪ Annual Dental Visit (MNCare) ▪ Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	
	F	D <ul style="list-style-type: none"> ▪ Controlling High Blood Pressure (F&C-MA, MNCare) 	C <ul style="list-style-type: none"> ▪ Annual Dental Visit (F&C-MA) 	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 21: IMCare CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	IMCare CAHPS 2016	IMCare CAHPS 2017	IMCare CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Getting Needed Care*	53%	60%	54%	25 th	54%
Getting Care Quickly*	55%	61%	56%	25 th	58%
How Well Doctors Communicate*	74%	83%	82%	90 th	81%
Customer Service*	69%	66%	72%	75 th	67%
Shared Decision Making*	86%	84%	86%	Benchmark Unavailable	82%
Rating of All Health Care**	43%▼	56%	49%	10 th	54%
Rating of Personal Doctor**	65%	72%	71%	90 th	71%
Rating of Specialist Seen Most Often**	59%	70%	74%	90 th	70%
Rating of Health Plan**	51%▼	55%	57%	25 th	60%
MNCare					
Getting Needed Care*	58%	65%	50%	10 th	54%
Getting Care Quickly*	62%▲	64%	61%	50 th	61%
How Well Doctors Communicate*	79%	78%	76%	50 th	81%
Customer Service*	62%	61%	64%	25 th	67%
Shared Decision Making*	84%	87%	84%	Benchmark Unavailable	84%
Rating of All Health Care**	54%	54%	52%	25 th	54%
Rating of Personal Doctor**	71%	64%	69%	75 th	70%
Rating of Specialist Seen Most Often**	71%	64%	66%	50 th	68%
Rating of Health Plan**	53%	53%	54%	25 th	55%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Table 21: IMCare CAHPS Performance – 2016, 2017 and 2018 (Continued)

CAHPS Measures	IMCare CAHPS 2016	IMCare CAHPS 2017	IMCare CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2017 Statewide Average
MSC+					
Getting Needed Care*	63%▲	64%	61%▲	90 th	56%
Getting Care Quickly*	67%▲	67%	76%▲	90 th	62%
How Well Doctors Communicate*	76%	75%	80%▲	90 th	77%
Customer Service*	78%▲	77%	75%▲	90 th	66%
Shared Decision Making*	77%	77%	78%	Benchmark Unavailable	77%
Rating of All Health Care**	63%	66%	60%	90 th	60%
Rating of Personal Doctor**	71%	75%	77%▲	90 th	75%
Rating of Specialist Seen Most Often**	69%	74%	73%	90 th	71%
Rating of Health Plan**	65%	71%	72%▲	90 th	66%

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Strengths

- **CAHPS (Member Satisfaction)** – IMCare performed well in regard to the following areas of member satisfaction:
 - MSC+
 - *Getting Needed Care*
 - *Getting Care Quickly*
 - *How Well Doctors Communicate*
 - *Customer Service*
 - *Rating of Personal Doctor*
 - *Rating of Health Plan*

Opportunities for Improvement

- **Financial Withhold** – IMCare did not earn full points for the F&C-MA, MNCare, MSHO and MSC+ programs. This was also noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age 2-64 Years
 - Hospital Admission Rate
 - MSHO and MSC+
 - Annual Dental Visit: Age 65 Years and Older
- **HEDIS (Quality of Care)** – IMCare demonstrates an opportunity for improvement in regard to the following areas of care:
 - F&C-MA
 - *Breast Cancer Screening*
 - *Cervical Cancer Screening*
 - *Chlamydia Screening in Women*
 - *Controlling High Blood Pressure*
 - MNCare
 - *Controlling High Blood Pressure*

Recommendations

- **Financial Withhold** – IMCare’s response to the previous year’s recommendations includes descriptions for a range of activities that aim to increase annual dental visits. IMCare should continue with this strategy for dental care and monitor the effectiveness of each initiative. IMCare should ensure that the reduction of hospital admissions is an organizational priority and that current initiatives aimed at reducing admissions continue.
- **HEDIS (Quality of Care)** – IMCare demonstrates an overall opportunity for improvement in regard to women’s health. IMCare should determine if there are access issues and/or quality of care issues negatively impacting preventive screenings for women. At a minimum, IMCare should routinely educate its female membership on the importance of preventive screenings and remind primary care providers and OB/GYNs of the recommended screenings and the frequency of such screenings.

MEDICA

Corporate Profile

Medica HMO contracts with DHS to provide services to enrollees in the MSC+, MSHO and SNBC programs. As of December 2017, enrollment totaled 28,487, accounting for 3% of the entire MHCP population. **Table 22** displays Medica’s enrollment as of December 2017.

Table 22: Medica Enrollment as of December 2017

Program	Enrollment (as of December 2017)
MSC+	4,129
MSHO	10,830
SNBC	13,528
Total Enrollment	28,487

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA on October 2, 2017 through October 6, 2017. The examination period covered January 1, 2015 to August 31, 2017, while the file review period covered January 1, 2016 to August 31, 2017. The MCO received two (2) mandatory improvements for the QAE and one (1) “not met” for the TCA.

Performance Improvement Projects

By the end of this reporting period Medica ended its participation in the F&C-MA program and therefore did not report 2017 data for the “Racial and Ethnic Disparities in the Management of Depression” PIP collaboration.

2017 Financial Withhold

Medica achieved 89.46 points (of 90 points) for the MSHO and MSC+ programs, and 45 points (of 60 points) for the SNBC program. **Table 23** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by Medica.

Table 23: Medica 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	14.46
Total	90	89.46
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	0
Total	60	45

Annual Quality Assurance Work Plan for 2017

Medica’s quality assurance work plan was compliant with Minnesota Administrative Rule 4685.1130. The QA work plan includes significant and measurable quality improvement initiatives that address one or more of the following: clinical quality, service quality, member experience, provider quality, patient safety, and/or regulatory/accreditation requirements. Activities are categorized into one of five types, including assessment/research, design/development, implementation, improvement, and evaluation. The QI work plan provides a detailed description of each activity, including the project owner, objective, rationale, expected impacts, key interventions/project outputs and milestones, and goals and outcomes. Activities included in the work plan cover a broad range of clinical and service areas and describes Medica’s activities as they relate to measurement and monitoring and delegated quality improvement. The work plan is approved by the Medical Committee of the Board of Directors.

Evaluation of the 2017 Annual Quality Assessment and Performance Improvement Program

The purpose of Medica’s QI program is to implement activities that will improve member care, service, access, and/or safety; improve service to providers, employers, brokers, and other customers and partners; and improve Medica’s internal operations. The MCO’s QI program is designed to encompass a wide range of clinical and service areas affecting all stakeholders. Key focus areas of the program include, but are not limited to: access to and availability of network providers; behavioral health; complaints, appeals, and grievances; continuity, coordination, and transition of care; credentialing and re-credentialing; delegation oversight; health and wellness coaching; medical record review; member satisfaction; patient safety; and utilization of medical services. Medica gathers information on how best to improve the quality and accessibility of care through member and provider satisfaction surveys, Member Advisory Council feedback, health outcomes, utilization management data, complaints and appeals data, and progress reports on QI work plan goals. Medicaid uses the Plan-Do-Study-Act (PDSA)

model to identify improvement opportunities, focusing on high-risk, high-volume, and problem-prone areas that may present adverse clinical or service outcomes.

Medica's senior medical director holds ultimate responsibility for QI program development, implementation, and oversight, in collaboration with the leadership team. The QI program extends to all departments and staff of Medica, with oversight from the Quality Improvement Department. The Medicaid Quality Improvement Subcommittee (QIS) directs and oversees the implementation of the QI program, and reports to the Medical Committee of the Board of Directors. The QIS receives and reviews aggregate data on all aspects of clinical and service quality, including the QI work plan, with ultimate approval of the QI work plan and evaluation falling to the Medical Committee of the Board of Directors.

MCO Clinical Practice Guidelines

Medica recognizes the following sources for clinical practice guidelines:

- NHLBI
 - Screening, prevention, diagnosis and treatment of asthma
- AACAP
 - Practice parameter for the assessment and treatment of children and adolescents with attention-deficit hyperactivity disorder
 - Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder
- American College of Cardiology (ACC) and AHA
 - Treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults
 - Management of heart failure
 - Lifestyle management to reduce cardiovascular risk
 - Management of overweight and obesity in adults
- Global Initiative for Chronic and Obstructive Lung Disease
 - Prevention, diagnosis and management of COPD
- APA
 - Treatment of patients with major depressive disorder
 - Treatment of patients with schizophrenia
 - Treatment of patients with substance use disorders
- ADA
 - Standards of medical care in diabetes
- JNC 8
 - Management of high blood pressure in adults
- CDC
 - Prescribing opioids for chronic pain
- NOF
 - Prevention and treatment of osteoporosis
- USPSTF
 - Preventive services

- Tobacco Use and Dependence Guideline Panel
 - Treating tobacco use and dependence

HEDIS and CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 24** and **Table 25**, respectively, while **Figure 8** displays the HEDIS Measure Matrix.

Table 24: Medica HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	Medica HEDIS 2016	Medica HEDIS 2017	Medica HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.2%	98.2%	98.5%	95 th	98.3%
Breast Cancer Screening (65-74 Years) ²	57.1%	55.7%	57.8%	33.33 rd	61.1%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	79.3%	80.5%	81.5%	95 th	79.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	95.1%	93.4%	94.2%	90 th	95.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	94.0%	93.5%	93.8%	75 th	93.3%
Breast Cancer Screening (65-74 Years) ²	30.2%	29.8%	27.9%	<10 th	41.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	70.2%	45.7%	62.7%	<10 th	76.9%
SNBC					
Adult BMI Assessment ¹ (Non-SNP)	90.5%	94.9%	94.4%	75 th	93.7%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	93.3%	92.6%	91.6%	95 th	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	96.5%	96.5%	96.2%	95 th	96.4%
Breast Cancer Screening (50-64 Years) ²	40.8%	37.8%	36.1%	<10 th	51.0%
Cervical Cancer Screening (24-64 Years) ²	42.7%	41.4%	42.7%	<10 th	46.4%
Chlamydia Screening in Women (16-24 Years) ²	52.1%	53.5%	47.3%	10 th	45.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	71.9%	72.3%	76.4%	95 th	64.5%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	92.5%	92.5%	93.3%	90 th	92.5%
Controlling High Blood Pressure ¹ (Non-SNP)	74.9%	74.2%	72.8%	90 th	72.9%
Medication Management for People With Asthma – 50% (19-64 Years) ²	69.3%	68.1%	68.9%	No Benchmark	69.4%
Medication Management for People With Asthma – 75% (19-64 Years) ²	49.7%	45.6%	43.7%	75 th	48.2%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 8: Medica 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C	<ul style="list-style-type: none"> Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	B	A
	D	<ul style="list-style-type: none"> Breast Cancer Screening (MSC+, MSHO, SNBC) Cervical Cancer Screening (SNBC) 	<ul style="list-style-type: none"> Controlling High Blood Pressure (SNBC) Comprehensive Diabetes Care – Eye Exam (MSHO) Comprehensive Diabetes Care – HbA1c Testing (MSHO, SNBC) 	<ul style="list-style-type: none"> Comprehensive Diabetes Care – Eye Exam (SNBC)
	F		D	C

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 25: Medica CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	Medica CAHPS 2016	Medica CAHPS 2017	Medica CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
MSC+					
Getting Needed Care*	53%	58%	59%	75 th	56%
Getting Care Quickly*	55%	67%	65%	90 th	62%
How Well Doctors Communicate*	75%	80%	79%	90 th	77%
Customer Service*	63%	67%	76%▲	90 th	66%
Shared Decision Making*	83%▲	79%	77%	Benchmark Unavailable	77%
Rating of All Health Care**	56%	59%	61%	90 th	60%
Rating of Personal Doctor**	66%▼	76%	81%▲	90 th	75%
Rating of Specialist Seen Most Often**	67%	72%	73%	90 th	71%
Rating of Health Plan**	59%	65%	68%	90 th	66%
SNBC					
Getting Needed Care*	52%	55%	53%	25 th	55%
Getting Care Quickly*	54%	56%	60%	50 th	60%
How Well Doctors Communicate*	75%	78%▲	77%	75 th	78%
Customer Service*	71%	64%	59%▼	<10 th	69%
Shared Decision Making*	80%	77%	80%	Benchmark Unavailable	80%
Rating of All Health Care**	51%	50%	54%	50 th	54%
Rating of Personal Doctor**	73%▲	73%▲	72%	90 th	72%
Rating of Specialist Seen Most Often**	64%	66%	66%	50 th	67%
Rating of Health Plan**	64%▲	57%	58%	50 th	62%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Strengths

- **CAHPS (Member Satisfaction)** – Medica performed well in the following areas of member satisfaction:
 - MSC+
 - *Customer Service*
 - *Rating of Personal Doctor*

Opportunities for Improvement

- **QAE** – Medica was not fully compliant with the contractual standards reviewed for the QAE. Medica received two (2) mandatory improvements.
- **TCA** – Medica was not fully compliant with the contractual standards reviewed for the TCA. Medica received one (1) “not met” determination.
- **Financial Withhold** – Medica did not achieve full points for the MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
 - MSHO and MSC+
 - Annual Dental Visit: Age 65 Years and Older
 - SNBC
 - Annual Dental Visit: Age 19-64 Years
- **HEDIS (Quality of Care)** – Medica demonstrates an opportunity for improvement in the following areas of care:
 - MSHO
 - *Breast Cancer Screening*
 - SNBC
 - *Breast Cancer Screening*
 - *Cervical Cancer Screening*
 - MSC+
 - *Breast Cancer Screening*
- **CAHPS (Member Satisfaction)** – Medica demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the statewide average for the following measure:
 - SNBC
 - *Customer Service*

Recommendations

- **Financial Withhold** – Medica should monitor the impact of the SNBC Dental Access and Improvement Project and identify initiatives that are transferrable to the MSHO and MSC+ populations. Medica should identify solutions for the capturing of member insurance information at partnering free dental clinics.
- **HEDIS (Quality of Care)** – Medica demonstrates an overall opportunity for improvement in regard to women’s health. Medica should include cervical cancer screening in all of the improvement activities described in its response to the previous year’s recommendation. Medica should also leverage its relationship with the American Cancer Society to identify best practices of health plans with similar memberships.

- **CAHPS (Member Satisfaction)** – As SNBC member satisfaction with customer service has steadily declined, Medica should consider ways of obtaining member feedback shortly after the member’s interaction with health plan staff to ensure member issues are addressed in an expedited fashion. Member feedback should be captured and reviewed to identify specific elements of the customer experience that can be modified.

PRIMEWEST HEALTH

Corporate Profile

Organized through a Joint Powers Board (JPB) of thirteen (13) local county governments as a CBP, PrimeWest is a publicly funded MCO. The MCO began enrollment in July 2003 for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO maintained NCQA accreditation status for its Medicaid lines of business for the 2017-2018 NCQA rating period. As of December 2017, enrollment totaled 42,562, accounting for 4% of the entire MHCP population. **Table 26** displays PrimeWest’s enrollment as of December 2017.

Table 26: PrimeWest Enrollment as of December 2017

Program	Enrollment (as of December 2017)
F&C-MA	34,373
MNCare	3,333
MSC+	779
MSHO	1,932
SNBC	2,145
Total Enrollment	42,562

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA on July 17, 2017 through July 20, 2017. The examination period covered November 1, 2014 to March 31, 2017, while the file review period covered May 1, 2016 to April 30, 2017. The MCO received a total of four (4) mandatory improvements for the QAE and four (4) “not met” determinations for the TCA.

Performance Improvement Projects

The following PIP was in progress:

- ***Antidepressant Medication Management with a Special Focus on Racial/Ethnic Disparities, F&C-MA (2015-2017)*** – The goal for this PIP was to increase, by 6 percentage points, the HEDIS *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure rate for the F&C-MA population. **Table 27** displays the MCO’s rates for this PIP.

Table 27: PrimeWest Rates for the 2015-2017 PIP

HEDIS Year	All
2013	34.43%
2014	37.43%
Baseline	35.89%
2015	39.63%
2016	37.17%
2017	37.92%
Net Change	+2.03

Member-focused interventions included:

- Health coaches identified members who were late with filling prescriptions and called these members each week to provide assistance, encourage follow-up appointments and medication adherence, provide general health education, and address barriers for members.
- If health coaches could not reach members by phone, reminder letters were mailed on a weekly basis. These letters contained information on coping with side effects, follow-up visits, adherence, etc., as well as a number to call with questions.

Provider-focused interventions included:

- Creation of a toolkit for all providers, including pharmacists, to be distributed electronically, containing resources including: how to approach depression, motivational interviewing techniques, and cultural considerations.
- Providers received a letter when members missed a prescription fill. MCO staff also reached out to providers after health coach calls to members were made to coordinate care between providers, pharmacies, and the MCO.

Community-focused interventions included:

- General community outreach was conducted, including public service announcement postings, training opportunities, website postings, etc., as needed.

2017 Financial Withhold

PrimeWest achieved 60.62 points (of 105 points) for the F&C-MA and MNCare programs, 83.75 points (of 90 points) for the MSHO and MSC+ programs, and 48.52 points (of 60 points) for the SNBC program. **Table 28** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by PrimeWest.

Table 28: PrimeWest 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-64 Years	15	0.62
Well-Child Visits in the First 15 Months of Life	15	0
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	0
Hospital 30-Day Readmission Rate	15	15
Total	105	60.62
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	8.75
Total	90	83.75
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	3.52
Total	60	48.52

Annual Quality Assurance Work Plan for 2017

PrimeWest submitted an annual QA work plan compliant with Minnesota Administrative Rule 4685.1130. The work plan clearly outlines each project’s scope, objectives, responsible persons, and timelines to achieve project goals. The work plan also delineates when projects are in development, and when data will be collected, aggregated, reported, and analyzed. The work plan covers a variety of topics, including quality of services, availability of practitioners, accessibility of services, member experience, quality of clinical care, safety of clinical care, utilization management, and quality program administration. Additionally, the MCO clearly denotes activities that affect the safety of its members.

Evaluation of the 2017 Annual Quality Assessment and Performance Improvement Program

PrimeWest’s QI program is designed around several goals, including, but not limited to, the following: achieve higher member satisfaction; improve quality of care, care outcomes, and population health; reduce health care spending; and develop an organizational culture that focuses on core values, performance excellence, teamwork, and shared success. The QI program includes activities aimed at improving clinical components; aspects of the MCO that affect accessibility, availability,

comprehensiveness, and continuity of health care; and member perceptions of quality of services. The MCO's Quality and Care Coordination Committee develops a quality plan and work plan each year in order to carry out quality improvement activities through the program. The MCO's governing body, the JPB, approves the plans.

The MCO engaged in several activities throughout the year in order to improve health outcomes for its members. The MCO saw improvement in some areas and identified additional areas with opportunities for improvement. The MCO continues to work with its community partners in order to achieve the goals of the QI program. Several areas in which the MCO focused its efforts include antidepressant medication management, combating obesity, reducing tobacco use, increasing check-ups for children and teenagers, assessing members for exposure to violence, and reducing low birth weight births. For 2018, the MCO will begin working on reducing opioid use among its members, as well.

MCO Clinical Practice Guidelines

PrimeWest recognizes the following source for clinical practice guidelines:

- AHRQ
 - Treating tobacco use and dependence
- AACAP
 - Assessment and treatment of children and adolescents with attention deficit hyperactivity disorder
 - Assessment and treatment of children and adolescents with depressive disorders
- ACCF/AHA
 - Management of patients with chronic heart failure
- ADA
 - Standards of medical care in diabetes
- APA
 - Pharmacological treatment of patients with alcohol use disorder
- CDC
 - Immunization schedule for adults
 - Child and adolescent immunization schedules
- ICSI
 - Diagnosis and management of chronic obstructive pulmonary disease
 - Treating adult depression
- NHLBI
 - Diagnosis and management of asthma
- USPSTF
 - Preventive services for adults, including breast cancer, cervical cancer, chlamydia screening and BMI assessment
- ACOG
 - Preconception, prenatal and postpartum care

- Journal of the American College of Cardiology (JACC)
 - Prevention, detection, evaluation and management of high blood pressure in adults

HEDIS and CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 29** and **Table 30**, respectively, while **Figure 9** displays the HEDIS Measure Matrix.

Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	PrimeWest Health HEDIS 2016	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	32.1%	44.8%	59.6%	66.67 th	42.4%
Adult BMI Assessment ¹	84.9%	79.3%	90.0%	50 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	85.0%	87.0%	85.3%	75 th	83.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	85.9%	88.2%	87.4%	50 th	87.2%
Annual Dental Visit ²	No Data	No Data	50.9%	25 th	47.1%
Breast Cancer Screening (50-64 Years) ²	65.0%	65.5%	69.4%	90 th	63.1%
Cervical Cancer Screening (24-64 Years) ²	56.0%	57.0%	57.1%	33.33 rd	58.9%
Childhood Immunization Status: Combo 3 (2 Years) ¹	68.9%	66.9%	64.7%	10 th	73.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	95.2%	95.7%	95.4%	33.33 rd	96.6%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	89.9%	89.1%	87.7%	50 th	90.2%
Children and Adolescents' Access to PCPs (7-11 Years) ²	91.2%	91.7%	92.2%	50 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	93.6%	93.1%	93.7%	75 th	93.1%
Chlamydia Screening in Women (16-24 Years) ²	37.3%	40.4%	39.9%	<10 th	52.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	69.0%	69.6%	72.5%	95 th	65.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	90.1%	92.1%	89.4%	66.67 th	90.9%
Controlling High Blood Pressure ¹	62.5%	62.0%	68.6%	75 th	67.0%
Medication Management for People With Asthma – 50% (5-64 Years) ²	66.2%	67.9%	76.1%	No Benchmark	63.9%
Medication Management for People With Asthma – 75% (5-64 Years) ²	43.9%	45.1%	55.4%	90 th	41.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	61.6%	58.0%	60.3%	25 th	63.8%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	58.2%	56.9%	56.7%	<10 th	63.6%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	PrimeWest Health HEDIS 2016	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	19.0%	43.8%	56.4%	50 th	28.9%
Adult BMI Assessment ¹	87.3%	83.7%	88.6%	50 th	91.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	78.3%	85.0%	85.8%	75 th	82.1%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	86.4%	89.0%	89.9%	75 th	88.0%
Annual Dental Visit ²	No Data	No Data	44.9%	10 th	39.2%
Breast Cancer Screening (50-64 Years) ²	68.0%	72.4%	76.1%	95 th	70.2%
Cervical Cancer Screening (24-64 Years) ²	48.9%	53.9%	58.5%	33.33 rd	56.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	96.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	90.2%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	89.6%
Chlamydia Screening in Women (16-24 Years) ²	37.9%	41.5%	42.0%	<10 th	51.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	66.9%	74.6%	80.6%	95 th	70.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	90.0%	94.1%	89.2%	50 th	94.6%
Controlling High Blood Pressure ¹	70.4%	63.4%	74.3%	95 th	72.5%
Medication Management for People With Asthma – 50% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	71.7%
Medication Management for People With Asthma – 75% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	49.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	Small Sample	Small Sample	Small Sample	Not Applicable	59.7%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology

Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	PrimeWest Health HEDIS 2016	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MSHO	-	-	-	-	-
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.8%	99.4%	99.1%	95 th	98.3%
Breast Cancer Screening (65-74 Years) ²	66.5%	64.6%	64.5%	75 th	61.1%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	83.5%	75.7%	79.7%	95 th	79.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	95.2%	94.1%	94.4%	95 th	95.2%
MSC+	-	-	-	-	-
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	95.0%	97.4%	97.6%	95 th	93.3%
Breast Cancer Screening (65-74 Years) ²	57.5%	61.8%	54.9%	33.33 rd	41.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	89.7%	88.9%	83.1%	10 th	76.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	PrimeWest Health HEDIS 2016	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
SNBC					
Adult BMI Assessment ¹ (SNP)	87.6%	93.8%	97.9%	95 th	96.4%
Adult BMI Assessment ¹ (Non-SNP)	84.5%	87.8%	92.5%	75 th	92.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	91.0%	90.0%	92.2%	95 th	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	96.5%	94.8%	96.0%	95 th	96.4%
Breast Cancer Screening (50-64 Years) ²	66.2%	61.6%	58.0%	33.33 rd	51.0%
Cervical Cancer Screening (24-64 Years) ²	46.1%	45.7%	45.2%	<10 th	46.4%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	45.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (SNP)	85.0%	89.7%	92.5%	95 th	79.0%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	68.6%	67.2%	64.4%	75 th	71.4%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (SNP)	95.0%	86.2%	92.5%	75 th	95.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Year) ¹ (Non-SNP)	85.7%	88.2%	83.5%	10 th	92.5%
Controlling High Blood Pressure ¹ (SNP)	73.5%	74.0%	85.7%	95 th	71.4%
Controlling High Blood Pressure ¹ (Non-SNP)	67.1%	61.4%	71.3%	90 th	72.9%
Medication Management for People With Asthma – 50% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	69.4%
Medication Management for People With Asthma – 75% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	48.2%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 9: PrimeWest 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> Controlling High Blood Pressure (F&C-MA, MNCare) 	A <ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA)
	D <ul style="list-style-type: none"> Cervical Cancer Screening (F&C-MA) Comprehensive Diabetes Care – HbA1c Testing (SNBC Non-SNP) Chlamydia Screening in Women (F&C-MA) Childhood Immunization Status – Combo 3 (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	C <ul style="list-style-type: none"> Breast Cancer Screening (MSHO, MNCare) Controlling High Blood Pressure (SNBC Non-SNP) Cervical Cancer Screening (MNCare, SNBC) Comprehensive Diabetes Care – Eye Exam (MSHO, SNBC Non-SNP) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSC+, MSHO, MNCare, SNBC SNP) Chlamydia Screening in Women (MNCare) Well-Child Visits in the First 15 Months of Life (F&C-MA) 	B <ul style="list-style-type: none"> Annual Dental Visit (MNCare) Adolescent Well-Care Visit (MNCare) Breast Cancer Screening (F&C-MA, MSC+, SNBC) Controlling High Blood Pressure (SNBC SNP) Comprehensive Diabetes Care – Eye Exam (F&C-MA, MNCare, SNBC SNP) Medication Management for People with Asthma-50% (F&C-MA) 	
	F	D	C <ul style="list-style-type: none"> Annual Dental Visit (F&C-MA) 	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 30: PrimeWest CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	PrimeWest CAHPS 2016	PrimeWest CAHPS 2017	PrimeWest CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Getting Needed Care*	48%	53%	54%	25 th	54%
Getting Care Quickly*	54%	58%	56%	25 th	58%
How Well Doctors Communicate*	81%	80%	83%	90 th	81%
Customer Service*	73%	64%	73%	90 th	67%
Shared Decision Making*	80%	86%	79%	Benchmark Unavailable	82%
Rating of All Health Care**	47%	51%	55%	50 th	54%
Rating of Personal Doctor**	67%	69%	70%	75 th	71%
Rating of Specialist Seen Most Often**	63%	57%	64%	25 th	70%
Rating of Health Plan**	52%	54%▼	60%	50 th	60%
MNCare					
Getting Needed Care*	58%	65%	50%	10 th	54%
Getting Care Quickly*	62%▲	64%	61%	50 th	61%
How Well Doctors Communicate*	79%	78%	76%	50 th	81%
Customer Service*	62%	61%	64%	25 th	67%
Shared Decision Making*	84%	87%	84%	Benchmark Unavailable	84%
Rating of All Health Care**	54%	54%	52%	25 th	54%
Rating of Personal Doctor**	71%	64%	69%	75 th	70%
Rating of Specialist Seen Most Often**	71%	64%	66%	50 th	68%
Rating of Health Plan**	53%	53%	54%	25 th	55%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Table 30: PrimeWest CAHPS Performance – 2016, 2017 and 2018 (Continued)

CAHPS Measures	PrimeWest CAHPS 2016	PrimeWest CAHPS 2017	PrimeWest CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
MSC+					
Getting Needed Care*	63%▲	64%	61%▲	90 th	56%
Getting Care Quickly*	67%▲	67%	76%▲	90 th	62%
How Well Doctors Communicate*	76%	75%	80%▲	90 th	77%
Customer Service*	78%▲	77%	75%▲	90 th	66%
Shared Decision Making*	77%	77%	78%	Benchmark Unavailable	77%
Rating of All Health Care**	63%	66%	60%	90 th	60%
Rating of Personal Doctor**	71%	75%	77%▲	90 th	75%
Rating of Specialist Seen Most Often**	69%	74%	73%	90 th	71%
Rating of Health Plan**	65%	71%	72%▲	90 th	66%
SNBC					
Getting Needed Care*	57%▲	53%	58%▲	50 th	55%
Getting Care Quickly*	58%	58%	59%	25 th	60%
How Well Doctors Communicate*	75%	73%	82%	90 th	78%
Customer Service*	73%▲	67%	78%▲	90 th	69%
Shared Decision Making*	82%	77%	84%	Benchmark Unavailable	80%
Rating of All Health Care**	49%	51%	60%	90 th	54%
Rating of Personal Doctor**	71%	70%	75%	90 th	72%
Rating of Specialist Seen Most Often**	69%	63%	69%	75 th	67%
Rating of Health Plan**	58%	54%	68%▲	90 th	62%

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Strengths

- **NCQA Accreditation Survey** – PrimeWest achieved NCQA accreditation for the F&C-MA and MNCare programs.
- **CAHPS (Member Satisfaction)** – PrimeWest performed well in the following areas of member satisfaction:
 - MSC+
 - *Getting Needed Care*
 - *Getting Care Quickly*
 - *How Well Doctors Communicate*
 - *Customer Service*
 - *Rating of Personal Doctor*
 - *Rating of Health Plan*
 - SNBC
 - *Getting Needed Care*
 - *Customer Service*
 - *Rating of Health Plan*

Opportunities for Improvement

- **QAE** – PrimeWest was not fully compliant with the contractual standards reviewed for the QAE. PrimeWest received four (4) mandatory improvements.
- **TCA** – PrimeWest was not fully compliant with the contractual standards reviewed for the TCA. PrimeWest received four (4) “not met” determinations.
- **Financial Withhold** – PrimeWest did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age 2-64 Years
 - Well-Child Visits in the First 15 Months of Life
 - Hospital Admission Rate
 - MSHO and MSC+
 - Annual Dental Visit: Age 65 Years and Older
 - SNBC
 - Annual Dental Visit: Age 19-64 Years
- **HEDIS (Quality of Care)** – PrimeWest demonstrates an opportunity for improvement in the following areas of care:
 - F&C-MA
 - *Cervical Cancer Screening*
 - *Chlamydia Screening in Women*
 - *Childhood Immunization Status: Combo 3*
 - *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*

- SNBC (Non-SNP)
 - *Comprehensive Diabetes Care – HbA1c Testing*

Recommendations

- **Financial Withhold** – In regard to dental care, PrimeWest should continue with the robust quality improvement strategy described in its response to the previous year’s recommendation. Initiatives should be routinely monitored for effectiveness. PrimeWest should ensure that reducing hospital admissions and the increasing well-child visits are maintained as organizational priorities and that successful interventions continue.
- **HEDIS (Quality of Care)** – In regard to women’s health and child health, PrimeWest should continue with its “five-year strategic plan” for organization-wide improvement. PrimeWest should ensure that diabetes care is included in its strategic plan as well.

SOUTH COUNTRY HEALTH ALLIANCE

Corporate Profile

South Country Health Alliance (SCHA) is a partnership of eleven (11) Minnesota counties formed in 2001 as a CBP. SCHA participates in the F&C-MA, MNCare, MSC+, MSHO and SNBC programs. As of December 2017, enrollment totaled 41,704, accounting for 4% of the entire MHCP population. **Table 31** displays SCHA's enrollment as of December 2017.

Table 31: SCHA Enrollment as of December 2017

Program	Enrollment (as of December 2017)
F&C-MA	32,601
MNCare	3,562
MSC+	878
MSHO	1,785
SNBC	2,878
Total Enrollment	41,704

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on May 16, 2016 through May 20, 2016. The examination period covered May 1, 2013 to February 29, 2016, while the file review period covered March 1, 2015 to February 29, 2016. The MCO received one (1) "not met" for the TCA and a total of two (2) recommendations, three (3) mandatory improvements, and three (3) deficiencies for the QAE.

Performance Improvement Projects

The following PIP was in progress:

- ***Elimination of Racial and Ethnic Disparities in the Management of Depression (2015-2017)*** – The goal of this PIP was to improve the rate of compliance with antidepressant medications among both White and non-White members, thereby supporting efforts to eliminate racial and ethnic disparities in the treatment of depression. Specifically, the goal was to increase, by 6 percentage points, the overall F&C-MA and MNCare HEDIS *Antidepressant Medication Management – Effective Continuation Phase Treatment* rate for all members. **Table 32** displays the MCO's performance rates for this PIP.

Table 32: SCHA Performance Rates for the 2015-2017 PIP

HEDIS Year	All
2013/2014	33.60%
2015	37.64%
2016	38.84%
2017	40.38%
Net Change	+6.78

Member-focused interventions included:

- Targeted, personalized mailings to identified members concerning: general education about the importance of follow up (one month), medication adherence and a reminder to continue (three months), and offering these members continued support in following treatment plans (six months).
- Call center conducted telephonic outreach to remind members to fill prescriptions, to provide education and to address barriers for members. A script was developed, which included talking points aimed at follow-up appointments and medication adherence. Interpreter services were made available.

Provider-focused interventions included:

- Contacting high-volume pharmacies to inform them of the project, to offer assistance and resources to support adherence, to determine which pharmacies have language services and which do not, and to offer information regarding telephonic interpreter services.
- Identifying prescribing physicians and network clinic systems to collaborate on depression care and best practices, as well as to share pharmacy claims data with providers regarding adherence.

MCO-focused interventions included:

- Obtaining a cultural competency training series via a vendor and making it available for all Member Services and Health Services staff.

2017 Financial Withhold

SCHA achieved 64.62 points (of 105 points) for the F&C-MA and MNCare programs, 75 points (of 90 points) for the MSHO and MSC+ programs and 45 points (of 60 points) for the SNBC program. **Table 33** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by SCHA.

Table 33: SCHA 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-64 Years	15	4.62
Well-Child Visits in the First 15 Months of Life	15	0
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	0
Hospital 30-Day Readmission Rate	15	15
Total	105	64.62
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0
Total	90	75
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	0
Total	60	45

Annual Quality Assurance Work Plan for 2017

SCHA submitted a QA plan compliant with Minnesota Administrative Rule 4685.1130. The work plan describes each improvement activity in terms of goals, objectives, actions and tasks to be taken, resources, responsible staff, timeline, status, and progress. SCHA’s work plan covers a variety of topics, including policies and procedures, delegation oversight, customer service, CAHPS, care coordination, grievances and appeals, and several other clinical and service areas.

Evaluation of the 2017 Annual Quality Assessment and Performance Improvement Program

SCHA’s QI program guides the formal process for evaluating and improving the quality and appropriateness of health care services and health status of the population served. SCHA’s mission is to empower and engage members, build connections with local agencies and providers, and be an accountable partner to the counties served. The QI program is guided by the MCO’s Diamond Values, which include collaboration, stewardship, communication, and excellence. The QI program has several established goals, including: establishing effective partnerships with providers committed to quality care; establishing and measuring performance expectations; improving the clinical and functional outcomes of members; improving member satisfaction; ensuring appropriate access; and meeting or

exceeding regulatory requirements. The scope of the QI program includes clinical, organizational, and member components.

The QI program description is evaluated for appropriateness and effectiveness by the JPB, with input from the Quality Assurance Committee. During the evaluation process, the following information is used to determine effectiveness: descriptions of completed and ongoing activities, trending of measures; and analysis and evaluation of the overall effectiveness and progress of the program, as well as evaluations and recommendations from regulatory agencies and external quality review organizations.

MCO Clinical Practice Guidelines

SCHA recognizes the following sources for clinical practice guidelines:

- USPSTF
 - Preventive services for adults
 - Preventative services for children and adolescents
- AAFP
 - Prenatal Care
- ICSI
 - Diabetes, Type 2
 - Asthma
 - Hypertension diagnosis and treatment
 - Depression in adults
- AACAP
 - Children and adolescents with attention-deficit hyperactivity disorder

HEDIS and CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 34** and **Table 35**, respectively, while **Figure 10** displays the HEDIS Measure Matrix.

Table 34: SCHA HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	SCHA HEDIS 2016	SCHA HEDIS 2017	SCHA HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	43.5%	37.3%	38.4%	10 th	42.4%
Adult BMI Assessment ¹	88.9%	85.2%	88.8%	50 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	83.1%	86.5%	84.7%	75 th	83.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	85.2%	87.2%	85.9%	33.33 rd	87.2%
Annual Dental Visit ²	No Data	No Data	46.3%	10 th	47.1%
Breast Cancer Screening (50-64 Years) ²	61.7%	68.1%	68.5%	75 th	63.1%
Cervical Cancer Screening (24-64 Years) ²	55.5%	59.5%	60.1%	50 th	58.9%
Childhood Immunization Status: Combo 3 (2 Years) ¹	77.7%	79.4%	76.9%	75 th	73.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	96.7%	96.0%	97.2%	75 th	96.6%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	90.4%	90.8%	89.5%	66.67 th	90.2%
Children and Adolescents' Access to PCPs (7-11 Years) ²	91.5%	92.3%	92.5%	66.67 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	93.1%	93.1%	93.6%	75 th	93.1%
Chlamydia Screening in Women (16-24 Years) ²	47.1%	45.7%	46.1%	10 th	52.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	64.7%	64.0%	66.1%	50 th	65.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	93.8%	92.6%	92.3%	75 th	90.9%
Controlling High Blood Pressure ¹	65.9%	60.6%	65.2%	66.67 th	67.0%
Medication Management for People With Asthma – 50% (12-64 Years) ²	63.7%	67.3%	68.8%	No Benchmark	63.9%
Medication Management for People With Asthma – 75% (12-64 Years) ²	45.1%	44.2%	47.7%	75 th	41.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	62.9%	63.9%	64.7%	33.33 rd	63.8%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	62.6%	64.4%	62.1%	10 th	63.6%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 34: SCHA HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	SCHA HEDIS 2016	SCHA HEDIS 2017	SCHA HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	32.4%	27.8%	28.1%	<10 th	28.9%
Adult BMI Assessment ¹	90.0%	83.1%	88.3%	33.33 rd	91.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	77.4%	81.9%	81.9%	66.67 th	82.1%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	84.4%	88.1%	87.9%	50 th	88.0%
Annual Dental Visit ²	No Data	No Data	35.7%	<10 th	39.2%
Breast Cancer Screening (50-64 Years) ²	68.9%	70.9%	71.4%	90 th	70.2%
Cervical Cancer Screening (24-64 Years) ²	49.5%	53.8%	54.1%	10 th	56.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	No Data	Small Sample	Small Sample	Not Applicable	96.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	90.2%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	89.6%
Chlamydia Screening in Women (16-24 Years) ²	49.2%	64.1%	50.0%	10 th	51.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	57.5%	63.3%	61.0%	50 th	70.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	95.3%	96.7%	96.5%	95 th	94.6%
Controlling High Blood Pressure ¹	74.2%	66.8%	69.6%	75 th	72.5%
Medication Management for People With Asthma – 50% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	71.7%
Medication Management for People With Asthma – 75% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	49.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	Small Sample	Small Sample	Small Sample	Not Applicable	59.7%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 34: SCHA HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	SCHA HEDIS 2016	SCHA HEDIS 2017	SCHA HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	97.8%	98.0%	97.9%	95 th	98.3%
Breast Cancer Screening (65-74 Years) ²	65.6%	67.9%	70.6%	90 th	61.1%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	75.0%	81.7%	73.9%	95 th	79.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	93.9%	95.9%	96.4%	95 th	95.2%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	92.3%	93.0%	94.8%	90 th	93.3%
Breast Cancer Screening (65-74 Years) ²	50.4%	52.6%	52.6%	25 th	41.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	80.5%	85.9%	85.8%	25 th	76.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 34: SCHA HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	SCHA HEDIS 2016	SCHA HEDIS 2017	SCHA HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
SNBC					
Adult BMI Assessment ¹ (SNP)	95.1%	91.2%	96.4%	95 th	96.4%
Adult BMI Assessment ¹ (Non-SNP)	93.1%	85.6%	89.5%	50 th	92.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	93.3%	95.4%	93.0%	95 th	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	97.4%	97.2%	97.6%	95 th	96.4%
Breast Cancer Screening (50-64 Years) ²	72.5%	71.0%	70.0%	90 th	51.0%
Cervical Cancer Screening (24-64 Years) ²	48.5%	49.7%	50.5%	10 th	46.4%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	45.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (SNP)	86.2%	82.2%	85.1%	95 th	79.0%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	68.7%	71.1%	70.8%	90 th	71.4%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (SNP)	96.9%	95.8%	97.9%	95 th	95.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	96.6%	95.4%	93.1%	90 th	92.5%
Controlling High Blood Pressure ¹ (SNP)	88.5%	87.0%	83.0%	95 th	71.4%
Controlling High Blood Pressure ¹ (Non-SNP)	75.1%	71.2%	72.0%	90 th	72.9%
Medication Management for People With Asthma – 50% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	69.4%
Medication Management for People With Asthma – 75% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	48.2%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 10: SCHA 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B	A
	D	<ul style="list-style-type: none"> ▪ Annual Dental Visit (MNCare) ▪ Comprehensive Diabetes Care – Eye Exam (MNCare) ▪ Chlamydia Screening in Women (F&C-MA) 	<ul style="list-style-type: none"> ▪ Adolescent Well-Care Visit (F&C-MA, MNCare) ▪ Breast Cancer Screening (MNCare) ▪ Controlling High Blood Pressure (F&C-MA, MNCare, SNBC Non-SNP) ▪ Cervical Cancer Screening (F&C-MA, MNCare) ▪ Comprehensive Diabetes Care – Eye Exam (F&C-MA, SNBC Non-SNP, SNBC SNP) ▪ Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSHO, MNCare, SNBC Non-SNP, SNBC SNP) ▪ Chlamydia Screening in Women (MNCare) ▪ Childhood Immunization Status – Combo 3 (F&C-MA) ▪ Medication Management for People with Asthma-50% (F&C-MA) ▪ Medication Management for People with Asthma-75%(F&C-MA) ▪ Well-Child Visits in the First 15 Months of Life (F&C-MA) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	<ul style="list-style-type: none"> ▪ Breast Cancer Screening (F&C-MA, MSC+, MSHO, SNBC) ▪ Controlling High Blood Pressure (SNBC SNP) ▪ Cervical Cancer Screening (SNBC) ▪ Comprehensive Diabetes Care – HbA1c Testing (MSC+)
	F	<ul style="list-style-type: none"> ▪ Annual Dental Visit (F&C-MA) 	D	C
				D

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 35: SCHA CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	SCHA CAHPS 2016	SCHA CAHPS 2017	SCHA CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Getting Needed Care*	47%	56%	55%	25 th	54%
Getting Care Quickly*	54%	58%	62% ▲	75 th	58%
How Well Doctors Communicate*	83%	82%	81%	90 th	81%
Customer Service*	73%	66%	76% ▲	90 th	67%
Shared Decision Making*	77%	86%	86%	Benchmark Unavailable	82%
Rating of All Health Care**	46% ▼	49%	54%	50 th	54%
Rating of Personal Doctor**	66%	74%	69%	75 th	71%
Rating of Specialist Seen Most Often**	58%	64%	68%	50 th	70%
Rating of Health Plan**	54%	62%	62%	75 th	60%
MNCare					
Getting Needed Care*	58%	65%	50%	10 th	54%
Getting Care Quickly*	62% ▲	64%	61%	50 th	61%
How Well Doctors Communicate*	79%	78%	76%	50 th	81%
Customer Service*	62%	61%	64%	25 th	67%
Shared Decision Making*	84%	87%	84%	Benchmark Unavailable	84%
Rating of All Health Care**	54%	54%	52%	25 th	54%
Rating of Personal Doctor**	71%	64%	69%	75 th	70%
Rating of Specialist Seen Most Often**	71%	64%	66%	50 th	68%
Rating of Health Plan**	53%	53%	54%	25 th	55%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Table 35: SCHA CAHPS Performance – 2016, 2017 and 2018 (Continued)

CAHPS Measures	SCHA CAHPS 2016	SCHA CAHPS 2017	SCHA CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
MSC+					
Getting Needed Care*	63%▲	64%	61%▲	90 th	56%
Getting Care Quickly*	67%▲	67%	76%▲	90 th	62%
How Well Doctors Communicate*	76%	75%	80%▲	90 th	77%
Customer Service*	78%▲	77%	75%▲	90 th	66%
Shared Decision Making*	77%	77%	78%	Benchmark Unavailable	77%
Rating of All Health Care**	63%	66%	60%	90 th	60%
Rating of Personal Doctor**	71%	75%	77%▲	90 th	75%
Rating of Specialist Seen Most Often**	69%	74%	73%	90 th	71%
Rating of Health Plan**	65%	71%	72%▲	90 th	66%
SNBC					
Getting Needed Care*	57%▲	53%	58%▲	50 th	55%
Getting Care Quickly*	57%	58%	59%	25 th	60%
How Well Doctors Communicate*	75%	73%	82%	90 th	78%
Customer Service*	73%▲	67%	78%▲	90 th	69%
Shared Decision Making*	82%	77%	84%	Benchmark Unavailable	80%
Rating of All Health Care**	49%	51%	60%	90 th	54%
Rating of Personal Doctor**	71%	70%	75%	90 th	72%
Rating of Specialist Seen Most Often**	69%	63%	69%	75 th	67%
Rating of Health Plan**	58%	54%	68%▲	90 th	62%

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Strengths

- **CAHPS (Member Satisfaction)** – SCHA performed well in regard to the following areas of member satisfaction:
 - F&C-MA
 - *Getting Care Quickly*
 - *Customer Service*
 - MSC+
 - *Getting Needed Care*
 - *Getting Care Quickly*
 - *How Well Doctors Communicate*
 - *Customer Service*
 - *Rating of Personal Doctor*
 - *Rating of Health Plan*
 - SNBC
 - *Getting Needed Care*
 - *Customer Service*
 - *Rating of Health Plan*

Opportunities for Improvement

- **QAE** – SCHA was not fully compliant with the contractual standards reviewed for the QAE. SCHA received a total of two (2) recommendations, three (3) mandatory improvements, and three (3) deficiencies.
- **TCA** – SCHA was not fully compliant with the contractual standards reviewed for the TCA. SCHA received a total of one (1) “not met”.
- **Financial Withhold** – SCHA did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age 2-64 Years
 - Well-Child Visits in the First 15 Months of Life
 - Hospital Admission Rate
 - MSHO and MSC+
 - Annual Dental Visit: Age 65 Years and Older
 - SNBC
 - Annual Dental Visit: Age 19-64 Years
- **HEDIS (Quality of Care)** – SCHA demonstrates an opportunity for improvement in the following areas of care:
 - F&C-MA
 - *Annual Dental Visit*
 - *Chlamydia Screening in Women*

- MNCare
 - *Annual Dental Visit*
 - *Comprehensive Diabetes Care – Eye Exam*
- MSHO
 - *Comprehensive Diabetes Care – Eye Exam*

Recommendations

- **Financial Withhold –**
 - As dental care continues to be an area of concern across all programs, SCHA should routinely evaluate the effectiveness of the improvement strategy described in its response to the previous year’s recommendation and modify the approach as needed. SCHA should continue to address access and also consider non-traditional ways of increasing access. For remote areas of the state, SCHA should consider the use of mobile dental services, or hosting local dental fairs where members can receive care, or contracting with bordering out-of-state dental providers.
 - As well-child visits in the first 15 months trends upward, SCHA should continue with the improvement strategy described in its response to the previous year’s recommendation. SCHA should enhance this strategy by including member education on the importance of well-care visits and the components of the well-care visit for each age.
 - SCHA should investigate the increase in hospital admissions and consider implementing a robust strategy that includes member education, member support for scheduling primary care appointments, member transportation to primary care appointments, urgent care resources, etc.
- **HEDIS (Quality of Care) –** Overall, SCHA should continue with the initiatives described in its response to the previous year’s recommendation. In addition, SCHA should investigate the notable decline in diabetic eye exams in the MSHO program and consider ways to expand the chlamydia screening improvement strategy.

UCARE

Corporate Profile

UCare is an independent, non-profit MCO founded in 1984 by the Department of Family Practice at the University of Minnesota Medical School. UCare serves enrollees in the F&C-MA, MNCare, MSC+, MSHO and SNBC programs. As of December 2017, enrollment totaled 273,811, accounting for 29% of the entire MHCP population. **Table 36** displays UCare’s enrollment as of December 2017.

Table 36: UCare Enrollment as of December 2017

Program	Enrollment (as of December 2017)
F&C-MA	202,343
MNCare	27,610
MSC+	4,429
MSHO	11,860
SNBC	27,569
Total Enrollment	273,811

Source: Minnesota Health Care Enrollment Totals December 2017 Report

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on March 14, 2016 through March 18, 2016. The examination period covered July 1, 2013 to November 30, 2015, while the file review period covered December 1, 2014 to November 30, 2015. The MCO received one (1) “Not Met” for the TCA and a total of three (3) recommendations, two (2) mandatory improvements, and six (6) deficiencies on the QAE.

Performance Improvement Projects

The following PIP was in progress:

- ***Elimination of Race and Ethnic Disparities in the Management of Depression (2015-2017)*** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Medica, MHP, and UCare. The goal for this PIP was to increase, by 6 percentage points, the HEDIS *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure rate for non-White F&C-MA and MNCare members. **Table 37** displays the MCO’s performance rates for this PIP.

Table 37: UCare Performance Rates for the 2015-2017 PIP

HEDIS Year	All
2014	23.08%
2015	16.67%
2016	18.75%
2017	23.91%
Net Change	+0.83

Member-focused interventions included:

- Telephonic outreach to members regarding education on depression, medications and their side effects, and symptoms, in addition to checking in with members on medication adherence, assisting in scheduling follow-up appointments, and referring members to behavioral health services, as needed.
- Through Beacon Health Strategies, a behavioral health delegate, the development of a health coaching program which consisted of an initial health coach phone call to offer enrollment in the program. If members agreed to enroll, they received educational materials, such as a depression brochure (available in English and Spanish), a list of resources and contact information, and support for medication adherence.

Provider-focused interventions included:

- In collaboration with other MCOs, development of training opportunities on cultural issues related to depression diagnosis and treatment. These were available to primary and specialty care providers, pharmacists, clinical nurses, etc.
- In collaboration with other MCOs, development of a provider toolkit aimed at patient education, which included resources, such as information on pharmacies that have the ability to print medication labels in different languages.
- Partnering with pharmacies to employ MTM. MTM included: pharmacists review of members' medications, identifying and synchronizing medications on a 30-day schedule, pharmacists consulting with members and physicians, etc.

Community-focused interventions included:

- A community event to create awareness during Minority Mental Health Month in July.
- Partnerships with organizations such as the NAMI-MN, religious groups, targeted clinics, etc. to raise awareness of depression.
- Sharing depression resources at local health fairs.
- Promoting culturally specific community events related to depression and mental health.

2017 Financial Withhold

UCare achieved 89.08 points (of 105 points) for the F&C-MA and MNCare programs, 75 points (of 90 points) for the MSHO and MSC+ programs and 47.38 points (of 60 points) for the SNBC program. **Table 38** displays the results of the 2017 Financial Withhold, including performance measures, point values, and points earned by UCare.

Table 38: UCare 2017 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-64 Years	15	14.08
Well-Child Visits in the First 15 Months of Life	15	15
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	15	0
Total	105	89.08
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0
Total	90	75
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	2.38
Total	60	47.38

Annual Quality Assurance Work Plan for 2017

UCare’s annual QA work plan was compliant with Minnesota Administrative Rule 4685.1130. QA activities are categorized into five focus areas: administrative, member experience, quality of clinical care, quality of service, and safety of clinical care. The work plan lays out each activity planned in a comprehensive and concise manner. For each activity, the MCO defines the focus area, the activity, which populations the activity applies to, annual objectives, planned activities, and the owner of the project. Additionally, the MCO identified the regulatory requirements for each activity, the report in which the results would be reported, and which MCO committees would be involved. The QA work plan was approved by the Quality Improvement Committee and the Quality Improvement Advisory and Credentialing Committee.

Evaluation of the 2017 Annual Quality Assessment and Performance Improvement Program

UCare’s quality program is a formal process to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service. The quality program utilizes a multi-dimensional approach and promotes accountability of all employees and affiliated personnel to be responsible for the quality of care and services provided to enrollees. The goals of the

program include, but are not limited to: maintaining NCQA accreditation; continuing to focus on maintaining and improving member health; coordination of quality improvement activities across all products to achieve efficiency and remove duplicative work; continuous improvement of quality, appropriateness, availability, accessibility, coordination, and continuity of health care; defining, demonstrating, and communicating the organization-wide commitment to quality improvement; fostering partnerships across stakeholders to promote effective health management and education, as well as encouraging appropriate use of health services; improving member outcomes, satisfaction, and safety; and collaboration with providers to share idea and implement improvement strategies. The quality program is overseen by the Board of Directors, which delegates activities to various committees, including, but not limited to, the Quality Improvement Advisory and Credentialing Committee, The Medical Management Committee, and the Quality Improvement Committee.

Many of UCare's Quality Program goals were achieved. Improvement was achieved in many areas, such as CAHPS results, medical record requirements, member safety, and appeals and grievances. Any activity that did not achieve established goals was considered for continuation into the following year.

MCO Clinical Practice Guidelines

UCare recognizes the following sources for clinical practice guidelines:

- Global Initiative for Asthma
 - Diagnosis and management of asthma
- ADA
 - Diagnosis and management of type 2 diabetes
- JACC
 - Management of heart failure in adults
- AAFP
 - Prevention and management of obesity in adults
 - Prenatal care
 - Preventive services for adults
- AAP
 - Preventive services for children and adolescents
- AACAP
 - Assessment and treatment of children with attention-deficit hyperactivity disorder
 - Assessment and treatment of children and adolescents with depressive disorders
- APA
 - Treatment of patients with major depressive disorder
 - Treatment of patients with schizophrenia
 - Treatment of patients with substance use disorders

HEDIS and CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 39** and **Table 40**, respectively, while **Figure 11** displays the HEDIS Measure Matrix.

Table 39: UCare HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures	UCare HEDIS 2016	UCare HEDIS 2017	UCare HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	41.1%	37.0%	32.4%	<10 th	42.4%
Adult BMI Assessment ¹	88.8%	85.6%	91.7%	66.67 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	84.0%	81.6%	79.8%	50 th	83.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	86.9%	86.0%	83.8%	25 th	87.2%
Annual Dental Visit ²	No Data	No Data	53.3%	33.33 rd	47.1%
Breast Cancer Screening (50-74 Years) ²	63.7%	60.4%	56.5%	33.33 rd	63.1%
Cervical Cancer Screening (24-64 Years) ²	58.7%	61.1%	62.2%	50 th	58.9%
Childhood Immunization Status: Combo 3 (2 Years) ¹	69.6%	75.6%	74.5%	66.67 th	73.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	97.0%	96.0%	97.4%	75 th	96.6%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	90.1%	87.6%	85.3%	33.33 rd	90.2%
Children and Adolescents' Access to PCPs (7-11 Years) ²	92.1%	85.3%	87.0%	10 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	92.0%	87.5%	87.7%	33.33 rd	93.1%
Chlamydia Screening in Women (16-24 Years) ²	59.2%	48.6%	44.2%	<10 th	52.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	64.4%	70.2%	66.9%	75 th	65.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	92.5%	93.7%	91.1%	75 th	90.9%
Controlling High Blood Pressure ¹	60.8%	48.1%	60.9%	50 th	67.0%
Medication Management for People With Asthma – 50% (5-64 Years) ²	52.9%	59.5%	61.9%	No Benchmark	63.9%
Medication Management for People With Asthma – 75% (5-64 Years) ²	27.4%	30.4%	41.0%	66.67 th	41.2%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	63.1%	57.9%	65.9%	33.33 rd	63.8%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	64.5%	62.9%	61.4%	10 th	63.6%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 39: UCare HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	UCare HEDIS 2016	UCare HEDIS 2017	UCare HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	26.8%	26.8%	33.3%	<10 th	28.9%
Adult BMI Assessment ¹	87.8%	84.2%	91.7%	66.67 th	91.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	75.9%	78.8%	78.4%	50 th	82.1%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	84.9%	79.9%	82.5%	25 th	88.0%
Annual Dental Visit ²	No Data	No Data	39.1%	10 th	39.2%
Breast Cancer Screening (50-64 Years) ²	70.6%	71.8%	57.7%	33.33 rd	70.2%
Cervical Cancer Screening (24-64 Years) ²	46.8%	57.6%	60.7%	50 th	56.0%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	96.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	82.2%	Small Sample	Small Sample	Not Applicable	90.2%
Children and Adolescents' Access to PCPs (12-19 Years) ²	90.4%	Small Sample	Small Sample	Not Applicable	89.6%
Chlamydia Screening in Women (16-24 Years) ²	59.4%	Small Sample	Small Sample	Not Applicable	51.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	65.9%	66.7%	77.2%	95 th	70.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	92.9%	95.8%	94.7%	95 th	94.6%
Controlling High Blood Pressure ¹	62.3%	31.1%	59.2%	50 th	72.5%
Medication Management for People With Asthma – 50% (12-64 Years) ²	64.7%	Small Sample	Small Sample	Not Applicable	71.7%
Medication Management for People With Asthma – 75% (12-64 Years) ²	38.8%	Small Sample	Small Sample	Not Applicable	49.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	53.4%	Small Sample	Small Sample	Not Applicable	59.7%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 39: UCare HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	UCare HEDIS 2016	UCare HEDIS 2017	UCare HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
MSHO	-	-	-	-	-
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.2%	98.0%	98.0%	95 th	98.3%
Breast Cancer Screening (65-74 Years) ²	64.7%	62.3%	61.6%	50 th	61.1%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	77.6%	80.8%	81.0%	95 th	79.4%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	95.1%	94.4%	95.9%	95 th	92.5%
MSC+	-	-	-	-	-
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	94.6%	95.6%	95.6%	90 th	93.3%
Breast Cancer Screening (65-74 Years) ²	46.3%	42.2%	42.2%	<10 th	41.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	86.9%	84.9%	85.0%	25 th	76.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 39: UCare HEDIS Performance – Reporting Years 2016, 2017 and 2018 (Continued)

HEDIS Measures	UCare HEDIS 2016	UCare HEDIS 2017	UCare HEDIS 2018	QC 2018 National Medicaid Benchmark Met/Exceeded	2018 Statewide Average
SNBC					
Adult BMI Assessment ¹ (SNP)	No Data	No Data	95.9%	90 th	96.4%
Adult BMI Assessment ¹ (Non-SNP)	90.0%	91.7%	92.2%	66.67 th	92.6%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	92.9%	92.8%	92.8%	95 th	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	96.7%	96.5%	96.5%	95 th	96.4%
Breast Cancer Screening (50-64 Years) ²	62.9%	61.3%	59.2%	50 th	51.0%
Cervical Cancer Screening (24-64 Years) ²	51.4%	50.1%	48.6%	10 th	46.4%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	Small Sample	43.2%	<10 th	45.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (SNP)	No Data	No Data	73.8%	95 th	79.0%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	67.0%	69.2%	70.8%	90 th	71.4%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (SNP)	No Data	No Data	94.4%	95 th	95.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	91.8%	92.0%	93.5%	90 th	92.5%
Controlling High Blood Pressure ¹ (SNP)	No Data	No Data	64.7%	66.67 th	71.4%
Controlling High Blood Pressure ¹ (Non-SNP)	59.9%	69.6%	67.4%	75 th	72.9%
Medication Management for People With Asthma – 50% (12-64 Years) ²	63.3%	64.6%	70.3%	No Benchmark	69.4%
Medication Management for People With Asthma – 75% (12-64 Years) ²	38.8%	44.4%	48.0%	75 th	48.2%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 11: UCare 2018 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> Controlling High Blood Pressure (F&C-MA, MNCare) 	A
	D <ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA) Breast Cancer Screening (MNCare) Controlling High Blood Pressure (SNBC) Chlamydia Screening in Women (F&C-MA) 	C <ul style="list-style-type: none"> Annual Dental Visit (MNCare) Adolescent Well-Care Visit (MNCare) Cervical Cancer Screening (MNCare) Comprehensive Diabetes Care – Eye Exam (F&C-MA, MSHO, MNCare, SNBC) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSHO, MNCare, SNBC) Childhood Immunization Status – Combo 3 (F&C-MA) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75%(F&C-MA) Well-Child Visits in the First 15 Months of Life (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	B <ul style="list-style-type: none"> Annual Dental Visit (F&C-MA) Breast Cancer Screening (SNBC) Cervical Cancer Screening (F&C-MA) Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	
	F	D	C <ul style="list-style-type: none"> Cervical Cancer Screening (SNBC) 	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 40: UCare CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures	UCare CAHPS 2016	UCare CAHPS 2017	UCare CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
F&C-MA					
Getting Needed Care*	55%	57%	55%	25 th	54%
Getting Care Quickly*	58%	54%	56%	25 th	58%
How Well Doctors Communicate*	82%	75%▼	77%	75 th	81%
Customer Service*	60%	62%	62%	10 th	67%
Shared Decision Making*	85%	80%	82%	Benchmark Unavailable	82%
Rating of All Health Care**	64%▲	57%	55%	50 th	54%
Rating of Personal Doctor**	74%	67%▼	70%	75 th	71%
Rating of Specialist Seen Most Often**	68%	63%	75%	90 th	70%
Rating of Health Plan**	58%	63%	64%▲	90 th	60%
MNCare					
Getting Needed Care*	63%	61%	57%	50 th	54%
Getting Care Quickly*	53%	59%	62%	75 th	61%
How Well Doctors Communicate*	83%	81%	82%	90 th	81%
Customer Service*	56%	52%	63%	10 th	67%
Shared Decision Making*	88%	85%	86%	Benchmark Unavailable	84%
Rating of All Health Care**	62%	62%▲	60%	90 th	54%
Rating of Personal Doctor**	77%	67%	73%	90 th	70%
Rating of Specialist Seen Most Often**	69%	52%	68%	50 th	68%
Rating of Health Plan**	52%	57%	55%	25 th	55%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Table 40: UCare CAHPS Performance – 2016, 2017 and 2018 (Continued)

CAHPS Measures	UCare CAHPS 2016	UCare CAHPS 2017	UCare CAHPS 2018	2018 CAHPS Database Benchmark Met/Exceeded	2018 Statewide Average
MSC+					
Getting Needed Care*	46%▼	61%	45%▼	<10 th	56%
Getting Care Quickly*	51%▼	68%	44%▼	<10 th	62%
How Well Doctors Communicate*	79%	78%	69%▼	10 th	77%
Customer Service*	63%	69%	47%▼	<10 th	66%
Shared Decision Making*	78%	82%	81%	Benchmark Unavailable	77%
Rating of All Health Care**	49%▼	61%	51%▼	25 th	60%
Rating of Personal Doctor**	73%	79%	61%▼	10 th	75%
Rating of Specialist Seen Most Often**	64%	76%	64%	25 th	71%
Rating of Health Plan**	61%	68%	53%▼	10 th	66%
SNBC					
Getting Needed Care*	52%	57%	53%	25 th	55%
Getting Care Quickly*	55%	67%▲	58%	25 th	60%
How Well Doctors Communicate*	69%	76%	70%▼	10 th	78%
Customer Service*	60%	67%	68%	50 th	69%
Shared Decision Making*	79%	79%	80%	Benchmark Unavailable	80%
Rating of All Health Care**	41%	60%	49%	10 th	54%
Rating of Personal Doctor**	58%▼	65%	71%	90 th	72%
Rating of Specialist Seen Most Often**	57%	61%	75%	90 th	67%
Rating of Health Plan**	56%	61%	60%	50 th	62%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

* Measure represents the percent of members who responded “yes” or “always”.

** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

Strengths

- **CAHPS (Member Satisfaction)** – UCare performed well in regard to the following area of member satisfaction:
 - F&C-MA
 - *Rating of Health Plan*

Opportunities for Improvement

- **Financial Withhold** – UCare did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. This was noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age 2-64 Years
 - Hospital 30-Day Readmission Rate
 - MSHO and MSC+
 - Annual Dental Visit: Age 65 Years and Older
 - SNBC
 - Annual Dental Visit: Age 19-64 Years
- **HEDIS (Quality of Care)** – UCare demonstrates an opportunity for improvement in regard to the following areas of care:
 - F&C-MA
 - *Adolescent Well-Care Visit*
 - *Chlamydia Screening for Women*
 - MNCare
 - *Breast Cancer Screening*
 - SNBC
 - *Controlling High Blood Pressure*
- **CAHPS (Member Satisfaction)** – UCare demonstrates an opportunity for improvement the following areas of member satisfaction:
 - MSC+
 - *Getting Needed Care*
 - *Getting Care Quickly*
 - *How Well Doctors Communicate*
 - *Customer Service*
 - *Rating of All Health Care*
 - *Rating of Personal Doctor*
 - *Rating of Health Plan*
 - SNBC
 - *How Well Doctors Communicate*

Recommendations

- **Financial Withhold –**
 - UCare should continue with its strategy to improve dental care. UCare should consider collaborating with other MCOs to identify and address common barriers.
 - As UCare has demonstrated improvement with hospital admissions, effective interventions should be leveraged to address readmissions.
- **HEDIS (Quality of Care) –**
 - Although not identified as an opportunity for improvement, the below average access to primary care rate for the 12-19 years group suggests that adolescent well-care visits are low partially because members are not accessing the system. As such, UCare should determine why members are not accessing the system, or if they are attempting to access the system, what barriers are they facing.
 - In regard to women’s health, UCare should conduct root cause analysis to determine the major factors negatively impacting certain screenings.
 - UCare’s dedicated workgroup should enhance its controlling high blood pressure strategy to include additional member-focused interventions. Effort should be made to improve member blood pressure readings to the clinical standards.
- **CAHPS (Member Satisfaction) –**
 - UCare should utilize the results of the secret shopper survey to improve provider network deficiencies. UCare should consider closing patient panels for providers who fail to meet contractual standards for wait times and appointment times. UCare should also consider conducting onsite audits of provider scheduling systems to determine compliance with contractual standards. UCare should educate members on standard appointment times to manage member expectations.
 - UCare should utilize member grievances and complaints to identify providers or provider sites that could benefit from direct outreach.
 - UCare should consider ways of obtaining member feedback shortly after the member’s interaction with health plan staff to ensure member issues are addressed in an expedited fashion. Member feedback should be captured and reviewed to identify specific elements of the customer experience that can be modified.

C. Common Strengths and Opportunities across MHCP

Annually, DHS evaluates statewide performance using the HEDIS administrative methodology for select measures. DHS also contracts with a certified-CAHPS vendor to annually assess statewide member satisfaction. To determine common strengths and opportunities for improvement across all MCOs participating in the MHCP, IPRO compared the HEDIS statewide averages to the national Medicaid benchmarks presented in the *Quality Compass* 2018 and compared the CAHPS statewide averages to the benchmarks published in the 2018 CAHPS Database. Measures performing at or above the 75th percentile were considered strengths; measures performing at the 50th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement. Common strengths and opportunities for improvement are discussed below. Statewide HEDIS and CAHPS performance, as well as IPRO's assessment, are displayed in **Table 41** and **Table 42**, respectively.

MHCP Common Strengths and Opportunities for Improvement

Common strengths among all MCOs participating in the MHCP include: access to primary care for adults and adolescents, and member satisfaction with personal doctor. MHCP rates for the following HEDIS and CAHPS measures met or exceeded the 75th percentile:

- *Adults' Access to Preventive/Ambulatory Health Services (all age groups)*
- *Children and Adolescents' Access to Primary Care Practitioners (12-19 Years)*
- *How Well Doctors Communicate*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

Common MHCP opportunities for improvement include: child/adolescent care, women's health screenings, and member satisfaction with MCO customer service. MCHP rates for the following HEDIS and CAHPS measures were below the 50th percentile:

- *Adolescent Well-Care Visit (12-21 Years)*
- *Annual Dental Visit*
- *Breast Cancer Screening (50-74 Years)*
- *Cervical Cancer Screening (24-64 Years)*
- *Childhood Immunization Status: Combo 3 (2 Years)*
- *Chlamydia Screening in Women (16-24 Years)*
- *Comprehensive Diabetes Care: HbA1c Testing (18-75 Years)*
- *Well-Child Visits in the First 15 Months of Life (6+ Visits)*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (3-6 Years)*
- *Getting Needed Care*
- *Customer Service*

Table 41: MHCP HEDIS Performance – Reporting Years 2016, 2017 and 2018

HEDIS Measures ¹	MHCP HEDIS 2016	MHCP HEDIS 2017	MHCP HEDIS 2018	Performance Assessment based on QC 2018 National Medicaid Benchmarks
Adolescent Well-Care Visit (12-21 Years)	35.3%	38.8%	35.0%	Opportunity
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	82.9%	86.1%	84.5%	Strength
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	88.4%	90.1%	90.2%	Strength
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	96.6%	96.7%	95.1%	Strength
Annual Dental Visit	No Data	No Data	45.6%	Opportunity
Breast Cancer Screening (50-74 Years)	59.3%	58.3%	56.2%	Opportunity
Cervical Cancer Screening (24-64 Years)	54.5%	57.6%	56.1%	Opportunity
Childhood Immunization Status: Combo 3 (2 Years)	65.6%	59.6%	63.5%	Opportunity
Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	96.7%	97.0%	96.6%	Average
Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	89.8%	90.3%	90.2%	Average
Children and Adolescents' Access to Primary Care Practitioners (7-11 Years)	92.4%	92.3%	92.3%	Average
Children and Adolescents' Access to Primary Care Practitioners (12-19 Years)	92.5%	92.7%	93.0%	Strength
Chlamydia Screening in Women (16-24 Years)	57.0%	57.2%	52.3%	Opportunity
Comprehensive Diabetes Care: HbA1c Testing (18-75 Years)	86.8%	85.2%	85.8%	Opportunity
Medication Management for People with Asthma – 50% Compliance (5-64 Years)	56.1%	61.2%	65.2%	No Benchmark
Medication Management for People with Asthma – 75% Compliance (5-64 Years)	32.1%	36.7%	42.7%	Average
Well-Child Visits in the First 15 Months of Life (6+ Visits)	60.6%	65.0%	63.8%	Opportunity
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (3-6 Years)	62.6%	64.5%	63.6%	Opportunity

¹ HEDIS rates were calculated by DHS using the administrative methodology.

Table 42: MHCP CAHPS Performance – 2016, 2017 and 2018

CAHPS Measures ¹	MHCP CAHPS 2016	MHCP CAHPS 2017	MHCP CAHPS 2018	Performance Assessment based on 2018 CAHPS Database Benchmarks
Getting Needed Care [*]	54%	57%	55%	Opportunity
Getting Care Quickly [*]	58%	61%	60%	Average
How Well Doctors Communicate [*]	78%	79%	79%	Strength
Customer Service [*]	65%	66%	67%	Opportunity
Shared Decision Making [*]	81%	81%	81%	Benchmark Unavailable
Rating of All Health Care ^{**}	52%	56%	56%	Average
Rating of Personal Doctor ^{**}	69%	70%	72%	Strength
Rating of Specialist Seen Most Often ^{**}	63%	68%	69%	Strength
Rating of Health Plan ^{**}	54%	58%	61%	Average

¹ MHCP rates were calculated by IPRO using DataStat data.

^{*} Measure represents the percent of members who responded “yes” or “always”.

^{**} Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10”.

CHAPTER 4: FOLLOW-UP TO 2016 ATR RECOMMENDATIONS

As in the past and in accordance with the BBA, Section 42 CFR 438.364(a)(5), IPRO requested the MCOs describe how they plan to address, or have addressed, the EQR recommendations. This chapter presents IPRO's 2016 improvement recommendations including verbatim responses from each MCO.

SPACE INTENTIONALLY LEFT BLANK

BLUE PLUS

- **2016 Recommendation: Financial Withhold** - Continue to work to address measures that failed to meet target goals. The MCO should ensure its Quality Work Plan is updated to address dental care for all age groups. Additionally, as the MCO continues to struggle with achieving points for the Emergency Department Utilization Rate, the MCO should assess the effectiveness of its current quality improvement strategy for this measure and modify its approach based on an updated root cause analysis.

MCO Response: Emergency Department Utilization: Blue Plus is committed to reducing unnecessary emergency department (ED) utilization and helping members access the care they need. Our goal is for members to receive the right care, at the right time, in the right place. We are tackling this goal through multiple avenues, including member education, program design, and provider value-based programs.

Member Education and Program Design – In 2016, Blue Plus launched the Health Connections Program, which centers on a team of Health Connectors that specialize in helping F&C – MA and MNCare (collectively, “Medicaid”) members navigate the complex health care system. The goal of the Health Connections Program is to empower Medicaid members through education and information to make the best decisions possible to meet individual health care needs. This model fosters high quality interactions that create a positive customer experience while guiding members to the most appropriate services, promoting quality, and managing the total cost of care. In 2017 and 2018, Health Connectors did targeted outreach to Medicaid members that used the ED in the previous month for non-urgent conditions. The Health Connectors educated members on alternatives to the ED for non-urgent conditions, including a new telehealth benefit through Doctor on Demand® and nurse line services. They also helped connect the member to a primary care provider, where applicable.

In 2017, Blue Plus launched a High Complexity Case Unit (HCCU) Program to meet the needs of our most complex members. The HCCU Program uses an interdisciplinary care team approach that includes a comprehensive, holistic assessment, an individualized plan of care, and provider collaboration. Analysis from the first cohort of members to participate in the program was positive and showed statistically significant reductions in inpatient admissions for members engaged in HCCU versus standard health coaching. Results also indicated shorter lengths of stay and fewer ED visits for these members.

Provider Value-Based Programs – Blue Plus first launched its Medicaid Provider Value-Based Program (VBP) in 2015 to focus specifically on improving health outcomes, increasing quality of care and managing costs in our F&C-MA and MNCare populations. Currently, the program serves over

60% of attributed members. ED utilization has been a metric in the Medicaid VBP since its inception. As part of the Medicaid VBP, Blue Plus regularly reviews performance with participating care systems and provides member-level reporting on at least a quarterly basis. Blue Plus and the care system work together to identify opportunities for improvement.

Despite not achieving the withhold, Blue Plus's ED utilization rates are trending down, indicating our work is having a positive impact in helping members access the appropriate level of care. In 2017, 50% of care systems participating in the Medicaid VBP achieved partial to full achievement towards goal by closing the gap between their baseline performance and goal by at least 50%. This reflects considerable improvement compared to 2016, when only 10% of participating care systems closed that gap by at least 50%. Blue Plus's HEDIS rate for Emergency Department Utilization (AMB-EDU) also has shown an improvement. The number of ED visits per 1,000-member months decreased for both F&C – MA and MNCare members from HEDIS 2017 (calendar year (CY) 2016) to HEDIS 2018 (CY 2017).

Hospital Readmission Rates: Blue Plus also is committed to reducing unnecessary readmissions by working to ensure members who have been hospitalized have the tools and resources they need to experience a smooth transition to home or other care setting. As with ED utilization, we are addressing this through a multi-pronged approach.

Provider Value-Based Programs – All cause readmissions has been a metric in our Medicaid VBP since its inception in 2015. As noted above, Blue Plus works closely with care systems participating in the Medicaid VBP to identify opportunities for improvement. This includes reviewing regular member and provider-level reporting on both admissions and readmissions. In 2017, 70% of care systems achieved partial to full achievement towards goal by closing the gap between their baseline performance and goal by at least 50%. This reflects considerable improvement compared to 2016, when only 33% of participating care systems closed that gap by at least 50%.

Program Design – A consistent barrier to our clinicians effectively assisting members with transitions of care has been lack of timely notification of admission and discharge. In 2017, Blue Plus enhanced its admission notification process, which feeds our case and disease management platform. Health Coaches reach out to members within two days of notification of inpatient discharge. The Health Coaches use a “Transitions of Care” assessment tool that is based on evidence-based models to reduce avoidable readmissions.

Although our efforts to date have not resulted in meeting the withhold, we are seeing improvement in the reduction of readmissions among the providers participating in our Medicaid VBP. Blue Plus will continue to look for opportunities to reduce the risk of readmissions among our members through enhanced clinical programs, member education and provider partnerships and will modify interventions based on further analysis.

Dental Care for All Age Groups: Blue Plus recognizes the importance of annual dental care for all age groups. Regular dental visits are essential for the maintenance of healthy teeth and gums and can identify oral health issues early when treatment is most successful. Blue Plus has initiated member interventions across all ages to encourage an annual dental visit, as outlined below. However, significant barriers remain to improving dental access for Medicaid members across the state.

Member Outreach and Rewards – To encourage healthy dental behaviors from an early age, Blue Plus included the annual dental visit in its Healthy Rewards Program, a member incentive program that rewards healthy behaviors. Members age 2 – 20 are eligible to receive a \$25 incentive if they complete an annual dental visit. Blue Plus supplements the member reward with outreach via email and mail reminding members of the importance of regular dental care. For our MSHO and MSC+ population, Blue Plus worked with its care coordinators to educate members about oral health. Throughout 2018, Blue Plus provided care coordinators gap in care lists that identified MSHO and MSC+ members who were due for their Health Risk Assessment (HRA) and had a gap in an annual dental visit. During the HRA visit, care coordinators educated members about the importance of regular preventive dental care, addressed any barriers the member may be experiencing, and provided the member with a flyer illustrating the importance of oral health for overall health.

Despite these efforts, Blue Plus’s annual dental visit rates have remained relatively flat, except for rates for MNCare members aged 4-6 and 11-18, which have showed an upward trend from HEDIS 2016 (CY 2015) to HEDIS 2018 (CY 2017). Blue Cross plans to enhance its outreach efforts in 2019 and 2020 and expand its member reward to F&C – MA and MNCare members of all ages. To target our outreach more effectively, we will use analytic tools to map hotspots of underutilization across the state. While important, these interventions do not address the significant dental access issue that exists in Minnesota. Minnesota has a total of 124 Dental Health Professional Shortage Areas across the state. Blue Plus is working with Delta Dental and other dental providers and health programs to address these dental health shortage needs and increase access to dental services, particularly in rural and Greater Minnesota.

- **2016 Recommendation: HEDIS (Quality of Care)** – As the MCO’s chlamydia screening rates trend upward, the MCO should continue with the intervention strategy outlined in the Health Plan’s response to the previous year’s recommendation, routinely monitor the effectiveness of the strategy and modify it as needed. The MCO should enhance its approach toward improving diabetes care and adolescent care to include provider- and system-level interventions.

MCO Response: Blue Plus has implemented several health and wellness initiatives to promote preventive care and engage members in self-management of chronic conditions. Intervention strategies for improving chlamydia screening, diabetes care, and adolescent care are highlighted below.

Chlamydia Screening: Minnesota Chlamydia Partnership: Blue Plus continues to participate in the state-wide community-based Minnesota Chlamydia Partnership (MCP) to raise awareness of the increasing numbers of young people contracting sexually transmitted infections (STI) throughout the state. A large focus of MCP's work is promotion of annual STI testing and treatment. MCP, along with community clinics and organizations, sponsors events that offer confidential and free/low cost testing. One such event is the Annual STI Testing Week led by the Community Restoring Urban Youth Sexual Health (CRUSH) group.

A collaborative of health plans, namely Blue Plus, HealthPartners, Medica and UCare, assist the MCP in the promotion of these events and serve as a resource regarding how health plans can help promote the importance of chlamydia screening to both members and providers. Community organizations and clinics are often unaware of the efforts by health plans to improve quality of care and how the use of quality performance measures can impact provider engagement in this and many other areas of health, wellness and disease management. The collaborative does annual updates to a provider resource manual (Chlamydia Screening Provider Toolkit) developed by the group in 2013. The toolkit is a wealth of information and helps providers by offering such things as an interview guide to what can be an uncomfortable discussion with a young person about their sexual activity. There are resources and information concerning the legal requirements on confidentiality and suggestions on how tests and results can be protected and kept confidential. A link to the tool kit is available via a public website of our Quality Improvement organization partner, Stratis Health at [PIP: Chlamydia Screening for Women](#).

Provider Value-Based Programs: With the goal of partnering more effectively with providers to improve chlamydia screening across the state, Blue Plus added chlamydia screening as a metric in its Medicaid VBP, effective in 2019. Blue Plus plans to provide participating care systems monthly gap in care reporting to facilitate member outreach and education. We also will highlight any disparities in providers' rates between their commercial and Medicaid populations, thus giving them further insight into their performance and the needs of their patient population.

Clinical Consultants for Provider Support – Blue Plus has a team of clinicians that offers consultation and education to providers on quality performance and improvement. They meet regularly with providers participating in our value-based programs and offer expertise on the HEDIS measures included as metrics in those programs. Although over 60% of our members are attributed to a provider participating in the Medicaid VBP, Blue Plus recognizes there are opportunities to better engage with providers that do not participate in these programs. Consequently, we are looking at expanding the Clinical Consultants' outreach and education beyond the care systems involved in our value-based programs, with the goal of creating additional provider partnerships throughout the state.

Healthy Rewards Program – Blue Plus has continued to offer a rewards program for F&C-MA and MNCare members with the goal of reinforcing healthy behaviors. Eligible members can earn \$25 if they complete an annual chlamydia screening.

As noted, Blue Plus’s chlamydia screening rates have been trending upward; however, rates remain below the Minnesota statewide average, indicating continued opportunity for improvement. A review of the rate trend over the last three HEDIS reporting years revealed that while F&C – MA screening rates increased across all age groups from HEDIS 2016 (CY 2015) to HEDIS 2018 (CY 2017), MNCare rates decreased among women aged 21 – 24, suggesting an opportunity for targeted interventions among this age group.

Diabetes Care – Eye Exam: Blue Plus has placed specific focus on diabetes care in recent years. In 2017, the company launched a corporate-wide initiative aimed at improving health for those living with diabetes and preventing the onset of type 2 diabetes. To support that goal, Blue Plus launched several initiatives in 2017 and 2018.

Member Outreach – In 2017 and 2018, Blue Plus reached out to members through multiple channels to promote the importance of annual eye and kidney screening for people living with diabetes. This included outreach via email, mail and telephone to members with a gap in screening. Diabetes management also continued to be a part of our member Healthy Rewards program. Because our nephropathy screening rates were continuing to trend downward, Blue Plus piloted a home kidney screening initiative in 2018. The goal of the initiative was to provide members with diabetes an easy and convenient option for kidney screening. We had a positive response to this initiative and expect it will help improve our HEDIS Comprehensive Diabetes Care (CDC)-Nephropathy Screening rates for HEDIS 2019 (CY 2018).

Clinical Consultants for Provider Support – Our clinical consultants provide focused provider education on all sub-measures of the HEDIS CDC measure. This includes encouraging primary care providers to work with vision care providers to ensure their patients with diabetes are getting routine diabetic eye exams. During the HEDIS hybrid review process, the clinical consultants also have an opportunity to identify areas in which providers can improve health outcomes and HEDIS rates. For example, they have identified recurring documentation issues with diabetic eye exams. Blue Plus is exploring opportunities to work with vision providers to improve documentation and communication with primary care providers.

Community Events – Blue Plus and Blue Cross and Blue Shield of Minnesota are committed to improving the lives of all Minnesotans. We have three Retail Centers in the community where we offer a variety of free classes focused on healthy living. This includes Living Well with a Diabetes, a 6-week workshop designed to help individuals with type 2 diabetes develop skills and tools to manage

their condition. The course is presented by trained Diabetes Self-Management Program leaders from the Metropolitan Area Agency on Aging, the Arrowhead Area Agency on Aging, and Stratis Health. In 2018, 172 community members attended a Living Well with Diabetes workshop in our Roseville and Duluth Retail Centers.

Although Blue Plus's HEDIS rate for the CDC-Eye measure dropped significantly in H2017 (CY2016), rates rebounded in H2018, particularly among MNCare members. Preliminary data from calendar year 2018 suggests this trend is continuing, indicating our efforts at improving the health of our members living with diabetes is having a positive impact.

Adolescent Well-Care Visits: The American Academy of Pediatrics and Bright Futures recommend annual well-care visits during adolescence to promote healthy behaviors, prevent risky ones, and detect conditions that can interfere with a teen's physical, social, and emotional development.⁴⁸ Efforts to improve the rate of adolescent well-care visits among our Medicaid members are highlighted below. Although our HEDIS rates decreased for both F&C – MA and MNCare from HEDIS 2016 (CY 2015) to HEDIS 2017 (CY 2016), F&C-MA rates rebounded for HEDIS 2018 (CY2017). MNCare rates remained flat, suggesting a need to further explore barriers in this population.

Member Outreach and Education – Blue Plus uses multiple channels to educate parents/guardians of members on the importance of an annual adolescent well-care visit. In 2017 and 2018, this included targeted outreach through email and telephone. As noted above, Blue Plus created a team of Health Connectors in 2016 with the goal of helping members access the care they need. In addition to focusing on members with ED visits, the Health Connectors reached out to members identified as underutilizing their health care benefits. The goal of the Health Connections Program is to empower Medicaid members through education and information to make the best decisions possible to meet individual health care needs, as well as help members navigate the health plan and receive the right services at the right time. The Health Connectors educated members on preventive screenings and immunizations and helped connect them to a primary care provider, as applicable. To further enhance our member outreach efforts, in 2019 Blue Plus implemented welcome calls, preventive health reminder mailings and overdue service reminder postcards promoting child and teen check-ups. Adolescent well-care visits and adolescent immunizations also continue to be a part of Blue Plus's Healthy Rewards Program.

Provider Value-Based Programs – To partner more effectively with providers to improve adolescent well care across the state, Blue Plus added the HEDIS Immunizations for Adolescents measure to its Medicaid Value Based Program, effective in 2019. Blue Plus plans to provide monthly gaps in care reporting to participating providers to help support their improvement efforts in this area.

⁴⁸ <https://www.medicaid.gov/state-overviews/scorecard/state-health-system-performance/prevention-and-treatment/index.html>

Community Events – In 2017, the Blue Plus Community Outreach team helped launch the Devote to Your Health Initiative. A collaboration with local churches, the Devote to Your Health initiative engages community members in taking control of their health within faith-based organizations. Blue Plus helped initiate several projects as part of this collaborative, including free health screenings, 5K running events, and workshops on preventive care, oral health, diabetes prevention, maternity health, chronic conditions and medication management. The program served more than 1,000 community members and screened 450 individuals.

- **2016 Recommendation: CAHPS (Member Satisfaction)** – Conduct a thorough root cause analysis for the measure listed above and implement interventions to address identified barriers. Additionally, identify best practices across programs and apply these practices to the MNCare program.

MCO Response: Our members' experience is of critical importance to us. Blue Plus monitors and uses CAHPS results to identify areas where we are doing well and where we can do better. Initiatives take into consideration member perception in receiving and obtaining care and services, knowing this significantly impacts member experience and satisfaction.

Beginning in late 2016, Blue Plus initiated a deep dive analysis of CAHPS and grievance data. A primary learning was the impact a new system migration may have had on the member experience. In 2015, Blue Plus began implementation of a new platform for our clinical programs. The BlueCore platform utilizes a primary nurse model where the member interacts with one health coach regardless of whether the member needs case or condition/disease management. Migration to the system created some challenges, which may have accounted for a decrease in satisfaction among members. Blue Plus also had a large influx of Medicaid members in 2016, which contributed to service issues. We identified an opportunity to improve communication around the transportation benefit, in particular.

The deep dive also revealed that our portal was not particularly user-friendly. In 2017, Blue Plus worked to ease access to its member portal from the public Blue Cross website. We also focused on simplifying language and improving the accessibility of the public website, where all communication is written at a seventh-grade reading level. The changes made it easier for most members to get to their personal information while reducing confusion due to different interfaces. CAHPS 2018 rates suggest our members have appreciated this effort. F&C – MA rates saw a 15-percentage point increase in the question *Written materials or Internet provided needed information*.

In early 2018, Blue Plus piloted a new customer service training model with the goal of continuing to improve the member experience. A primary aim of the training was to increase the accuracy of the information provided to members. CAHPS 2018 rates for F&C – MA saw a four-percentage point

increase in the question, *Customer Service provided needed information or help*, suggesting the training is having a positive impact on our members' experience.

HEALTHPARTNERS

- **2016 Recommendation: Financial Withhold** – The MCO should continue with the intervention strategy described in its response to the previous year’s recommendation, specifically the use of Community Health Workers, targeting “medium-risk” members and the use of internal member support resources. The MCO should also update the strategy to include dental care for children and adults. As the MCO achieved all possible points for Annual Dental for Visit for the 7-18 age group, best practices for this group should be identified and applied across the low performing age groups.

MCO Response: Readmission: HealthPartners has an internal work group that meets regularly and closely monitors the status of the withhold measures for our DHS contracts and seeks opportunities for improvement in our performance on these withholds. Individual measures have smaller work groups that develop and implement interventions specific to that measure. We continue to seek improved results and outcomes through data analysis, and the refinement and addition of interventions.

Efforts to decrease hospital readmissions have continued to be a challenge for HealthPartners. In 2016, HealthPartners established a workgroup to examine admission and readmission trends, conduct root cause analysis, identify opportunities for improvement, and determine next steps. This analysis and planning for intervention continued throughout 2017.

One finding of the analysis is that social determinants of health directly impact utilization of services, including admissions and readmissions. There has been significant research in this area and the workgroup felt it is important to note that impact, especially among our Medicaid membership. Utilizing a Community Health Worker (CHW) has proven to be an effective intervention in reducing admissions and readmissions among members working with the CHW. CHWs are able to educate members about health related issues and also assist the member in accessing resources which can positively impact their social determinants of health. In 2017, an additional FTE was added to expand the reach of the program identified in the targeted community.

While many of the highest risk members are already engaged with complex case management with the health plan, for others it has been difficult to engage the highest medically at-risk members. Lack of good contact information, resistance to interventions, and other priorities make engagement a challenge. However, our analysis showed there was opportunity to impact these measures by including medium-risk members in interventions. Collaboration with our care system allowed us to identify data elements to enhance risk stratification and prioritize outreach to those medium-risk members for care coordination services and offer support for social issues when needed as well.

Additional analysis showed that it is not the highest risk members who necessarily experiences a readmission. In many cases it is the less managed, low-risk population who experience readmissions. This is possibly because they do not have the supports in place in advance to assist them with management post-discharge. One focus of discharge planning is to ensure that the member has timely follow-up with their primary care provider, however lack of follow-up care does not appear to be a driver or predictor of readmissions.

As a health plan, we are working to better utilize and promote our internal member support resources such as care coordination and MTM services. For example, we have added a full time employee in our busiest hospital to offer complex case management specifically to our Minnesota Health Care Program members to enhance discharge planning including referrals to MTM services as appropriate. The Inpatient Case Management team works collaboratively with each hospital's care management and care teams on discharge planning as well as referring into our outpatient disease and case management and MTM services. The hospital care management teams promote the availability of after-hours care such as our twenty-four hour nurse line to address care needs before they become urgent.

Reducing readmissions continues to be a focus of HealthPartners and we continue to work to refine our risk identification algorithms. Other initiatives include working more closely with Transitional Care Units and Skilled Nursing Facilities to ensure appropriate palliative care and symptom management on-site, reducing the need for the member to return to the hospital or the emergency room. For other members, referral to a community paramedic can be the support they need post-discharge. We are exploring the feasibility of documentation by community paramedics in the care group electronic medical record system to assist with care coordination with the member's primary care provider.

Dental: Access to dental providers has been identified as an ongoing issue for Medicaid members in Minnesota. To assist members in locating a dentist who is open to new patients, HealthPartners created a Minnesota Health Care Programs Navigator role within Member Services. Member Services Representatives can look to this navigator for assistance with dental support on complex benefits, provider access, and as a resource for community services when non-plan benefits are needed.

HealthPartners has established a cross-enterprise work group with the goal of improving annual dental rates in our Minnesota Health Care Programs populations. As part of that work, the HealthPartners Dental Group established a Patient Dental Call Center where staff reaches out to parents of one to six year old PMAP members who have not been in for a dental appointment in the last year. This project will continue to reach out to 20-25 families per week to schedule a pediatric exam appointment, with a goal of scheduling at least 50% with New Patient Exams.

Access to a dental provider who accepts Medicaid is severely limited in greater Minnesota. HealthPartners continuously explores opportunities to contract with additional dental providers. HealthPartners has a dental incentive for children under the age of nine who live outside of the seven county metro area. For every child who receives their first preventive appointment as a HealthPartners member, they receive an oral health kit and \$15.00 gift card. In 2016, there were 1,518 members who met the criteria and received the oral health kit and dental incentive.

- **2016 Recommendation: HEDIS (Quality of Care)** – The MCO should consider including non-clinic providers in their quality improvement strategy to ensure the entire provider network benefits from the activities described in the MCO’s response to the previous year’s recommendation. The MCO should also consider developing member incentive programs for preventive screenings. Additionally, the MCO should routinely assess the effectiveness of its quality improvement activities, and modify these activities as needed.

MCO Response: HealthPartners analyzes our HEDIS results each year and focuses specific attention on measures which are clinical priorities for our membership. For those measures, extensive root cause analysis is conducted and evaluation of potential interventions is assessed and implemented as appropriate. HealthPartners has implemented several strategies to impact our HEDIS rates which include deep analytic examination of drivers behind measures, in addition to provider and member focused strategies to lift these measures.

We have an internal cross-discipline group which includes project managers, informatics, quality and provider relations leaders and representatives from both the health plan and our care delivery. This group meets monthly to examine our rates and strategize performance.

Health Informatics provides this group and other stakeholders a monthly monitoring report which compares our current rates on HEDIS measures to the same time in the last reporting year. This allows us to be nimble with interventions as we assess which measures may need attention or intervention enhancement mid-year.

The monthly monitoring report utilizes our internal claims data. Hybrid measures lack that data, but it is still a valid reflection of how those rates are trending. The monitoring report includes analysis of the performance of our own care delivery system as well as a breakdown of contracted care groups and how they are performing on the measures for our health plan members. We can see the number of Minnesota Health Care Program members that each care group is serving who are in the HEDIS measure denominator, and of those how many are currently a positive HEDIS hit for that measure. This identifies partnership opportunities to collaborate with care groups and have an immediate impact on rates.

HealthPartners has implemented several layers of provider interventions with care groups including:

- Provider Registries – HealthPartners provides a claims-based registry report to our contracted clinics on a quarterly basis to identify members who have gaps in their preventive screenings and chronic disease care.
 - Clinics receive notification each time that the registries are updated with new member information.
 - HealthPartners utilizes our provider newsletter to share updates or changes to the registry as well as highlight measures that we identify as a priority.
- Quality Consultations – HealthPartners offers consultative services through the Quality Improvement and Compliance Department to clinic groups to support their quality improvement initiatives. Clinics may choose technical assistance on clinic processes or they may benefit from analysis of data specific to their clinic.
 - The Quality Consultant (QC) may identify specific measures that a clinic has an opportunity to improve or the clinic may seek assistance with a measure or a clinic process.
 - The QC tailors their level of involvement to the needs of the participating care group. Data analytics may be an important element of information for the care group or a plan Medical Director may be involved to offer support or elevate the importance of action.
- Quality Connections Forum – Quality Connections Forum is a gathering of key quality improvement leaders from major contracted clinics which meets three times per year to share initiatives, best practices, successes, and failures in efforts to improve publicly reported quality measures. Participants share the latest science and best practice methods as well as share successes and challenges related to their quality improvement efforts. Surveys of the Quality Connections group has shown that care groups value the collaborative nature of the group and most systems have implemented improvements or strategies discussed in the group.
- Clinic incentive programs – Many of our care systems participate in HealthPartners incentive programs based on the three dimensions of the Triple Aim; health, experience and affordability. While these incentives do not specifically target Minnesota Health Care Program members, this membership benefits from the efforts that the clinics implement across their patient population. The Partners in Excellence (PIE) awards program recognizes providers in excellence, innovation and sustainable change to impact quality improvement measures. PIE goals are aligned with HEDIS.

In addition to these provider-based interventions, HealthPartners utilizes numerous member focused interventions such as member mailings for preventive screenings, social media messaging, and alerts that Disease and Case Management, health coaching staff, and Member Services can deliver when a member contacts the health plan. When a measure is both a HEDIS measure and a Medicaid withhold, particular focus is given to that issue.

HealthPartners has member incentive programs in place to encourage preventative care. Each program is tailored to the needs of the population in addition to focusing on measures identified as priority measures for the population. We continually review these programs to respond to trends and to align with priority measures.

In 2017, we had the following member incentives in place for our Minnesota Health Care Program members:

- PMAP and MinnesotaCare: Well Child Visits, Healthy Pregnancy Program, Postpartum Care, Adolescent Immunizations, Asthma Management Program
 - SNBC: Primary Care Visit, Cervical Cancer Screening
 - MSHO: Osteoporosis, Breast Cancer, and Colorectal Cancer Screenings
- **2016 Recommendation: CAHPS (Member Satisfaction)** – Conduct thorough root cause analyses for the measures listed above and implement interventions to address identified barriers.

MCO Response: HealthPartners analyzes CAHPS results to identify strengths and improvement opportunities and communicates these to its leadership. Underperforming measures go through a root-cause analysis and evaluation of potential interventions is assessed and implemented as appropriate. Actions are guided by an internal cross-discipline group which includes customer service, quality utilization, pharmacy, provider relations and contracting, and representatives from HealthPartners care delivery. The autumn Member Stakeholders meeting also provides a forum to gather members’ perspectives and feedback on proposed actions.

Three CAHPS measures fell below their respective Minnesota State Averages:

- F&C-MA: Shared Decision Making
 - Analysis identified discussing why not to take a medicine with a doctor or other care provider to be the critical factor in this measure.
 - Action Taken: HealthPartners launched a promotional initiative for its MTM service. The promotion emphasized a one-on-one meeting with a pharmacist to identify the right combination of medicine to help members feel their best.
 - Goal: Along with an improved CAHPS score in this measure, we expected a MTM utilization gain of 20 percent (to 588 members).
 - Result: CAHPS 2018 score improved 7 percentage points and MTM utilization grew 42 percent (851 members).
- SNBC: Rating of Personal Doctor and How Well Doctors Communicate
 - 2017 was the first year of HealthPartners CAHPS results for the SNBC population in Greater Minnesota and overlapped with efforts for enhanced opioid prescribing oversight. An annual survey of physicians about pharmacy authorization processes also identified opportunities for improved practices. HealthPartners streamlined authorization processes for medicines, as well as promoted and supported provider

webinars about cultural awareness and supporting patients with disabilities (especially those in need of behavioral health care). Also, the above-mentioned MTM program was heavily promoted to SNBC members.

- Goal: Improved CAHPS scores for SNBC on provider-related measures.
- Result: CAHPS for SNBC members in Greater Minnesota made significant gains in 2018. Personal Doctor Rating gained 7 percentage points and How Well Doctors Communicate gained over 10 percentage points.

HENNEPIN HEALTH

- **2016 Recommendation: HEDIS (Quality of Care)** – Conduct root cause analysis to identify barriers to care and implement interventions to address these barriers. The MCO’s quality improvement strategy should include member-, provider- and system-level quality improvement initiatives.

MCO Response: Hennepin Health was awarded a PMAP/MNCare contract by DHS, effective January 1, 2016, resulting in Hennepin Health providing services and benefits to women and children in addition to the Medicaid Expansion members. Hennepin Health began as a Medicaid Expansion program in CY 2012; therefore, long-term data, including behavioral characteristics of the Medicaid Expansion population, is not available. As of December 31, 2016, the Hennepin Health PMAP/MNCare program had an enrollment of 9,818 members as of December 31, 2016. Most of the Hennepin Health’s PMAP/MNCare population are Medicaid Expansion members, who are single adults without children with the median age being 37. Males represent 66% of the population.

Hennepin Health is part of Hennepin County and work collaboratively with other Hennepin County Departments such as Health and Human Services. Hennepin Health, as a part of Accountable Care-like Organization, also collaborates with Hennepin Healthcare System (formerly Hennepin County Medical Center) and NorthPoint Health and Wellness Center in strategic initiatives to assist members who are part of the Medicaid Expansion program as well as PMAP/MNCare women and children.

The Hennepin Health HEDIS 2017 Breast Cancer Screening rate was 48.1%, significantly lower than the 2016 HEDIS rate of 68.5%. The eligible population for the HEDIS Breast Cancer Screening measure, women ages 50 – 64, was 134 members, significantly less than the NCQA required sample size 411. When continuous enrollment requirements are applied for data such as HEDIS measures (especially for female-only measures since Hennepin Health is approximately two-thirds male), the sample size becomes small and potentially unreliable. Using claim data only, sixty-three women had a mammogram either on or between October 1, 2013 and December 31, 2016. Data limitations included, but were not limited to, not having the claims data for women only enrolled with Hennepin Health for 2016 or claims information indicating the woman had a bilateral mastectomy.

A high percentage (>85%) of the Medicaid Expansion members have a behavioral health diagnosis with 41% having a mental illness (MI) diagnosis, 27% having a substance use disorder (SUD) diagnosis and 21% have both a MI and SUD diagnoses. Individuals with substance abuse and/or mental illness diagnosis often lack adequate shelter, food, transportation and financial supports. Their basic needs required for survival are not met. There is a high rate of homelessness for this population. Members may also lack transportation. Involvement in the criminal justice system is not uncommon for this population as well. Many Hennepin Health members live in what some may call the “survival mode”; thinking only of present day and what their needs are in that moment. What they might need a month, a year, or multiple years from now is not something in the forefront of

many members' thoughts. This aversion to thinking long term is often a major barrier to members seeking out primary/preventive health care services as evidenced by the HEDIS preventive services visit utilization rate. The focus areas for Hennepin Health members are addressing these basic survival needs in addition to their psychosocial and medical needs. The Medicaid Expansion population generally seeks acute episodic care and do not see the need for ongoing primary and preventive care, especially if they feel "better". In addition, many members have had significant and/or several traumatic events in their lives, disrupting health development, adversely affecting relationships, and contributing to mental health issues including substance abuse, domestic violence, and child abuse. If the trauma goes untreated, this may lead to criminal activity, loss of wages, and threat to the stability and support of the family. Many members are resistant to allowing a primary care physician into their personal health. It is documented in current literature that successfully addressing an individual's basic survival needs first allows the individual to focus on their psychosocial and medical needs.

In discussion with some primary care providers (PCP), it appears PCPs have a different perspective regarding the process women could use to obtain a mammogram. Some PCPs prefer having a discussion with the member prior to ordering a mammogram; other PCPs allow members to obtain a mammogram without an order and have the results sent to the PCP. Mammogram Service Centers also have different protocols. Some require the member to have a PCP within the respective healthcare system; others do not have this requirement and will send the mammogram results to the designated PCP. Some allow walk-in mammograms; others do not.

Implementing quality improvement initiatives to overcome the barriers identified above is a challenge as changing member's behavior patterns and beliefs is a long-term process. For the member to benefit from these initiatives, the members need to know about the services, be educated on their health care benefits and show up for appointments. Perhaps, the toughest challenges are finding effective strategies to overcome the member's behavior patterns and beliefs, in addition to locating the members. A communication method to reach the members consistently is also lacking. Locating the member is a challenge as member contact information received can be inaccurate by the time it is received through the enrollment files. Many members do not have a permanent address and receive mail through General Delivery. They do not regularly receive their mail. Additionally, many members do not have access to a cell phone. Hennepin Health does provide transportation for covered medical services; however, informing members of these services is a challenge as the traditional methods to communicate with members are not consistently available. To address the transportation issue, Hennepin Health provides a monthly bus pass for members having four or more health care system appointments; thus, allowing the member to ride free numerous times during the month. Hennepin Health offers access to organizations providing free cell phones to members who meet certain qualifications, two to three times during the year at the monthly Wellness Wednesday event.

At a 2018 Wellness Wednesday event, Hennepin Health did provide information on breast cancer screening and resources on where to obtain a mammogram to members. Information about primary care services was provided as well. Assistance in finding a primary care provider was also available when requested. Hennepin Health did investigate having a Mobile Mammogram Center on-site to provide mammograms during this event; however, a resource to provide this service could not be located. Hennepin Health also has a Social Service Navigation team who are available to assist members in establishing a primary care provider medical home.

Hennepin Health Social Service Navigation and Complex Case Management teams work collaboratively with Hennepin County Health and Human Service staff to assist our members and address their specific social determinants of health. This involves meeting members where they are at physically and psychologically, using trauma informed care principles. The teams will meet members at homeless shelters, homeless camps, in their homes and/or on the street. It can take frequent encounters and time to establish a trust relationship with members and/or for members to agree to care management services and establishing a medical home. The teams also work with members on housing resources, food resources and employment opportunities. Team members will also arrange transportation and accompany members to medical and other appointments.

In addition, Hennepin Health staff work with two other agencies, AVIVO and RISE that assist with care coordination and social issues such as housing and employment. Often times, AVIVO staff will identify members who may benefit from their services through use of emergency department utilization data. AVIVO staff will meet with members while the member is in the emergency department. Hennepin Health staff meet with AVIVO and RISE on a monthly basis, or more frequently if needed, to review and discuss cases.

Hennepin Health has a Walk-In Service Center staffed with Community Health Workers who can assist members by providing the necessary referrals for support services. On a month basis, approximately 500-600 members use the Walk-In Service Center for services, which may include obtaining a bus card pass, arrange transportation or assistance with other needs. Information is readily available, encouraging members to seek preventive medical or dental services. Computers are also available for members' use, giving access to appropriate websites.

Hennepin Health, Hennepin County Health and Human Services, AVIVO and RISE work with members and encourage them to seek appropriate medical care to address chronic medical conditions and/or mental health and chemical dependency care. AVIVO and RISE staff will make appointments for members. Within the Hennepin Healthcare system, Healthcare for the Homeless Clinic is present. This clinic provides walk-in medical care and coordinated medical and social services. Members can receive medical care and dental care. A Social Worker is part of this team and is available to work with members on any concern such as food, housing, advance directives, etc. Hennepin Health tracks the number of members monthly who have engaged in care

coordination, establishing a primary medical care relationship, received support services such as housing, etc.

Hennepin Health does not offer a member or provider breast cancer screening incentive; although these options were investigated. These options may be revisited in the future. A member incentive may not produce the results intended due to the member's "survival mode" mentality and the inability to locate members as a large portion of Hennepin Health members are homeless with no consistent means of reaching them.

Providers are encouraged to provide and/or coordinate preventive services, such as obtaining mammograms when members are seen for acute care visits. Hennepin Health encourages primary care providers to stress to their patients the importance of having a mammogram. This has been communicated through the Hennepin Health provider website, including the provider bulletin. The greatest opportunity for Hennepin Health to address breast cancer screening is to encourage members to seek preventive health care services and establish a primary care relationship. Hennepin Health continues to work with its providers on strategies to increase preventive health visits for this population.

Note: The following recommendations were made to MHP in the 2016 Annual Technical Report. MHP's SNBC program is now operating under Hennepin Health. Hennepin Health submitted the following responses to the recommendations made to MHP:

- **2016 Recommendation: Financial Withhold**
 - The MCO should consider establishing partnerships with community dental clinics, such as Helping Hands, to obtain visit information in the absence of claims information.
 - The MCO should utilize primary care providers as champions of dental care to promote and encourage annual dental visits to patients.
 - In regard to the Dental Oral Health Center at HCMC, the MCO should communicate the availability of the clinic to its members and leverage its partnership with HCMC to establish data collection processes that allow the MCO determine the clinic's impact on its membership.

MCO Response: Hennepin Health did not achieve full points for the SNBC annual dental visit, age group 19-64 years, as the target goal was not met. The Department of Human Services and the MCOs have identified that the annual dental visit utilization for SNBC members is low and is a state-wide issue. In response to this effort, the MCO Collaborative SNBC Dental Access Improvement Project was initiated in 2016 and is ongoing. This project includes both member and provider initiatives. Hennepin Health participates in this collaborative which includes Medica, PrimeWest, South Country Health Alliance and UCare.

Hennepin Health has explored additional strategies to address the low annual dental utilization for the SNBC members, including those strategies identified above. Hennepin Health has reached out to several community dental clinics, including Helping Hands and the Minnesota Dental Association Mission for Mercy event coordinators. These organizations are not willing to engage in a partnership with Hennepin Health or any MCO to identify members who are using the dental services and/or to encourage the members to contact Hennepin Health for assistance in obtaining services and/or establishing a dental home. These organizations do not inquire if an individual seeking their services has dental insurance with a health plan as they do not want to disincentivize members from seeking dental services. The organizations are willing to provide the dental visit record to the individual who requests it. The individual can then send the information to Hennepin Health if they desire to.

Hennepin Health encourages primary care providers to stress to their patients the importance of having an annual dental visit. This has been communicated through the Hennepin Health provider website, including the provider bulletin.

The Dental Oral Health Center at Hennepin Healthcare, formerly HCMC, does not provide preventive dental services to members over the age of 14. The Dental Oral Health Center provides only restorative services for adult members who are current or past patients at Hennepin Healthcare. Most Hennepin Health SNBC members receive their health and/or dental care from non-Hennepin Healthcare providers. Hennepin Health communicates the availability of the Dental Oral Health Center to its members.

Hennepin Health will continue to work on improving the number of members receiving an annual dental visit, which can lead to better overall health for the member. A monetary incentive in the form of a gift card was implemented in 2017 which a member can receive after completing a dental visit. Encouraging and supporting the members' behavior change to seek dental care is an ever-ongoing process. The Department of Human Services and the SNBC Dental Access Improvement Project MCO collaborative conducted a member and SNBC care coordinator survey to obtain feedback regarding dental care. Issues identified as to why members do not seek dental care include, but are not limited to, members having other health care needs requiring attention and dental care was not received as a child, so it is not a service the member sees as important. This withhold measure will be an ongoing present focus for Hennepin Health. Hennepin Health will continue to participate in the MCO SNBC Dental Access Improvement Project collaborative.

- **2016 Recommendation: HEDIS (Quality of Care)** – Conduct root cause analysis for the measure listed above and implement quality improvement initiatives to address identified barriers. The MCO should expand the reach of interventions to ensure members who are not in the Diabetes Disease Management Program also benefit from implemented interventions.

MCO Response: The Hennepin Health – SNBC program is a relatively small program having approximately 2000 members. The HEDIS 2017 Comprehensive Diabetes Care: Eye Exam (18-64) rate was 61.7%, slightly lower than the Hennepin Health 2016 HEDIS rate of 62.5%. NCQA’s Quality Compass 2017 National Medicaid Benchmark was 66.67% and the statewide average was 70.5%. The eligible population for the HEDIS Comprehensive Diabetes Care measure was 201, which is 50% lower than the NCQA required 411 sample size. When continuous enrollment requirements are applied for data such as HEDIS measures, the sample size becomes small and potentially unreliable.

Of the 2000 members, approximately 700 members are actively engaged with care coordination services provided by Hennepin Health’s SNBC care coordination agencies. The other members either refuse care coordination services or are non-reachable. Many members have a behavioral health and/or chemical dependency illness, so establishing a relationship with a different provider other than their primary care practitioner and/or behavioral health/chemical dependency provider may be difficult. Chart review has revealed that members are often no-shows for the scheduled eye exams or cancel the appointments without rescheduling. Members often refuse eye dilation as it can be uncomfortable for them for several hours after the appointment. Hennepin Health does provide transportation to medical appointments for members who need it. Members with diabetes often do not understand the importance of annual eye exams, even if they have eye health issues, as they did not receive it as a child or during early adulthood. In addition, the SNBC member may have other health care conditions requiring their attention.

Hennepin Health, through various programs, have made extensive attempts to engage these members or to contact them. Hennepin Health promotes the monthly Wellness Wednesday event which provides information about services and health care, such as diabetes care. Care Coordination Agency and the Disease Management staff frequently attend these events. Hennepin Health encourages the care coordination agency staff to urge members to get an annual eye exam. In addition, a reminder to schedule an eye exam and the importance of an annual eye exam was mailed to all members with diabetes by the Hennepin Health Disease Management Program coordinators. Hennepin Health encourages primary care providers to stress to their patients with diabetes the importance of having an annual eye exam. Hennepin Health urged providers to include a reminder in the electronic medical record as a prompt, so, at the time of the medical visit, the provider can encourage their patient to get an annual eye exam. Hennepin Health will continue to review and implement strategies to increase the diabetic member eye exam utilization and will continue to monitor this rate.

ITASCA MEDICAL CARE (IMCARE)

IPRO Comment: Some aspects of IMCare’s response to the 2016 recommendations address MCO performance for 2017, 2018 and present time.

- **2016 Recommendation: Financial Withhold** – The MCO should update its quality improvement strategy to include dental care for children and adults. As the MCO achieved all possible points for Annual Dental for Visit for the 7-18 age group, best practices for this group should be identified and applied across the low performing age groups.

MCO Response: The data provided in the ATR is over two years old and as a result is not an accurate reflection of IMCare’s dental rate. Furthermore, DHS no longer uses the HEDIS Annual Dental Visit (ADV) as a withhold benchmark, but developed their own dental measure which does not match the ADV data. IMCare implemented several dental measures within the last year to promote dental access and utilization including, but not limited to the following:

- IMCare conducted a geographical evaluation of enrollees without dental visits in 2017, to determine any patterns or gaps in location of dental clinics.
- In partnership with Itasca County Public Health, IMCare Network Dentists and other community partners, IMCare formed the Itasca County Dental Access Subcommittee, to identify barriers to dental care for residents of Itasca County and work towards solutions.
- IMCare Dental Committee met on several occasions to identify outreach opportunities within their practice.
- IMCare provided each network dentist with a list of enrollees who had previously received a dental visit in 2015, 2016 or 2017, but had not yet received a visit in 2018. The dental offices did outreach to those enrollees to try and get visits scheduled.
- IMCare sent individual mailings to all enrollees who had not received a dental visit in 2018, educating them about the importance of oral health, provided them with transportation information and a list a network dental providers.
- IMCare developed a list of currently enrolled individuals who have not had any dental care in the last three years and made reminder calls, to offer information about scheduling a dental visit.
- IMCare attended the Community Connect event in October, 2018 and provide information about annual dental visits and other preventative care services.
- IMCare developed a Dental Integrated Care System Partnership (ICSP), which is a pay-for-performance quality project that may further incentivize network dentists to assist in increasing our dental utilization rates and in-turn earn our 2018 withhold.

The above interventions have already been implemented and IMCare will determine whether to repeat or continue such interventions when the final dental withhold measures are released.

- **2016 Recommendation: HEDIS (Quality of Care)**

- The MCO's process of contacting enrollees to "assess any potential barriers to accessing needed screenings" should be a formal process in which barriers are tracked and trended, and addressed by tailored interventions.
- The MCO should consider increasing the frequency of the Stakeholder Advisory Committee, especially if this is the key method by which the MCO addresses quality initiatives.

MCO Response: IMCare utilizes the enrollee screening tool developed by the enrollee screening workgroup in 2018 to address barriers for individual enrollees. This data is tracked and now has an annual reporting requirement. Any individuals identified through the enrollee screening process or other methods can receive case management services from IMCare as indicated. Additionally, IMCare has customer service representatives or afterhours line available 8am-8pm to assist with any member barriers on an as-needed basis. IMCare also conducts an annual analysis of CAHPS data and implements interventions as indicated. Lastly IMCare, as required by DHS participates on the National Core Indicators work group which addressed enrollee's quality of life factors, results from that data will be evaluated and interventions implemented as indicated. IMCare hosts the Stakeholder Advisory Committee but will accept enrollee feedback about barriers via phone, mail or email or at any community outreach event. Lastly IMCare conducts an annual analysis of practitioner availability, network adequacy and accessibility of services for IMCare enrollees.

Enrollee screening surveys are sent monthly to those newly enrolled, including three attempts if IMCare does not receive a response. Analysis of CAHPS data occurs annually after the data is made available to MCO, generally in 4th quarter. Case management services are trackable and specific barriers that case managers find that enrollees are encountering could be addressed at a case management meeting or via email amongst the team. Analysis of practitioner availability, network adequacy and accessibility of services for IMCare enrollees occurs in 3rd quarter.

QI initiatives are addressed quarterly at the Provider Advisory Subcommittee and the QI/UM Subcommittee with both internal and external participants. Additionally, IMCare holds internal Quality meetings to address ongoing initiatives as indicated to meet the needs of the plan; in addition to the day-to-day operations that impact quality initiatives. The purpose of the Stakeholder Advisory Committee (SAC) is to gather input about potential barriers or issues from enrollees or people who represent them. IMCare holds a biannual meeting as required by the DHS Seniors contract, however this does not limit the enrollee from submitting any concerns via phone, mail or email as indicated above. If IMCare received several concerns between biannual meetings, an additional meeting could be held.

IMCare does not plan to hold additional SAC meetings on a scheduled basis, as quality initiatives are being addressed in several other ways.

MEDICA

- **2016 Recommendation: Financial Withhold** – As the MCO continues to struggle with the Hospital 30-Day Readmission measure, the MCO should reevaluate the effectiveness of its current strategy to decrease readmissions. In addition to performing root cause analyses to identify barriers, the subgroup created to address dental care should consider collaborating with other MCOs to identify and address community issues, such as free dental clinics that do not submit claims.

MCO Response: Medica has and will continue to address the opportunity for improvement in our hospital readmission rates with our current Medicaid populations. While Medica is no longer contracted in the Families and Children’s space, prior to exiting the contract in April 1, 2017, Medica utilized an inpatient and care transition management with the Families and Children’s population. This program was a collaborative process to support coordination of members care and services across departments and teams by organizing and coordinating resources to support an integrated response to health care needs of patients; providing a unified member view of improved care and communication. The program supported delivery of health care and services at the most appropriate level of care; evaluated appropriateness and medical necessity of admissions, lengths of stay (LOS), discharge practices, and related factors that contribute to effective resource and service utilization. In addition, it facilitated the achievement of expected patient outcomes and discharge within an appropriate length of stay. The objective was to promote and support transitions to the appropriate post-acute disposition by engaging internal resources early in the hospital stay for discharge planning with hospital care team (i.e. case management and care coordination). Desired outcomes for this project included: Reduction of unnecessary inpatient days and increase referrals to case management and care coordinators for follow up after admission.

Readmissions continue to be a focus for our ongoing Medicaid products of MSHO, MSC+ and SNBC. Medica has multiple approaches to monitoring readmission rates, including at the Care Coordination Product and Quality Improvement leadership level. For our MSHO, MSC+ and SNBC Care Coordination program, Medica relies on Care Coordinators to manage member transitions. Use of the member’s CC ensures that both planned and unplanned transitions are managed with a consistent person supporting the member and/or family members or guardians across all settings. Medica has provided education and training for Care Coordinators about the Eric Coleman model for managing transitions, as well as training from Medica’s Medical Director about the importance of effective transition management. In addition, Medica has readmission reduction programs available to MSHO members. This benefit includes four visits by a Community Companion. In addition, members receive medication reconciliation and home safety evaluation. Short-term meals are available for members not receiving meals through a waiver. Medica also offers the supplemental benefit for MSHO members of a post hospitalization member care kit, which includes a reacher,

long-handled scrub brush, long-handled shoehorn, one week four row pill minder, and written materials on the use items and care tips.

Medica has a Utilization Management Subcommittee, which reviews utilization rates, including ED use, admission, and readmissions. The UM Subcommittee reports to the Quality Improvement Subcommittee of the Medical Committee of the Medica Board of Directors. Medica's Quality Improvement Subcommittee, directs, oversees, and evaluates the Medica quality improvement program with the goal of promoting and continually improving clinical quality, service quality, provider quality, and patient safety. The UM Subcommittee continues to conduct root cause analysis to identify appropriate interventions to reduce readmission rates across our populations.

The SNBC Dental Access and Improvement Project, a collaborative effort amongst all SNBC MCO's has taken numerous steps to address dental access within the SNBC population. This includes multiple provider surveys, and interviews with dental experts working with the disabled population to gather input on barriers to care. Further education and outreach with the dental provider community, and care coordinators is planned for 2019. The group will explore a partnership with one of the free dental clinics. This has been reviewed in the past, however organizers of these clinics are reluctant to ask for member insurance information for fear it will detract members from participating in the clinics.

▪ **2016 Recommendation: HEDIS (Quality of Care)**

- Despite having a multifaceted intervention approach, Medica continues to struggle with improving cancer screening rates for women across multiple programs. The MCO should analyze the effectiveness of related interventions and expand upon those determined to be most effective.
- The MCO should update its quality improvement strategy to include asthma medication management.

MCO Response: Medica staff continued efforts to improve Colorectal Cancer Screening and Breast Cancer Screening rates. Actions implemented in 2017 designed to help improve cancer screening rates include: spring and fall gaps in care mailings that provide members with individualized information about gaps in preventive care; work with the American Cancer Society to implement cancer screening initiatives in clinics; and CVS Rx bag tags promoting colorectal cancer screenings. The gaps in care mailing, also offered in 2018, included education on the importance of screening and resources to help the member schedule an appointment.

Medica continues to collaborate with the American Cancer Society to implement initiatives with provider clinics and to provide education for Care Coordinators who work with the SNBC and Senior populations. Breast Cancer Screening and Colorectal Cancer screening were both included in

Medica's EBM Gaps in Care initiative, with both considered priority gaps in care, addressed by Medica Care Coordination and Health Management staff working with members.

Other interventions continued including: total cost of care clinic quality measures in provider contracts; provider newsletter articles and member newsletter articles twice per year highlighting the importance of preventive care.

The 2016 Annual Technical Report indicates that the HEDIS measure for Medication Management for People with Asthma was an opportunity for improvement with the Families & Children MA population. As indicated previously, Medica exited the Families and Children's contract in April 2017. Prior to that time, Medica members in this program were eligible to receive disease management support for asthma through our Disease Management program. This program provides a targeted, condition-specific focus that Medica believes will have greater impact with our members. Members have access to online tools and resources, and high-risk members receive the support of an experienced, dedicated nurse. During the initial telephone session, the nurse conducts an assessment, which when combined with medical and pharmacy claims data serves as the foundation for a detailed action plan. Subsequent phone sessions allow the nurse to identify gaps in care, help the member set goals, assign homework and chart the member's progress toward achieving goals. Members who have an asthma diagnosis received support with understanding their asthma medication management.

Medica's Quality Improvement (QI) program supports our mission to meet our customers' needs for health plan products and services. The QI program's purpose is to identify and implement activities that will: improve member care, service, access and/or safety; improve service to providers, employers, brokers and other customers and partners; and/or improve Medica's internal operations. Our QI program encompasses a wide range of clinical and service quality initiatives affecting our members, providers, employer and brokers, as well as internal stakeholders throughout Medica. The Quality Improvement department at Medica compiles the QI Work Plan with input from business units and stakeholders throughout Medica. The QI Work Plan is intended to highlight significant activities with potential to influence clinical quality, service quality, provider quality and safety for our members, including members in Medica's current Medicaid products: MSHO, MSC+ and SNBC.

PRIMEWEST HEALTH

- **2016 Recommendation: Financial Withhold** – As dental care is an area of concern across all programs, the MCO should ensure that the Annual Dental Visit measure is included in its five year strategic improvement plan. The MCO should also consider adding annual dental visit as an Accountable Rural Community Health facility outcome measure; as well as consider collaborating with other MCOs to identify and address community issues, such as free dental clinics that do not submit claims.

MCO Response: IPRO recommends that PrimeWest Health focus on the Annual Dental Visit measure and include it in strategic planning and ARCH efforts. We have made many efforts to encourage members to have an annual dental visit. Our most vigorous strategies are below.

- Inclusion of Annual Dental Visit in ARCH efforts: As stated in the Care Management section of Exhibit 2 of PrimeWest Health’s Accountable Rural Community Health (ARCH) contracts, we require ARCH facilities to demonstrate internal person-centered care management, chronic disease management, and population health management processes that effectively facilitate the coordination and integration of the following to improve health outcomes for designated members: primary care, acute care, long-term care, dental care, community services, public health and human services, and mental and behavioral health services, as applicable. This includes care coordination or navigation strategies for increasing dental visits related to the HEDIS measure, Annual Dental Visit.
- Deployment of mobile dental outreach clinic services: PrimeWest Health currently contracts with four dental clinics that provide outreach dental services to PrimeWest Health members via mobile dental clinics. We strongly support bringing dental services to sites within our communities, not only to increase access but also to provide an extra level of comfort to members who may experience sensory triggers or anxiety about traveling to or attending a dental appointment, barriers that are often overlooked. PrimeWest Health collaborates with mobile dental outreach providers who have the ability to cover any identified area of need.
- Provision of oral health education and support at the member, provider, and county levels: PrimeWest Health provides education and support to our members, our providers, and our owner counties’ Public Health and Social/Human/Family Services agencies to promote the importance of oral health care and the prevention of oral health conditions in an effort to increase dental visits for members and improve members’ oral health practices.
- Development of a Dental Care Management program to facilitate timely and convenient access to comprehensive dental care, to help members establish dental homes, and to promote good oral health: PrimeWest Health’s Dental Care Management program helps our members establish a dental home and assists with service plan navigation and coordination of comprehensive oral health services. This allows members to take an active and informed role in their oral health as well as their overall health. PrimeWest Health’s Dental Care

Management program is available to members who need help finding a dental home, making a dental appointment, and/or managing their oral health care. The PrimeWest Health Dental Services Coordinator works directly with our members and dental providers to set appointments according to the member's specific needs and choices and without a lengthy wait time. An important element of our Dental Care Management program is talking with members about any possible barriers to care, including dental anxiety, transportation concerns, and physical or emotional barriers. Motivational interviewing techniques are utilized and, based on feedback from the Dental Services Coordinator, are effective.

- Participation in the DHS Special Needs Basic Care (SNBC) Dental Access Improvement and Evaluation Project: The goal of this project is to increase SNBC member access to dental providers and encourage greater utilization of dental services. The project consists of three mandatory and three recommended interventions. The three mandatory interventions are Dental Case Management, a Special Needs Community Dentist and Staff Mentoring Program, and a Teledentistry Demonstration Project.
- Utilization of new member survey: New Families and Children and MinnesotaCare members are encouraged to complete a new member survey. The Dental Services Coordinator places outreach phone calls to members who indicate on the survey that they have not had a dental visit in the last 12 months. During the call, the Dental Services Coordinator offers help making an appointment and provides education about the importance of an annual dental visit.
- Provision of an educational program for nursing home staff: PrimeWest Health provides education to staff at nursing homes where our members reside. Topics include tips and tools for staff and caregivers to help residents with their oral health care, information on how oral health affects overall health, and recommendations for provision of on-site dental services that allow residents to have routine dental services available.
- Collaboration with Head Start: PrimeWest Health has relationships with all Head Start programs operating within our 13 counties. These relationships allow us to offer educational resources for Head Start staff and Head Start children and families about the importance of oral health. PrimeWest Health is available to assist with coordinating routine on-site dental services for Head Start students, as well as coordinating necessary treatment and follow-up care.
- Collaboration with other external partners: PrimeWest Health utilizes our relationships with external partners to make an impact on the oral health education available across our 13 counties. PrimeWest Health works closely with the Early Childhood Dental Network (ECDN), which brings together statewide oral health stakeholders, and PrimeWest Health's Dental Services Coordinator is a member of the Minnesota Oral Health Coalition Board of Directors, the statewide resource for engaging people, communities, and organizations in partnerships that promote oral health through prevention, education, advocacy, and access to care. One benefit of these partnerships is the opportunity they provide PrimeWest Health to collaborate on consistent and persistent communication about the importance of an annual

dental visit through alternative methods such as public service announcements and social media, an innovative solution to mail and phone call fatigue.

The above efforts will continue in 2019, and we hope to see improvement in HEDIS 2020. Withhold measures are reviewed annually; any changes that need to be made to the strategic plan or ARCH contracts are made at a leadership level.

- **2016 Recommendation: HEDIS (Quality of Care)** – As the MCO continues to struggle with child health and women’s health, the MCO should ensure that these areas of care are priorities in its five year strategic improvement plan. The MCO should leverage its “in house” HEDIS process to perform frequent data analysis, and to drive quality improvement actions.

MCO Response: IPRO recommends that PrimeWest Health focus on HEDIS measures aimed at women and children in our strategic planning. In 2017, PrimeWest Health’s HEDIS/Star Strategy workgroup created a five-year strategic plan for organization-wide improvement. This process included prioritizing certain measures, involving staff from across the organization in plan development, and modifying prior interventions based on data analysis. The following women/children measures are part of the strategic plan. Information on current efforts in these areas, along with data gathered since the 2016 ATR, is shown below.

- Childhood Immunization Status (CIS) – PrimeWest Health had a voucher program for this measure in 2016. For each well-baby visit (up to age 15 months), families could earn a \$25 gift card. Additionally, a \$100 gift card was provided as incentive for a child to receive all of his/her immunizations by age 2. While vouchers for this measure are not currently being utilized, due to the long lookback period for this measure, PrimeWest Health continues to see the voucher program’s positive impact. PrimeWest Health currently sends personalized immunization schedules to families, letting them know when their babies are due for their next vaccines. We hope this personalized information will be more effective than generic education. The PrimeWest Health CIS Combo Ten measure increased from 28.22 percent in HEDIS 2017 to 34.31 percent in HEDIS 2018.
- Chlamydia Screening in Women (CHL) – PrimeWest Health works hard to educate our providers and members on the importance of chlamydia screening. We worked with the Minnesota Department of Health (MDH) to coordinate provider trainings at several of our clinics in 2018. We are also starting two pilot projects in 2019. One involves working with a third party lab to send at-home testing kits to our members, and the other involves allowing direct access for chlamydia screening at one of our hospital labs. The effectiveness of these interventions will be evaluated at the end of 2019. The PrimeWest Health CHL rate increased from 35.62 percent in HEDIS 2016 to 39.98 percent in HEDIS 2018.
- Adolescent Well Care Visits (AWC) – PrimeWest Health has a voucher program for well-child visits for members ages 12 – 21 in which members can earn a \$25 gift card for completing this service. PrimeWest Health also has seen an increase in our well-child visit rates due to

clinic electronic medical record (EMR) systems asking screening questions related to mental development and anticipatory guidance at all visits. These count towards the HEDIS measure in medical record review. The PrimeWest Health rate in HEDIS 2017 was 44.77 percent; the HEDIS 2018 rate is 59.61 percent.

- Breast Cancer Screening (BCS) – PrimeWest Health includes breast cancer screening in our voucher program and in our ARCH program. Members ages 50 – 74 can earn a \$100 gift card for receiving a mammogram. Additionally, ARCH providers can earn shared savings for reaching their goal in this area. PrimeWest Health has seen an increase in BCS rates over the years; HEDIS 2015 was 60.74 percent and HEDIS 2018 is 68.35 percent.

PrimeWest Health continues to work on HEDIS measures aimed at women and children and tracks progress no less than annually. The strategic plan is in place for five years, and is evaluated and updated as needed. Updates to the strategic plan for each intervention are followed and sub-workgroups are often created to ensure that feedback and input from multiple departments is taken into consideration. We continue to utilize our in-house HEDIS process to pull data and rates more frequently than required for reporting purposes, guide chart chase efforts, and create risk lists for outreach purposes.

SOUTH COUNTRY HEALTH ALLIANCE (SCHA)

▪ **2016 Recommendation: Financial Withhold**

- In regard to the HEDIS Well-Child Visits in the First 15 Months of Life Measure, the MCO should develop specific interventions to address the barriers described in its response to the previous year's recommendation. For example, work with in-network clinics to enhance EMR systems to capture necessary documentation.
- Conduct root cause analysis for annual dental visits by age group and by program, and development interventions to address identified barriers. The MCO should also consider collaborating with other MCOs to identify and address community issues, such as free dental clinics that do not submit claims.

MCO Response: Well-Child Visits in the First 15 Months of Life Withhold Measure – South Country implemented a comprehensive strategy to promote and improve compliance with recommended infant well-child visits. This included a reward program that offers parents a gift card reward if their child completes 6 well-child visits by 15 months of age. Parents of eligible children are mailed information about the importance of the well-child visits alongside a reward program voucher; the topic is also heavily promoted by South Country's partnering public health agencies.

A root cause analysis for this measure was conducted during HEDIS 2016 and 2017 using the hybrid specifications outlined for medical record review. The following themes were noted:

- Many children receive the recommended number of well-child visits during infancy, however, the sixth visit commonly falls outside the parameters of the practice guidelines, generally within a range of one to 60 days after the child turns 15 months.
- Similarly, lack of or inadequate health history documentation in the patient's chart (particularly for children seen for ongoing acute and/or chronic medical conditions) causes many well-child visits to be deemed incomplete.
- Infants with ongoing acute or chronic conditions are seen on a frequent basis by their provider for follow-up care. However, components for well-child preventive services are not necessarily included as part of the provider visit.

These findings were published in our provider newsletter and shared during strategic planning meetings with our network providers and partnering public health agencies as a means of addressing causal factors and collaboratively aligning performance improvement strategies for infant well-care visits. Frequent touch point meetings have provided the opportunity to learn and share best practices, as well as gain a better understanding of the challenges providers experience in delivering well-child services to our members.

Starting in 2016 and through 2017, South Country Pay for Performance (P4P) programs were in place with six health care delivery systems that collectively serve over 80% of our membership. These programs provide financial incentives to provider groups for aligning efforts with South Country to improve specific quality of care measures and health outcomes of members. A priority topic for P4P program is HEDIS Infant Well-Child visits measure (6 visits by 15 months of age). Intensive collaboration between South Country and the clinics to understand identified barriers, share data and align intervention strategies.

Annual Dental Visits – A root cause analysis for annual dental visits measure was conducted which showed that Annual HEDIS Dental Rates increased from the previous year's rates. The following themes were noted:

- The purpose of the Smiling Stork Program, through DentaQuest, is to prevent the development of, or complications associated with periodontal disease, among pregnant women. Primary objectives include providing education to pregnant women on the importance of screening and treatment, establishing good oral health habits, and also improving member access to dental care.
- South Country's change to remove the Prior Authorization requirements for 3rd and 4th cleanings for SNBC members in 2016 and for SeniorCare Complete (MSHO) in 2017 resulted in eliminating the administrative burden for providers. This allows our members to more easily receive increased preventive care.
- South Country is actively involved with the Early Childhood Dental Network project through Southern Minnesota Initiative Foundation. Initiatives include; reviewing data showing the number of children receiving services, provide outreach, education and collaboration with primary care providers and to provide education on oral health disparities.
- The Re-routing Emergency Dental Care Program purpose is to decrease utilization of the ER for non-traumatic dental care. The program is monitored on a quarterly basis to determine trends in member utilization, including repeat ER visits by the same member and the ER locations most frequently utilized.

In July 2016, South Country began working with other Minnesota Managed Care Organizations (MCO's) on a SNBC Dental Access Improvement and Evaluation Project proposed by the Minnesota Department of Human Services (DHS). The project is based on the 2016 RFP in which MCOs were asked to propose a dental access quality improvement and evaluation plan, that through ongoing measurements and interventions, results in significant improvement, sustained over time, in administrative management and/or innovations in clinical care that is expected to have a favorable effect on dental access.

The Primary goal of the project is to improve dental access for SNBC members, ages 18-64, over the next three to five years (2017-2021). Collaborative interventions and efforts with the other MCOs,

Minnesota Department of Human Services (DHS), DHS Direct Care and Treatment Dental Clinics (CDT-DC) will primarily focus on dental case management, special needs community dentist and staff mentoring program and a tele-dentistry demonstration project.

The Minnesota Department of Human Services (DHS) sponsored dental surveys of people with disabilities in the Medicaid program in 2017 to individuals who received dental services during the past year and to individuals who had not received services in the past year. The surveys were given to individuals who were enrolled in an SNBC product and to individuals who were enrolled as a Fee for Service. The purpose of the survey was to establish baseline information for the SNBC Dental Access Project as to why members accessed or did not access dental services. The intended outcome was to assist DHS and MCOs:

- Understand member's experiences with dental services
- Explore causal factors and/or reasons for underutilization of dental services
- Identify barriers to accessing and using dental services
- Share information and knowledge on service utilization and access
- Promote effective change by identifying access improvement opportunities

An electronic survey of dental clinics to assess their interest and willingness to make physical and practice accommodations needed to treat SNBC enrollees with special needs was also conducted in 2017 as a collaborative project by the DHS Special Needs Purchasing Unit and MCOs offering SNBC health care plans. The survey was conducted to verify a hypothesis that dental clinics want and can provide services for individuals with special needs if physical and behavioral barriers can be overcome.

Results of the survey have been made available to the public and can be found on South Country's website under Provider Accessibility Service Results in the member section. Survey results will be used to develop additional strategies for this project as it progresses forward.

Case management training, including a webinar, was provided to all case managers and care coordinators regarding the importance of educating members on oral health practices, the importance of members being able to access dental services and helping members understand their dental benefits. In keeping with a person-centered approach to working with SNBC members, case managers and care coordinators were encouraged to offer members the option of identifying a goal related to dental health as part of the member's care plan, as considered appropriate, to address the member's oral health needs.

The following tools were created by the MCOs for use by CM:

- Dental Outreach Letter
- Oral Care Tip Sheet
- CM Information Guide

- Dental Benefit Sheets

Care Coordination follow-up was completed via telephone whenever possible, unless the timing aligned with a scheduled face to face appointment. The level of assistance provided depended on the individual member needs and wants. For members who have a guardian/authorized representative in place, the Care Coordinator communicated with the guardian regarding the member's dental care needs. If the Care Coordinator was unable to reach member via phone, follow-up occurred via mail. Members who declined or chose not to be engaged in care coordination services previously, received outreach by Care Coordinators to educate about the members dental benefit, provided encouragement and support, and offered assistance to connect with a dentist and in scheduling an appointment. This outreach was conducted by telephone or mail depending on the member's level of engagement and willingness to participate in the calls. Outreach was conducted by mail for members requesting no contact and for those members who did not have a valid phone number. The level of support and assistance provided depended on individual member needs and wants.

Education and support provided during outreach calls and mailings included the following topics:

- Education on the importance of routine preventive dental care and link to overall health
 - Educational materials on available dental benefits, how to locate a dentist, along with identification of any barriers to accessing dental services;
 - Assistance with connecting with a dentist for an appointment and transportation needs and;
 - Education on the importance of keeping scheduled dental appointments, as well as the impact of no show appointments.
- **2016 Recommendation: HEDIS (Quality of Care) –**
- In regard to chlamydia screening, evaluate the effectiveness of the interventions described in the MCO's response to the previous year's recommendation and modify the interventions as needed. The MCO should expand all provider initiatives to include gynecologists as well.
 - Conduct root cause analysis for measures newly identified as opportunities for improvement and develop interventions to address identified barriers to care.

MCO Response: Chlamydia Screening: Quality Improvement Strategies – South Country's Be Rewarded! member wellness program continues to promote evidence-based health care guidelines and is designed to improve the health status of members through education and rewards. In 2017 a bonus reward was added to the existing young adult well-care visit reward for all eligible members, ages 18-21, for completing Chlamydia screening during their well-care exam. A monthly outreach campaign was implemented, targeting members who did not have an annual well-child visit in the previous six months. Members receive a supportive outreach letter, an educational flyer describing facts about Chlamydia, information on screening and treatment, and a rewards program voucher to take with them to their next well-care exam. This information is also made available to county public

health agencies to distribute and provide education to eligible members who use services provided by their agencies.

Starting in 2016, South Country began partnering with public health agencies for conducting annual Child and Teen Checkup (C&TC) meetings with key primary care providers and their clinic staff. The purpose of these meetings was to promote C&TCs, discuss implementation of preventive screening practices (including coding and maximization of accurate billing practices), share educational materials and provide information on preventive care rewards. This included promoting Chlamydia screening for both male and female young adults.

Additional outreach strategies for 2016-2017 have included provider network newsletter articles on best practices in rewarding preventive care, as well as information on the Be Rewarded! incentive programs offered to eligible South Country members. South Country's member newsletter also includes articles focused on the importance of preventive care services, including Chlamydia education and screening.

Identified strategies to improve member satisfaction for 2017 included implementation of a consumer awareness plan focused on marketing and education to new and current members (recognizing South Country as their managed care plan), outreach and collaboration with provider and clinic systems in addressing consumer concerns directed at service delivery and provider continuity of care, and enhancing member assistance in locating primary care providers.

Newly identified opportunities – A root cause analysis is conducted yearly regarding South Country's HEDIS rates pertaining to child and adult preventive services.

South Country implements member health promotion programs using evidence-based practice guidelines and South Country's HEDIS results, with the intent of improving and supporting the health status of members through education and incentives around wellness topics. In addition, these programs promote provider and member compliance with clinical guidelines for child and adult preventive services.

Several changes were made to South Country's Take Charge! Wellness programs during 2017, most of the specific to our Be Rewarded! Preventive care reward protocols. The Family Health Committee, comprised of representatives from South Country and county public health departments, served in an advisory role for the design and implementation of the health promotion changes.

- Revised the 12-year Childhood Immunization program incentive to focus solely on the completion of the HPV immunization series by age 13.
- Revised the Young Adult Well-Care incentive program to include a gift card bonus reward for completing Chlamydia screening during the well-care exam.

- Developed the Be Rewarded Member Well-Care voucher booklet so that families could readily access vouchers from one source.
- Developed a Health & Wellness Checklist for county public health departments to use in facilitating discussions about and persuade members to complete recommended preventive care services.
- Implemented targeted monthly mailings to eligible members on HPV immunization, Chlamydia screening and Cervical Cancer Screening.
- Implemented targeted monthly mailings of the Be Rewarded! Well-Care booklet to eligible members with newborns to promote Postpartum Care and the importance of Infant well-care visits.

Be Rewarded! Programs provided gift card incentives to eligible South Country members who complete preventive care services within the recommended time frames and submit a completed voucher.

- Prenatal Care: Completion of a prenatal care visit with a healthcare provider during the first trimester (or within 42 days of enrollment).
- Postpartum Care: Completion of a postpartum care visit with a healthcare provider between 21 and 56 days after delivery.
- Infant Well-Child Visits: Completion of at least six well-child check-ups before 15 months of age.
- Lead Screening: Completion of a blood lead test by age one and again or by age two.
- 2 Year Childhood Immunizations: Compliance with receiving all recommended immunizations by age 2.
- Adolescent HPV Immunizations: Completion of the HPV immunization series (two shots) by 13 years of age.
- Child Well-Care Visit: Completion of an annual well-care exam by members ages 3 -6 years of age.
- Adolescent Well-Care Visit Reward Program: Completion of an annual well-care exam by members ages 11-17.
- Young Adult Well-Care Visit: Completion of an annual well-care exam and screening for Chlamydia by members 18-21 years.
- Mammogram Reward and Outreach Program: Completion of a mammogram by women ages 50 and older.

Several health promotions initiatives have been under development in collaboration and consultation with our Member Services, Communication/Marketing teams, a team of Analysts and Family Health Committee, since mid-2017, for implementation in 2018. These initiatives are designed to incorporate health promotion best practices supported by research and include the following strategies:

- Mapping of member mailings lists, health promotions data to effectively track members participation in the rewards program.
- Processing of health promotion incentive vouchers in a new system.
- Reviewing and updating all health promotion material and voucher forms to ensure the information is clear and consistent in explaining the importance of preventive care.
- Revision/realignment of incentive programs to include greater focus on voluntary preventive care participation across South Country's products.
- Availability of all the preventive care vouchers in a Be Rewarded Member Well-Care booklet to families.
- Continued mailing of the Be Rewarded Member Well-Care booklet to new mothers. Enhance provider awareness of health promotion incentive through annual clinic provider meetings with clinic managers and member counties' Child & Teen Check-up Coordinators.

UCARE

Annually, a cross-departmental team reviews and analyzes all of UCare's HEDIS data, withhold measures, and member satisfaction surveys (CAHPS) to review performance based on our comparison to the previous year, statistical significance of increases and decreases, comparison to NCQA national percentiles, and comparison to the Minnesota state average (which UCare leads and coordinates with the other health plans). UCare uses this analysis to set priorities for the year.

A committee is dedicated to the improvement of priority HEDIS, withholds, and CAHPS measures and assigns responsibility for improving the measures to Quality Improvement Specialists who work with content experts throughout the organization. These specialists conduct focused studies following the Plan-Do-Study-Act model for improvement taught by Institute for Clinical Systems Improvement (ICSI) staff. They perform a root-cause analysis for all identified measures, which includes an understanding of the issue/measure, an environmental scan and literature review, barrier analysis, intervention planning and implementation, and analysis of the intervention. If the intervention is successful, it is operationalized within UCare.

▪ **2016 Recommendation: Financial Withhold**

- As the MCO continues to struggle with emergency department utilization and well-child visits, the MCO should evaluate the effectiveness of its current improvement strategy and modify it based on updated root cause analyses.
- To address annual dental visits, the MCO should modify and expand upon its current dental outreach program described in the MCO's response to the previous year's recommendation. At a minimum, a modified approach should be based on root cause analysis and should address barriers across the various age groups and programs.

MCO Response: Well-Child Visits (6 visits by 15 months, ages -15 months): UCare has an internal workgroup dedicated to improving the access to primary care provider (PCP) measure, and in 2017, UCare continued to conduct a number of different initiatives to improve this rate and the care for our young members. Interventions strategies that were implemented to improve efforts for child access to PCPs included:

- A \$50 incentive for completing six well child visits by 15 months of life.
- A member engagement specialist who made specific calls to members to provide education over the phone (specifically on the importance of a well child visit), assisted in scheduling well child visits and assisted with scheduling transportation and an interpreter as needed.
- Interactive voice recording calls in English, Spanish, Hmong and Somali to prompt members to get their well child visit and flu vaccine.
- Collaboration with Parents in Community Action (PICA) to provide education on well child, adolescent well care, and postpartum care visits.

- Customer Services hold-time messages and articles for members and providers on the importance of scheduling C&TC visits.
- Collaboration with community groups for various C&TC initiatives and educational opportunities
- Articles in our provider newsletter, [health lines](#).
- Articles in our [member newsletter](#) *A Healthier U* and in the [Zerkalo](#), a Russian newspaper and community services directory.
- Mailing our Management of Maternity Services (MOMs) [booklet](#) to all expecting members, which includes information on well child visits and the periodicity schedule.
- Providing the [Parent's Guide](#) after delivery, which includes information on the importance of well child visits and the periodicity schedule.

Emergency Department Utilization Rate: UCare has adopted a multi-prong approach to reducing avoidable emergency room utilization. We have a cross-organizational team that designs, implements, and oversees our efforts. We routinely review emergency room utilization on a quarterly basis via our Utilization Management Work Group and Medical Management Committee, paying particular attention to identifying members with frequent utilization, facilities with high volume of avoidable visits, and primary care clinics with high volume emergency room patients.

Following is a description of a few key strategies UCare employed in 2017 to address the state mandated emergency room withhold.

- **Nurse advice services:** UCare collaborates with a national vendor to provide on-demand health guidance and support to our members seeking health advice, telephonic triage services, and easy access to medical information and treatment recommendations. This service is available 24/7/365 and immediately connects members to a nurse with each call. UCare also offers members the option of a secure on-line WebNurse as another way to make care more accessible and convenient. The web-based non-emergent nurse advice service is accessed through our member portal any time of the day, and members receive a response to general health questions within 24 hours. UCare analyzed our nurse advice line data and found we had a >56% emergency room avoidance rate in 2017.
- **Health coaching:** UCare offers a telephonic health coaching program based on a therapeutic intervention model called Dynamic Somato-Social Theory delivered by cross-trained clinicians to break down psychological and social barriers, then address specific medical needs. This program targets members with multi-chronic conditions, exacerbating behavioral comorbidities and psychosocial challenges. In 2017, almost 13,000 members participated in this program. Overall, validated outcomes showed a reduction in both emergency room visits and inpatient admissions and a significant reduction in member costs.

- **Minnesota Restricted Recipient Program:** UCare maintained a high rate of enrollment of members in this program throughout calendar year 2017. Analysis of member utilization and costs both showed significant reduction in emergency room utilization by members in this program, along with significant reduction in the use of narcotics and pharmacy costs.
- UCare works closely with provider groups and care management entities to support interventions via a care manager or primary care provider.

Dental: UCare has an internal workgroup dedicated to improving the access to dental providers, and in 2017, UCare conducted a number of different initiatives to try to improve this rate. Interventions strategies that were implemented to improve efforts for dental access included:

- A Member Engagement Specialist, who provided telephonic outreach to members who had a gap in care for dental visits. The specialist helped members to find a dentist and get transportation scheduled. Members who were not reached via phone received an educational letter about the importance of scheduling a dental exam.
 - UCare's delegate, Delta Dental, provided additional telephonic outreach to members who had a gap in care for dental services and assisted members to find a dental home and schedule a dental exam.
 - Interactive Voice Response (IVR) call campaigns to educate members on scheduling preventive dental exams.
 - An ER diversion letter to members who had a non-traumatic dental visit on how and where to find appropriate care. Members also received a phone call from an outreach specialist (a new position) to educate them on appropriate care and to schedule a follow up dental exam.
 - Re-launch of the mobile dental clinic, in conjunction with the University Of Minnesota School Of Dentistry. Outbound and IVR calls were conducted to assist members with scheduling on the mobile dental clinic -- especially for members living in rural counties -- due to the limited number of providers accepting new patients and Medicaid reimbursement.
 - Care coordinator training to educate on the importance of scheduling annual dental exams for members. Care coordinators were trained on how to use Delta Dental to assist with finding dental homes for members.
 - A dental postcard to hand out to members through care coordinators as well as conferences and events to educate members on their dental benefits.
- **2016 Recommendation: HEDIS (Quality of Care)**
 - As the MCO continues to struggle with improving the controlling high blood pressure rates, the MCO should intensify the improvement strategy described in the MCO's response to the previous year's recommendation. The MCO should consider an approach that includes a variety of member- and provider-level interventions.

- For measures newly identified as opportunities for improvement, the MCO should conduct root cause analyses to identify barriers and update its overall quality improvement strategy to include these measures.

MCO Response: UCare has an internal workgroup dedicated to improving and controlling high blood pressure, and in 2017, UCare used a number of different interventions to improve this rate, such as:

- As in past years, reviewed charts of members who were identified as having hypertension. Charts were reviewed to determine blood pressure readings, determine the appropriate level of care specific to members' providers, number of follow up visits conducted with their provider in the given year, and an analysis to determine how members' blood pressure readings were documented in charts. Results of the charts showed that members' blood pressure was in control based on the feedback from their provider regardless of the established guidelines for HEDIS. Some members missed the control readings by a couple numbers, which meant they were not compliant.
 - Provided education to providers about ongoing monitoring of members' blood pressure and guidelines.
 - Developed a member letter, education handout, and tracking card for members to educate them and provide a better understanding of how to monitor their blood pressure.
 - Hold-time messages on the Customer Services line providing education to members about controlling high blood pressure.
- **2016 Recommendation: CAHPS (Member Satisfaction)** – To enhance member experience with their personal doctors:
 - Continue to share survey results with providers and continue to work with providers to improve member-provider experience.
 - Consider developing metrics that allow the MCO to routinely evaluate the member-provider experience; as well as increase the frequency of the Quality Management Department and Member Experience Manager's review of member satisfaction.
 - Utilize complaints and grievances as a source to identify and address trends that may impact the member-provider experience.

MCO Response: UCare's Member Experience Manager and cross-departmental Member Experience Workgroup annually reviews the CAHPS data and develops improvement activities and interventions to impact our CAHPS scores. UCare combines the CAHPS data with other data sources to get a comprehensive view of members' satisfaction with their UCare plan. Data sources include appeals and grievances, member panels and focus groups, internal member surveys, post-call surveys, customer services call monitoring, speech miner, and other member feedback received directly from customer services and sales representatives.

In 2017, UCare conducted a number of quality improvement activities based on various CAHPS measures.

- Member Interventions:
 - A Survey Workgroup comprised of various departments/areas including Pharmacy, Customer Services, Quality Management, Provider Relations and Product Management (member engagement) identified and implemented interventions based on measures.
 - Before the CAHPS survey was sent, all members received a reminder call recorded by UCare's Chief Medical Officer on the upcoming survey and the importance of completing the survey.
 - Member newsletter articles provided education on survey participation and the CAHPS measures.
 - CAHPS-related education for care coordinators on the survey and how to engage members in completing the survey.
- Customer Services Interventions:
 - Education for Customer Services staff on related CAHPS measures and how to improve outcomes when speaking with members effectively over the phone.
 - UCare's Customer Services Quality Assurance Team monitors post calls, which are conducted after the CAHPS survey as an additional method to get more information on members' survey responses. Members who score a Customer Services representative low on the post call survey or who appear to be dissatisfied with the call receive a follow-up call by a Customer Services Supervisor within 24 hours. The Quality Assurance Team also closely monitors Customer Services calls for accuracy to ensure members are treated with courtesy and respect. Customer Services managers provide feedback to representatives based on the call performance to improve member satisfaction.
 - Customer Services managers continue to provide ongoing refresher trainings for Customer Services representatives regarding product benefits, answering member questions effectively and efficiently, as well as treating members with courtesy and respect. Additional training is provided for Customer Services representatives on oral grievances. Training includes understanding how to address people who need to file a grievance, how to try and problem solve and provide a resolution for these members, as well as learning how to deescalate complaints. In addition, a centralized group of Customer Services representatives are trained to handle oral grievances for members.
- Getting Care Quickly Interventions:
 - Providers received education on the importance of CAHPS measures and having discussions with members related to these measures. Additional education was provided to providers about how CAHPS scores and HG and CG-CAHPS overlap.
 - UCare conducted annual secret-shopper calls to assess the availability of the network and to ensure providers are following standard guidelines for network adequacy.

- To determine gaps and the need for additional providers (especially in rural counties), UCare continued to analyze the provider network for access across primary care, specialty and behavioral health.
- UCare's Provider Relations and Contracting Department and its Appeals and Grievances area reviewed network requests and determined if there was a gap in providers pursued additional contracts -- especially in rural counties.
- o Shared Decision Making Interventions:
 - The [shared-decision making site](#) was implemented to educate providers and members on how to engage in shared-decision making when deciding on treatment options.
 - Provider toolkits included specific shared decision making tools relating to Antidepressant Medication Management treatment.

CHAPTER 5: MCO FEEDBACK ON 2017 ATR

The DHS/MCO Contract, Section 7.5.3, states that each MCO shall be provided with the opportunity to review and comment on the final draft of the ATR prior to publication. This chapter presents MCO feedback on the final draft of the 2017 ATR. MCO comment resulting in modification to the ATR is noted as “addressed”.

BLUE PLUS

- Corporate Profile edits. **Addressed.**
- Quality Assurance Examination and Triennial Compliance Assessment edits. **Addressed.**
- Performance Improvement Project edits.
 - Recommend this be written in past tense since the project ended at the end of 2017. **Addressed.**
 - We decided not to prioritize based on depression diagnosis due to medical claims lag. **Addressed.**
 - Updated based on our PMAP/MNCare PIP Final Report, which was submitted to DHS 9/1/2018. The information here looks to be from the initial PIP proposal. **Addressed.**
 - We did two community events with local Catholic parishes, but they did not occur in July. **Addressed.**
- Strengths: NCQA Accreditation Survey edits. **Addressed.**

HEALTHPARTNERS

- Page 15 and page 31, delete space between Health Partners. **Addressed.**
- Throughout document change “HealthPartners’s” to “HealthPartners””. **Addressed.**
- Page 31, under Quality Assurance Examination and Triennial Compliance Assessment, include this statement: “The 2016 mid-cycle review determined that the MCO was compliant in executing its CAP for the Quality Assurance Examination.” **Addressed.**
- Page 34, change word “of” to “on”. **Addressed.**
- Page 40, MSC+ CAHPS, change the significance symbol for the Getting Care Quickly 2018 rate. **Addressed.**

HENNEPIN HEALTH

- Corporate Profile, page 43 When MHP changed its name to Hennepin Health in September 2016, the F&C MA/MNCare program was renamed Hennepin Health – PMAP/MNCare. Cornerstone, Hennepin Health’s SNBC program, was renamed Hennepin Health – SNBC. **Addressed.**
- Quality Assurance Examination and Triennial Compliance Assessment, page 43 – seventeen (17) “Not Mets” for the TCA. Hennepin Health’s response – After re-reviewing the report, it appears that how the “Not Mets” were counted included the “Not Mets” at each Element Heading and the “Not Mets” in the sub-elements under each Element Heading. There were 6 element headings “Not Met”. The Element Heading is highlighted in yellow. Depending on the counting methodology, Hennepin Health had 6 “Not Met” Element Headings or fifteen or sixteen (16) sub-elements as 3. Element 5 a. and b. are the same issue.
 1. Element 2A - Utilization Management - 2016 Contract Section 7.1.3
“Not Met” – the entire element I, ii, iii, iv, v
 2. Element 2B – NCQA Standard UM 1 Utilization Management Structure
“Not Met” – NCQA Standard UM 1 Element A: Written Program Description
 3. Element 5 – Annual Quality Assessment and Performance Improvement Program Evaluation – 2016 Contract Sections 7.1.8
“Not Met” - A
“Not Met” NCQA QI 1 - Element B (iii)
Both a. and b. identified the same issue– the overall quality program was not evaluated to determine its progress in meeting its goals
 4. Element 7 – Disease Management – 2016 Contract Section 7.3 and NCQA QI 6
“Not Met” – NCQA DM Standard - Element F Eligible Member Active Participation
“Not Met” – NCQA DM Standard Element I Experience with Disease Management
“Not Met” – NCQA DM Standard Element J Measuring Effectiveness
 5. Element 11 – Contract Section 9.3.1 Written Agreement; Disclosures
“Not Met” – A. Disclosure
“Not Met” – B. Subcontractors reporting
 6. Element 11 – Contract Section 9.3.16 Exclusions of Individuals and Entities;
“Not Met” – A. Confirming Identity
“Not Met” – B. Verification through OIG list and Excluded Parties List
“Not Met” – C. No agreements with excluded entities
“Not Met” – D. Reporting to MCO
“Not Met” – E. Informing State
“Not Met” – F. Inform State of action taken
“Not Met” – G. Not entering into any subcontract prohibited.**Addressed. The total number of “not met” determinations was updated to 19.**
- Practice Guidelines, page 46 – In addition to ICSI Guidelines, the following sources for clinical practice guidelines were:

- Medical Preventive Services in Adults: US Preventive Services Task Force Recommendation (USPSTF): Preventive Screenings
 - Diabetes Management: MN Community Measurement (MNCM) D5Goals: Diabetes Mellitus; American Diabetes Association
 - Asthma: ICSI: Diagnosis and Management of Asthma, USPSTF: Children and Asthma
 - Childhood Immunization: ICSI: Immunization Update and Preventive Services for Children and Adolescents; USPSTF: Immunization for Adults and Children
 - Adolescents Immunization: ICSI: Immunization Update and Preventive Services for Children and Adolescents; USPSTF: Immunization for Adults and Children
 - Prenatal and Post Partum Care: USPSTF Maternal and Child Health Measures; ICSI: Routine Prenatal Care
 - Follow-up Care After Hospitalization for Mental Illness: ICSI: Depression, Major, In Adults in Primary Care; Agency of Healthcare Research and Quality: Evidence-Based Psychotherapies; American Psychiatric Association: Depression; American Academy of Child and Adolescent Psychiatry
 - Depression, Adults Primary Care: ICSI: Depression, Major, In Adults in Primary Care; USPTF Recommendation: Screening for Depression in Adults
 - Alcohol and Drug Treatment: ICSI: Health Lifestyles; USPTF Recommendation for Alcohol Misuse **Addressed**.
- Table 15: Hennepin Health HEDIS Performance: SNBC, page 52 – Please refer to MHP section of the 2016 ATR report for HEDIS 2016 and 2017 Data as currently it states “No Data”. **Addressed**.
 - Opportunities for Improvement, Page 59; TCA – Received seventeen (17) “Not Mets” – see item # 2 above. **Addressed. The total number of “not met” determinations was updated to 19.**

ITASCA MEDICAL CARE (IMCARE)

No suggested edits.

MEDICA

- Table 1 should be updated to reflect participation in MSHO, MSC+ and SNBC only. ***Addressed.***

PRIMEWEST HEALTH

- Page 75, seems to indicate we were accredited by NCQA for only 2017-2018, but we respectfully suggest something like below instead: *“The MCO achieved NCQA accreditation status for its Medicaid lines of business in 2014 and has maintained the NCQA Health Plan accreditation status.”*
Addressed.
- Page 83, I think our 2016 CAHPS score for FC rating of personal doctor should be 66 instead of 67 percent. ***IPRO Comment: The MDHS 2016 CAPHS Project Summary Report shows a rating of 66.5% for Rating of Personal Doctor. IPRO rounded this rating to 67%. No change required.***
- Page 85, I think our 2016 CAHPS score for SNBC getting care quickly should be 57 instead of 58. ***IPRO Comment: The MDHS 2016 CAPHS Project Summary Report shows a score of 57.5% for Getting Care Quickly. IPRO rounded this score to 58%. No change required.***

SOUTH COUNTRY HEALTH ALLIANCE (SCHA)

No suggested edits.

UCARE

- Please add a footnote to the HEDIS tables stating, “Substantial changes in enrollment may make year to year comparisons unreliable.” ***No change.***

CHAPTER 6: EQRO RECOMMENDATIONS TO DHS

Recommendations

- DHS should consider including a description of the 2018 SNBC Dental Access Improvements and Evaluation Project in the 2018 Annual Technical Report. Although this project focuses on the SNBC population, successful interventions may be transferrable to other MHCP sub-populations that also need improved access to dental care.
- DHS should consider conducting a statewide “secret shopper” appointment availability survey for primary care providers. In addition to determining provider compliance with state access standards, this activity would also assist MCOs with identifying and addressing network adequacy issues.
- DHS should consider including a summary of the DHS quality strategy for MHCP into the 2018 Annual Technical Report to provide interested parties a broader view of DHS’s goals and priorities for health care.



PREPAID MEDICAL ASSISTANCE PROJECT PLUS (PMAP+)
SECTION 1115 WAIVER

Interim Evaluation Report 2014-2018

Minnesota Department of Human Services
June 2020

Table of Contents

PMP+ Waiver Population Analyses.....	1
Evaluation Questions	1
MA One-Year-Olds	1
Caretaker Adults	1
Pregnant Women.....	2
General Methodology and Limitations	2
Population-Specific Reporting	5
MA One-Year-Olds	5
Methodology.....	5
Hypotheses	6
Results.....	6
Limitations and Conclusions	14
Caretaker Adults with 18-Year-Old	15
Methodology.....	15
Hypotheses	15
Results.....	15
Limitations and Conclusions	28
Pregnant Women.....	29
Methodology.....	29
Hypotheses	29
Results.....	29
Limitations and Conclusions	31
MERC Analyses.....	32
Evaluation Questions	32
Methodology.....	33
Hypotheses	34
Results.....	34
Limitations and Conclusions	36

PMAP+ Waiver Population Analyses

Evaluation Questions

MA One-Year-Olds

One of the goals of the demonstration is to preserve eligibility for children ages 12 through 24 months so that this population can continue to receive the care they need. To meet that goal the PMAP+ waiver provides expenditure authority for Medicaid coverage for children having incomes above 275% and at or below 283% of the federal poverty level (FPL) who would not normally qualify for Medicaid coverage. Relatedly, another goal of the demonstration is to ensure equitable access to and quality of preventive care to the MA one-year-old population as compared to other children enrolled in public health care programs. Thus, the evaluation questions are as follows:

- a) Did the MA one-year-old population experience comparable utilization of services when compared to the national Medicaid averages?
- b) Do the rates of the measures vary by race in this population?

Caretaker Adults

Beginning in 2014, the PMAP+ waiver provided expenditure authority for Medicaid coverage for adults without children and caretaker adults with incomes up to 133% of the FPL. Both groups are eligible for the full MA benefit set, and health care coverage and cost sharing are the same. Caretaker adults have been defined as adults who live with and assume responsibility for a youngest or only child who is age 18 and not enrolled full time in secondary school. However, the waiver authority allows Minnesota to disregard the requirement to track the full-time student status of children age 18 living with a caretaker since coverage is the same whether adults have no children or a child age 18 at home. The goals are to avoid requesting private data that is not relevant to eligibility determination, to relieve the burden on consumers, and to create efficiency in administration of benefits. It is important to achieve these goals while maintaining quality of care for MA beneficiaries. Thus, a further goal of the demonstration is to ensure at least equitable access to 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. Thus, evaluation questions are as follows:

- a) Did the MA caretaker adult waiver population in Minnesota experience utilization of preventive and chronic disease care services for adults comparable to other adults enrolled in MA in Minnesota?

- b) Did the MA caretaker adult waiver population in Minnesota experience utilization of preventive and chronic disease care services for adults comparable to national Medicaid averages?

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. Previously, under hospital PE covered benefits for pregnant women during a presumptive eligibility period were limited to ambulatory prenatal care. Currently, however, Minnesota has secured PMAP+ waiver authority to allow pregnant women to receive additional services during a presumptive eligibility period, including the full benefit set available to qualified pregnant women in accordance with section 1902(a)(10)(i)(III) of the ACA. The goal of the demonstration is to ensure at least equitable access to and quality of prenatal and postpartum care to pregnant women enrolled in MA through the PMAP+ waiver authority as compared to national Medicaid averages. Thus, evaluation questions are as follows:

- a) Did the MA pregnant women waiver population experience comparable utilization of prenatal care when compared to national Medicaid averages?
- b) Did the MA pregnant women waiver population experience comparable utilization of postpartum care when compared to national Medicaid averages?

General Methodology and Limitations

To address questions of access to and quality of health care in the relevant waiver populations, we calculated a number of performance measures. Data for these measures were drawn from the Medicaid Management Information System (MMIS). For Minnesota Health Care Programs (MHCP) including Medical Assistance (MA), the Department of Human Services (DHS) uses MMIS to establish coverage and enrollment information into a service delivery entity (managed care, fee for service) and also to process and pay claims. These data are kept in a data warehouse platform making information regarding program enrollment, services rendered, and more (e.g., provider data) available for analysis. Enrollment data are updated monthly (on the first of each month) while claims are updated bi-weekly at the end of the MMIS warrant cycle process. A large percentage of members are enrolled into managed care; for such enrollees, claims are processed by the managed care organization (MCO) and then sent to DHS via MMIS. While this process introduces opportunity for error, DHS has implemented a “control reporting” process where DHS provides each MCO with line-level feedback for every claim and line submitted. For data that are not usable, precise feedback is provided that defines the problem(s) and they are asked to resubmit the claim. This process has greatly improved the accuracy and completeness of encounter data.

Performance measure specifications came from the Healthcare Effectiveness Data and Information Set (HEDIS). These measures are stewarded by the National Committee for Quality Assurance (NCQA) and 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). Rates were calculated on an annual basis and reported for calendar years 2014 to 2018. Table 1 describes in detail the measures used to assess access to and quality of health care in all three waiver populations. Note that in the descriptions there are sometimes age limits mentioned; measures were calculated with the combination of these criteria as well as the waiver population criteria. For example, the specifications for rate calculation of Follow-up after Hospitalization for Mental Illness (FUH) include all members age 6 and older but the caretaker adult waiver population includes only adults. Thus, FUH rates for that group were based on individuals over 18.

Table 1. NCQA’s HEDIS measure descriptions.

Waiver Population	Measure	Description
MA One-Year-Olds	CAP	The percentage of members 12-24 months who had a visit with a PCP during the measurement year or the year prior to the measurement year.
	CIS, Combo 6	The percentage of children 2 years of age who had all of the following vaccinations by their second birthday: DTaP (4), IPV (3), MMR (1), HiB (3), Hep B (3), VZV (1), PCV (4), Influenza (2)
	W15, 6+ Visits	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.
Caretaker Adults	ADV	The percentage of members who had at least one dental visit during the measurement year.
	AAP	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.
	CCS	The percentage of women 21-64 years of age who were screened for cervical cancer during the measurement year.
	CDC, HbA1c Testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c testing during the measurement year.
	FUH, 7-Day and 30-Day	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days or 30 days after discharge.
	MMA, 50% and 75% Compliance	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 50% (sub-measure 1) and 75% (sub-measure 2) of their treatment period.
	Pregnant Women	PPC, Timeliness of Prenatal Care and Postnatal Care

Note. AAP = Adults’ Access to Preventive/Ambulatory Health Services; ADV = Annual Dental Visit; CAP = Children (and Adolescents’) Access to Primary Care Practitioners; CCS = Cervical Cancer Screening; CDC = Comprehensive Diabetes Care; CIS = Childhood Immunization Status; FUH = Follow-up after Hospitalization for Mental Illness, MMA = Medication Management for People with Asthma; PPC = Prenatal and Postpartum Care; W15 = Well-Child Visits in the First 15 Months of Life

For all three waiver populations, comparisons were made between calculated HEDIS rates and NCQA Quality Compass benchmark rates during years for which such rates were available to us.

Specifically, NCQA Quality Compass provides a national average rate for each measure as well as the rates equal to the 5th, 10th, 25th, 33rd, 50th, 67th, 75th, 90th, and 95th percentiles. From these, Minnesota's percentile rank was estimated yearly and used to evaluate healthcare quality and access for each waiver population.

A limitation of the data that applies to the one-year-olds and pregnant women is the small size of the populations. The number of identified members of the populations amounted to only a few hundred each year. Furthermore, the denominators of each measure include only a proportion of the overall waiver population (see explanation below) so numbers are reduced even more; particularly, in the case of the one-year-olds, each year denominators only occasionally surpassed 100 and in some cases were fewer than 30. In fact, on average only about a third of the identified one-year-olds were included in the denominators. This begs the question of representativeness. On one hand, it may be the case that results cannot be generalized to the population overall; on the other hand, HEDIS specifications incorporate specific criteria that are applied to determine which individuals can reasonably be considered to have had sufficient opportunity to obtain services that would qualify them for the numerator. If an individual meets an age criterion, for example, but is enrolled in MA for only a few months, he or she would likely not have been able to meet numerator criteria such as having six well-child visits over the course of the year. In that case, it does not seem appropriate to include that individual in either the numerator or denominator. Thus, one could argue that the denominators, though only a small proportion of the overall population, are indeed representative of a relevant subgroup of the population for which results can be generalized.

Still, the observation of small denominators is problematic from a statistical standpoint. That is, drawing conclusions about how a population compares across years or to other populations is difficult because each individual data point carries more weight in the overall average. If an observation in a small sample is an outlier in the population (not representative), then that observation will have substantial power to skew the average and therefore the conclusions made about the population. In such cases, it is important to consider the actual size of the group differences and trends in data in addition to statistical significance.

Population-Specific Reporting

MA One-Year-Olds

Methodology

The MA one-year-old population included children between the ages of 12 and 24 months (inclusive) meeting the following criteria: 1) have third-party liability (TPL) insurance, and 2) have incomes above 275% and at or below 283% of the FPL. In the first analysis, quality measure rates calculated for this group were compared to those of Medicaid beneficiaries of

the same age on a national level (via the NCQA benchmarks, as discussed previously). The following three HEDIS measures were calculated: Childhood Immunization Status (CIS) – Combination 6 sub-measure, Well-Child Visits in the First 15 Months of Life (W15) – 6 or More Visits sub-measure, and Children (and Adolescents’) Access to Primary Care Practitioners (CAP) – 12-24 Months sub-group.

For the second analysis data were separated into two racial-ethnic groups, Persons of Color (including Asian-Pacific Islander, Black, Hispanic, Native American, and multiple) and Non-Hispanic Whites (additionally a third group of unknown race/ethnicity is reported in all relevant analyses). The original intent was to compare each racial-ethnic group individually, but this resulted in denominators that were too small for meaningful analysis. Groups were compared formally with a test for equality of proportions for each HEDIS rate and a $p < 0.05$ statistical significance cutoff.

Hypotheses

Providing health care coverage to the MA one-year-old population will result in

- a) Access to and quality of care for this population that is comparable to children enrolled in other public programs; specifically, Minnesota will rank near the 50th percentile or higher for each calculated HEDIS rate.
- b) Comparable HEDIS rates between Persons of Color and Non-Hispanic White racial-ethnic groups; specifically, HEDIS rates will not differ substantially and tests for equality of proportions will produce non-significant results.

Results

Table 2 displays the number of distinct enrollees meeting criteria for the PMAP+ waiver population of one-year-olds during calendar years 2014 to 2018; it reflects growth across all years, substantially so between years 2014 and 2015 and between 2016 and 2017.

Table 2. Annual enrollment of MA one-year-olds

Year	Number of Enrollees
2014	165
2015	221
2016	223
2017	315
2018	322

Tables 3-5 present numerators, denominators, and rates with confidence intervals for HEDIS CAP, CIS, and W15 measures, respectively, across years 2014 to 2018. Additionally, the average national rates obtained from NCQA’s Quality Compass are included for comparison purposes when available. Complementary figures (1-3) are included to emphasize differences by measurement year and further by racial-ethnic group (4-6).

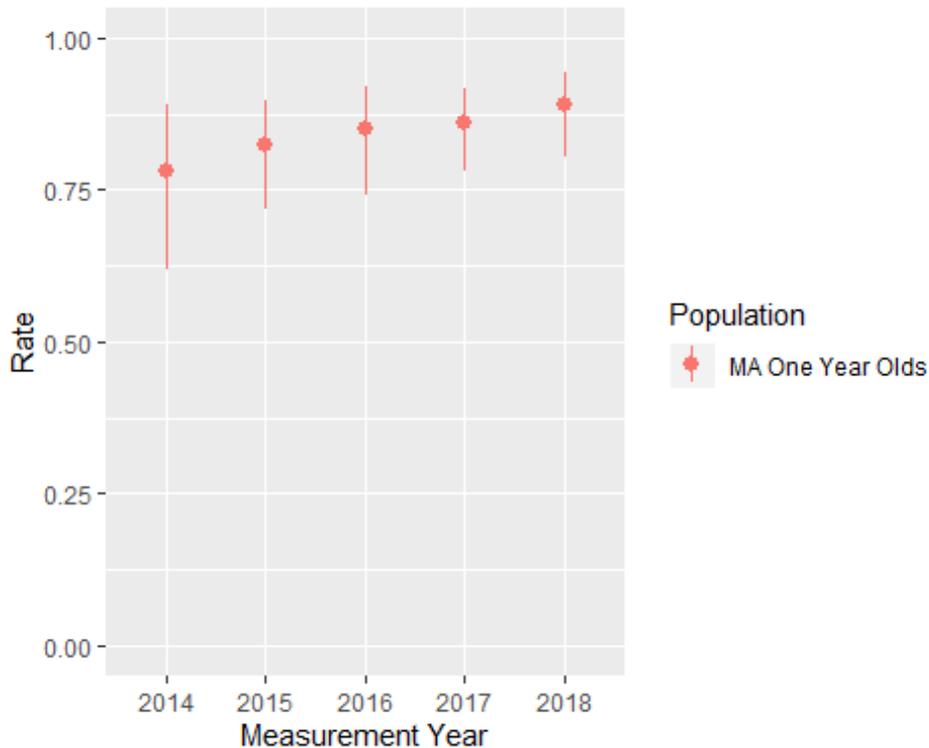
CAP Rates.

As can be seen in table 3, CAP rates steadily increased from 2014 to 2018 by a total of about 10%; however, overlapping confidence intervals suggest these changes were not significant in this population. Visual representation of these rates is available in figure 1. In all years available for comparison, the rate of this population was lower than the NCQA benchmark by 5 to 10 percentage points. Minnesota’s rate for one-year-olds ranked below the 5th percentile on this measure in 2016 (5% = 88.14) and 2017 (5% = 88.93) and between the 5th and 10th percentiles (5% = 87.84, 10% = 91.04) in 2018.

Table 3. Annual CAP rates for MA one-year-olds.

Year	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	32	41	78.05	61.97	88.89	N/A
2015	65	79	82.28	71.71	89.63	N/A
2016	62	73	84.93	74.21	91.88	94.69
2017	99	115	86.09	78.09	91.59	94.78
2018	81	91	89.01	80.29	94.32	94.65

Figure 1. Annual CAP rates for MA one-year-olds.



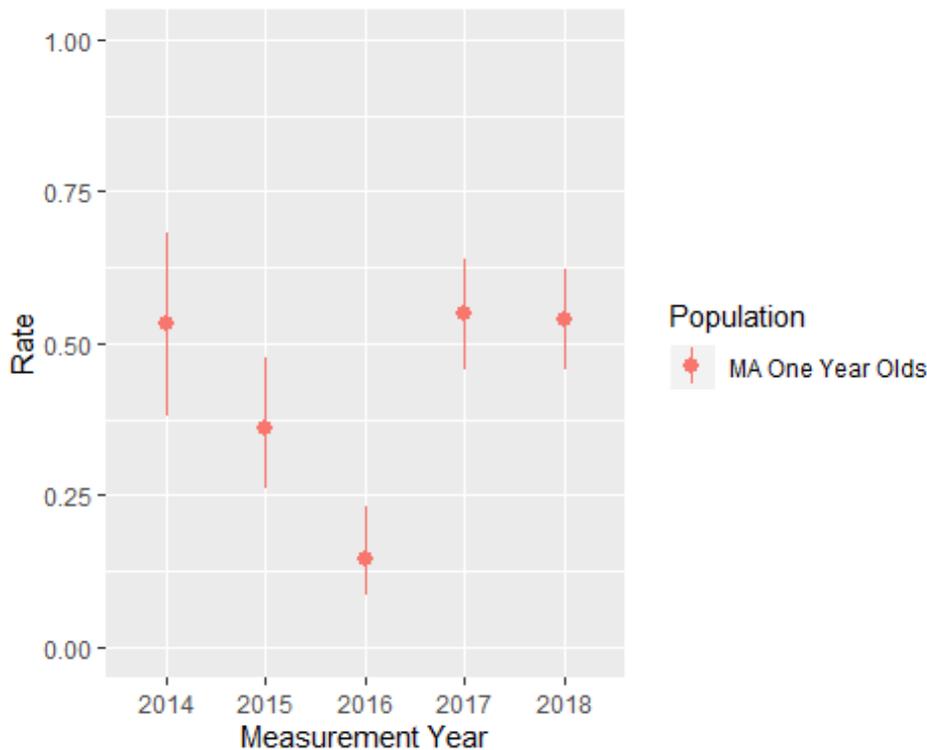
CIS Rates.

As can be seen in table 4, CIS rates were similar in years 2014, 2017, and 2018 while rates were much lower in 2015 and 2016; however, confidence intervals suggest these changes were not significant in this population. Visual representation of these rates is available in figure 2. In 2016, the rate of this population was lower than the NCQA benchmark by about 25 percentage points; Minnesota’s rate for one-year-olds ranked below the 5th percentile (5% = 19.18) on this measure that year. However, in subsequent years Minnesota performed much better. Specifically, in 2017 and 2018 rates ranked just under the 90th percentile (90% = 55.23 and 55.26, respectively).

Table 4. Annual CIS rates for MA one-year-olds.

Year	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	24	45	53.33	38.04	68.07	N/A
2015	30	83	36.14	26.09	47.49	N/A
2016	15	104	14.42	8.56	22.99	39.01
2017	67	122	54.92	45.67	63.85	38.87
2018	80	148	54.05	45.69	62.20	40.91

Figure 2. Annual CIS rates for MA one-year-olds.



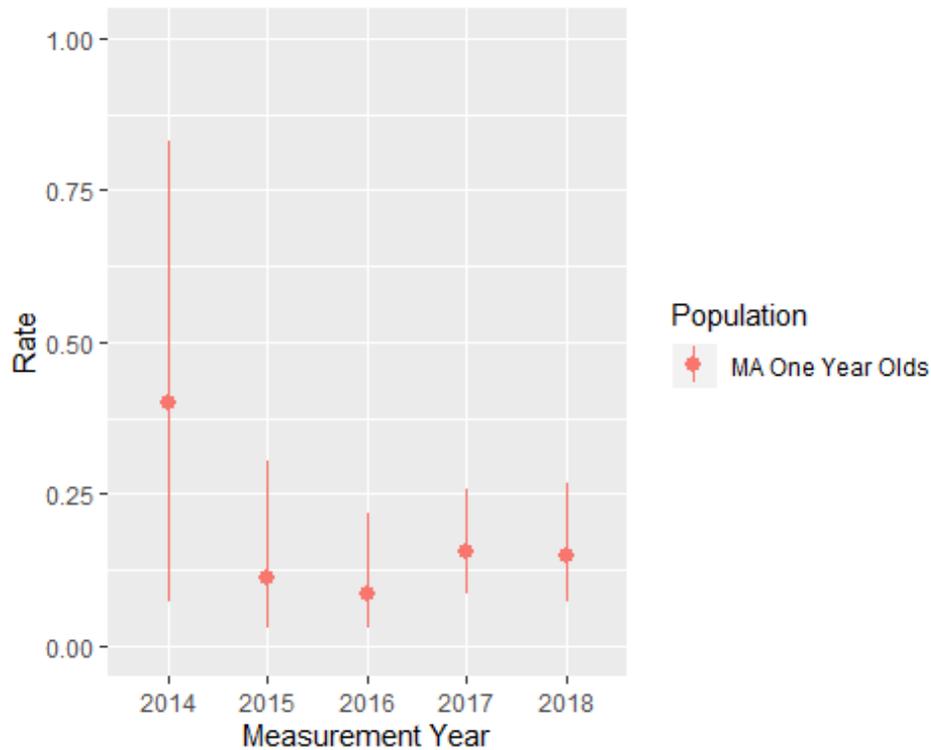
W15 Rates.

As can be seen in table 5, W15 rates varied between 8% and 40% from year to year in an inconsistent pattern; however, overlapping confidence intervals suggest these changes were not significant in this population. Visual representation of these rates is available in figure 3. From 2016-2018, the rate of this population was lower than the NCQA benchmark by about 50 percentage points. Minnesota’s rate for one-year-olds ranked below the 5th percentile on this measure in 2016, 2017, and 2018 (5% = 40.97, 44.04, 46.02, respectively).

Table 5. Annual W15 rates for MA one-year-olds.

Year	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	2	5	40.00	7.26	82.96	N/A
2015	3	27	11.11	2.91	30.30	N/A
2016	4	46	8.70	2.82	21.69	59.35
2017	12	78	15.38	8.54	25.73	61.70
2018	9	61	14.75	7.38	26.67	64.14

Figure 3. Annual W15 rates for MA one-year-olds.



Analyses by Racial-Ethnic Group.

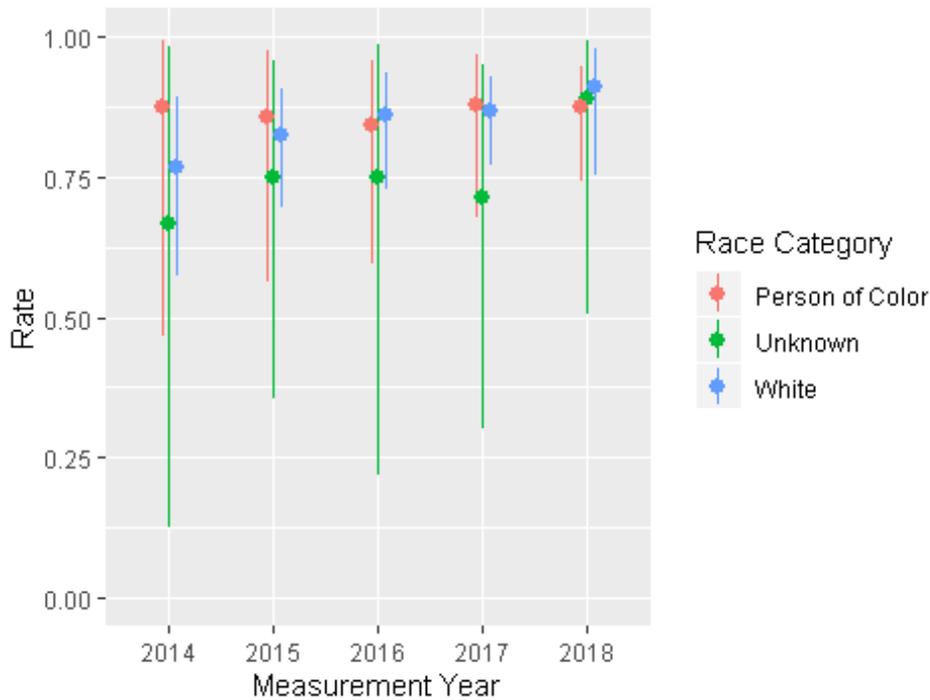
CAP Rates.

As evident in table 6, during each year the rates for Persons of Color were within 5% higher or lower than those of Non-Hispanic Whites (with exception of 2014 where the difference was still within 10%). However, such rates do not appear to significantly differ given overlapping confidence intervals (see figure 4). Indeed, tests for the equality of proportions were conducted separately for each year and none met the statistical significance criterion set prior to analysis.

Table 6. Annual CAP rates by racial-ethnic group.

Year	Population	Numerator	Denominator	Rate	LBound	UBound
2014	Persons of Color	7	8	87.50	46.68	99.34
	Non-Hispanic White	23	30	76.67	57.30	89.36
	Unknown	2	3	66.67	12.53	98.23
2015	Persons of Color	12	14	85.71	56.15	97.49
	Non-Hispanic White	47	57	82.46	69.64	90.83
	Unknown	6	8	75.00	35.58	95.55
2016	Persons of Color	16	19	84.21	59.51	95.83
	Non-Hispanic White	43	50	86.00	72.64	93.72
	Unknown	3	4	75.00	21.94	98.68
2017	Persons of Color	22	25	88.00	67.66	96.85
	Non-Hispanic White	72	83	86.75	77.11	92.88
	Unknown	5	7	71.43	30.26	94.89
2018	Persons of Color	42	48	87.50	74.06	94.81
	Non-Hispanic White	31	34	91.18	75.19	97.69
	Unknown	8	9	88.89	50.67	99.42

Figure 4. Annual CAP rates by racial-ethnic group.



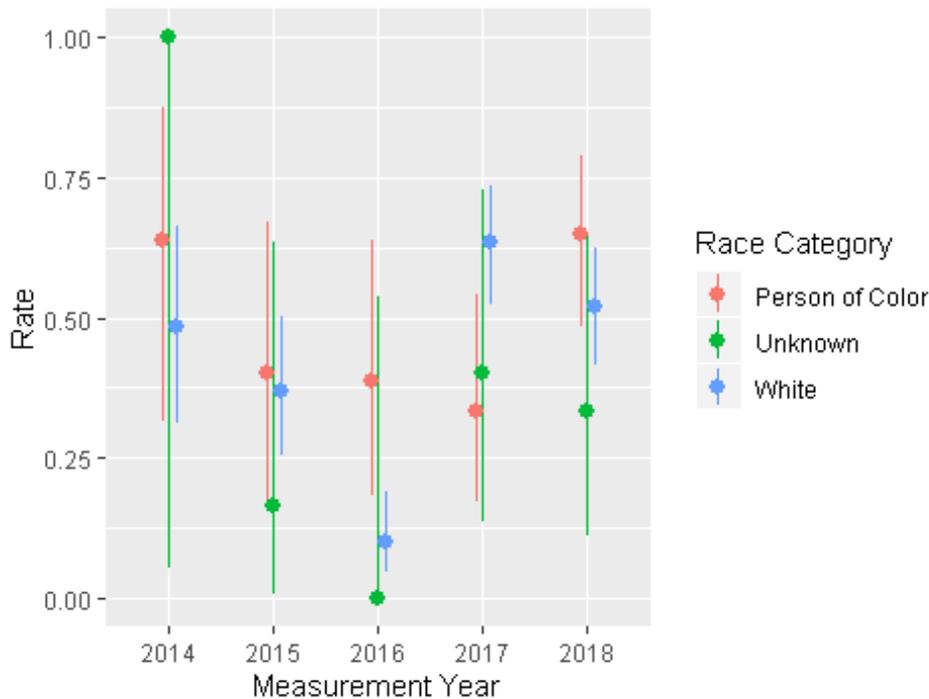
CIS Rates.

As evident in table 7, with exception of 2017, the rates for Persons of Color were 3-30% higher than those of Non-Hispanic Whites during each year. However, such rates do not appear to significantly differ given overlapping confidence intervals (see figure 5). Indeed, tests for the equality of proportions were conducted separately for each year and only two met the statistical significance criterion set prior to analysis (years 2016 and 2017). In 2016, the rate for Persons of Color was about 30% higher than that of Whites; in 2017, however, the exact opposite pattern occurred.

Table 7. Annual CIS rates by racial-ethnic group.

Year	Population	Numerator	Denominator	Rate	LBound	UBound
2014	Persons of Color	7	11	63.64	31.61	87.63
	Non-Hispanic White	16	33	48.48	31.17	66.15
	Unknown	1	1	100.00	5.46	100.00
2015	Persons of Color	6	15	40.00	17.46	67.11
	Non-Hispanic White	23	62	37.10	25.45	50.35
	Unknown	1	6	16.67	0.88	63.52
2016	Persons of Color	7	18	38.89	18.26	63.86
	Non-Hispanic White	8	81	9.88	4.67	19.04
	Unknown	0	5	0.00	0.00	53.71
2017	Persons of Color	9	27	33.33	17.24	53.98
	Non-Hispanic White	54	85	63.53	52.32	73.50
	Unknown	4	10	40.00	13.69	72.63
2018	Persons of Color	26	40	65.00	48.26	78.90
	Non-Hispanic White	50	96	52.08	41.70	62.30
	Unknown	4	12	33.33	11.27	64.56

Figure 5. Annual CIS rates by racial-ethnic group.



W15 Rates.

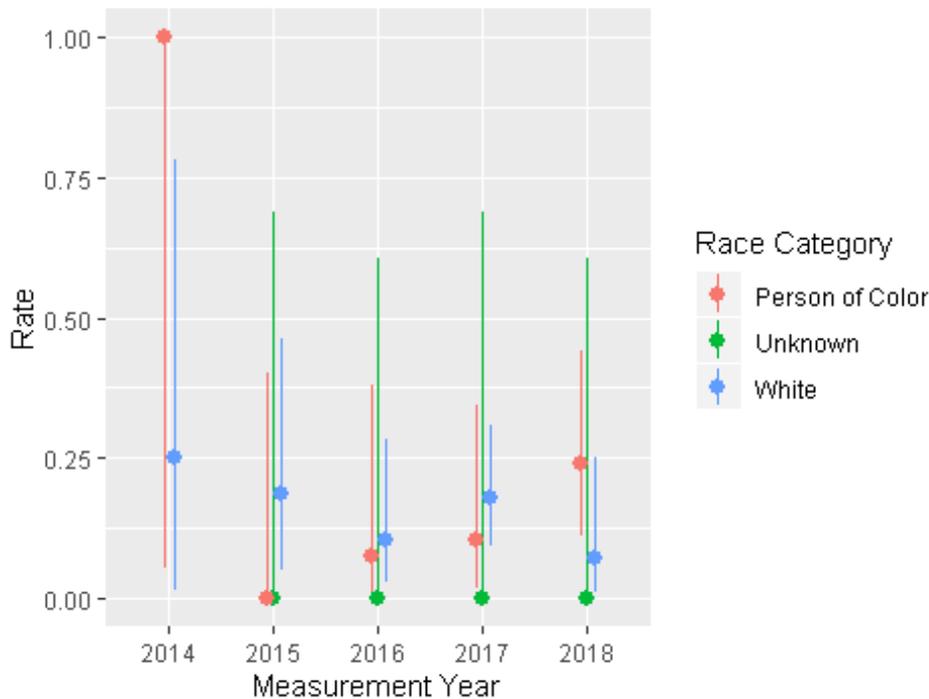
No discernible pattern is evident for the comparison of rates of Persons of Color to Non-Hispanic Whites across years. Specifically, rates differ by as little as 3% in 2016 and as much as 75% in 2014. Furthermore, such rates do not appear to significantly differ given overlapping

confidence intervals (see figure 6). Indeed, tests for the equality of proportions were conducted separately for each year and none met the statistical significance criterion set prior to analysis.

Table 8. Annual W15 rates by racial-ethnic group.

Year	Population	Numerator	Denominator	Rate	LBound	UBound
2014	Persons of Color	1	1	100.00	5.46	100.00
	Non-Hispanic White	1	4	25.00	1.32	78.06
	Unknown	0	0	0.00	0.00	0.00
2015	Persons of Color	0	8	0.00	0.00	40.23
	Non-Hispanic White	3	16	18.75	4.97	46.31
	Unknown	0	3	0.00	0.00	69.00
2016	Persons of Color	1	13	7.69	0.40	37.91
	Non-Hispanic White	3	29	10.34	2.71	28.50
	Unknown	0	4	0.00	0.00	60.42
2017	Persons of Color	2	19	10.53	1.84	34.54
	Non-Hispanic White	10	56	17.86	9.34	30.85
	Unknown	0	3	0.00	0.00	69.00
2018	Persons of Color	7	29	24.14	11.02	43.93
	Non-Hispanic White	2	28	7.14	1.25	24.96
	Unknown	0	4	0.00	0.00	60.42

Figure 6. Annual W15 rates by racial-ethnic group.



Limitations and Conclusions

For all three measures, rates were substantially below the national average in 2016; in fact, Minnesota ranked below the 5th percentile in all cases that year which would suggest that this waiver population was not receiving the same access and quality of care as the rest of the country's MA population where preventative/primary care is concerned. However, we cannot make that conclusion after considering the following points.

First of all, as far as vaccinations are concerned, in years after 2016, rates for CIS increased significantly and Minnesota's ranking was near the 90th percentile, suggesting comparable performance in recent years. Such results support the first proposed hypothesis.

Secondly, comparison results for CAP should be interpreted in light of the ceiling effect observed for this measure. That is, the national average rate is very close to 100% in all years suggesting little possibility for variation across states; arguably, rates between 80% and 90% (as observed in 2017-2018) represent strong performance regardless of being below the national average, and Minnesota's rates have been steadily rising across the years.

Finally, this population consists of individuals who have other insurance in addition to Medicaid. Since Medicaid is the payer of last resort, claims are first submitted to other payers; if the entirety of the claim is paid by other insurance, then MA is not billed, and thus we have no record available for analysis. The measures on which we are reporting examine rates of preventative care, a category of care that is likely to be covered entirely by third-party insurance. Therefore, there are most certainly missing claims that could qualify individuals for the numerator, and it is impossible to know to what extent this is a problem.

The second hypothesis proposed considers differences in rates across racial-ethnic groups, specifically Persons of Color and Non-Hispanic Whites. With few exceptions, in years 2014 to 2018 rates were not significantly different across groups. However, due to small denominators discussed previously, it is important to consider effect sizes and trends in addition to statistical significance. The first point of note is that rates are far more variable from year to year within these smaller groups; while group rates for the CAP measure were generally within 5% of each other in a given year, the magnitude of group differences changed vastly from year to year for the CIS and W15 measures. In one instance, there was as large as a 75% difference between groups. Importantly, though, neither the Persons of Color nor the Non-Hispanic White groups were consistently outperforming the other. Within measures, the higher-performing group changed randomly from one year to the next. This suggests little to no racial-ethnic disparity in access to or quality of care overall, thus supporting the second hypothesis.

Caretaker Adults with 18-Year-Old

Methodology

For the following analyses, caretaker adults were defined as adults of any age enrolled in Medicaid who live with and assume responsibility for a child who is age 18. Comparisons were made between this group and adults without children (defined as any adult who meets MA criteria, is age 21-64, and does not have children under 19 living at home). Additionally, adults with children (“parents”; anyone meeting MA criteria with at least one child under 18 living at home) were included as a second comparison group. Finally, calculated rates for this group were compared to those of adult Medicaid beneficiaries on a national level (i.e., NCQA Quality Compass benchmark rates). The following NCQA HEDIS measures were calculated: Annual Dental Visit (ADV), Adults’ Access to Preventive/Ambulatory Health Services (AAP), Cervical Cancer Screening (CCS), Comprehensive Diabetes Care (CDC) – HbA1c Testing sub-measure, Follow-Up after Hospitalization for Mental Illness (FUH) – 7-Day and 30-Day sub-measures, and Medication Management for People with Asthma (MMA) – Medication Compliance 50% and Medication Compliance 75% sub-measures.

Hypotheses

Providing health care coverage to the adult caretaker waiver population will result in

- a) Access to and quality of prevention and chronic disease care for this population that is comparable to other adults enrolled in MA in Minnesota; specifically, HEDIS rates will not differ substantially across groups of caretakers, parents, and adults without children, and tests for equality of proportions will produce non-significant results.
- b) Access to and quality of prevention and chronic disease care for this population that is comparable to other adults enrolled in public health care programs; specifically, Minnesota will rank near the 50th percentile or higher for each calculated HEDIS rate.

Results

Table 9 displays the number of distinct enrollees meeting criteria for the PMAP+ waiver population of caretaker adults during calendar years 2014 to 2018; it reflects growth across all years, substantially so from 2015 to 2017.

Table 9. Annual enrollment of caretaker adults.

Year	Number of Enrollees
2014	4,296
2015	5,317
2016	5,625
2017	6,112
2018	6,380

Tables 10-17 present numerators, denominators, and rates with confidence intervals of HEDIS measures for caretakers, adults without children (“AX adults”), and parents across years 2014

to 2018. Complementary figures (7-14) are included to emphasize differences among groups. Additionally, the average national rates obtained from NCQA’s Quality Compass are included for comparison purposes (when available).

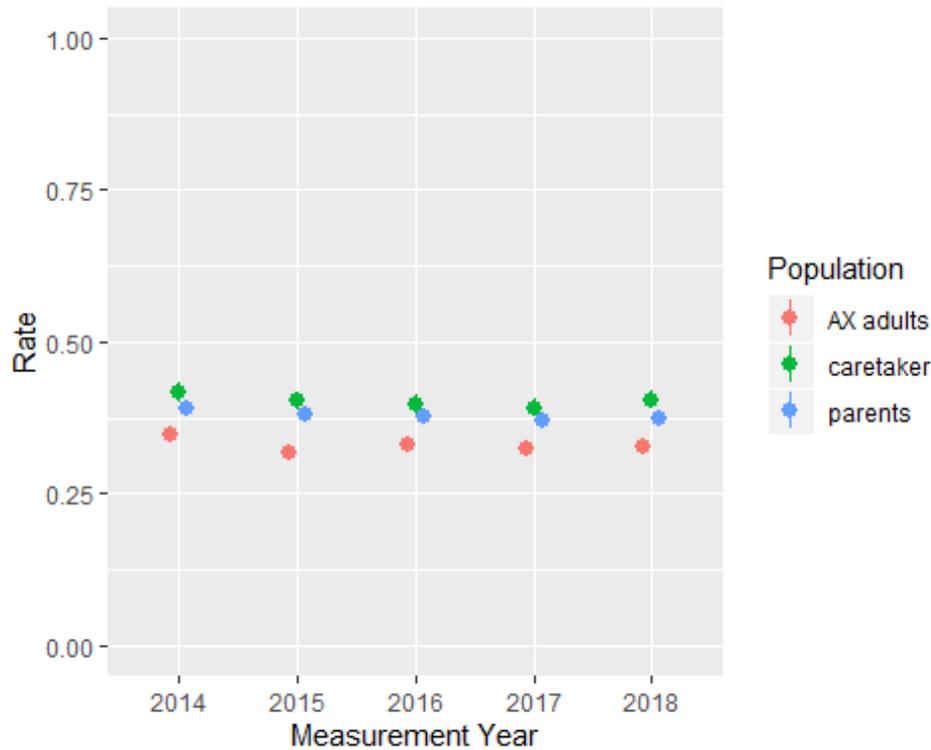
ADV Rates.

As can be seen in table 10, ADV rates were generally stable across years and overlapping confidence intervals suggest these changes were not significant for the caretaker group. On the other hand, group differences do appear to be significant given the confidence intervals. Indeed, tests for the equality of proportions were conducted separately for each year and all met the statistical significance criterion set prior to analysis. Specifically, in each year the caretaker rates were about 2-3% higher than the parent rates, which were about 4-5% higher than the adults without children rates (all pairwise comparisons involving caretakers were significant at $p < 0.05$). Visual representation of these rates is available in figure 7. Unfortunately, NCQA Quality Compass ADV rates are not available for an adult population.

Table 10. Annual ADV rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	43,356	125,333	34.59	34.33	34.86	N/A
	Caretakers	1,444	3,462	41.71	40.06	43.38	
	Parents	54,707	140,474	38.94	38.69	39.20	
2015	AX Adults	52,707	165,778	31.79	31.57	32.02	N/A
	Caretakers	1,619	4,025	40.22	38.71	41.76	
	Parents	52,144	137,484	37.93	37.67	38.18	
2016	AX Adults	46,141	139,455	33.09	32.84	33.33	N/A
	Caretakers	1,603	4,038	39.70	38.19	41.23	
	Parents	49,601	131,688	37.67	37.40	37.93	
2017	AX Adults	51,222	157,400	32.54	32.31	32.77	N/A
	Caretakers	1,796	4,585	39.17	37.76	40.60	
	Parents	48,858	131,870	37.05	36.79	37.31	
2018	AX Adults	49,576	150,975	32.84	32.60	33.07	N/A
	Caretakers	1,852	4,576	40.47	39.05	41.91	
	Parents	49,415	131,738	37.51	37.25	37.77	

Figure 7. Annual ADV rates of caretaker adults and comparison groups.



AAP Rates.

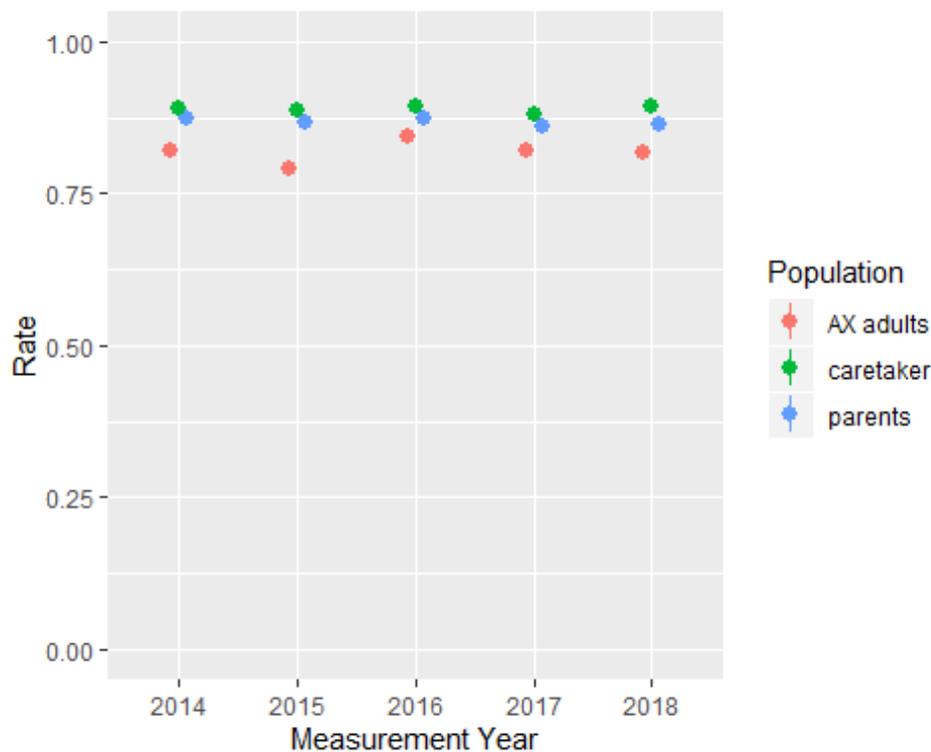
As can be seen in table 11, AAP rates were stable across years and overlapping confidence intervals suggest these changes were not significant for the caretaker group. On the other hand, group differences do appear to be significant given non-overlapping confidence intervals (see figure 8). Indeed, tests for the equality of proportions were conducted separately for each year and all met the statistical significance criterion set prior to analysis. Specifically, in each year caretaker rates were about 2-3% higher than the parent rates, which were about 3-7% higher than the adults without children rates (all pairwise comparisons involving caretakers were significant at $p < 0.05$).

In the years for which NCQA average rates were available, the AAP rates for all three groups were higher than the NCQA benchmark. In fact, the caretakers group ranked near or above the 95th percentile in 2016, 2017, and 2018 (95th = 88.86, 88.93, and 88.89, respectively) on this measure (parents and adults without children ranked near the 90th and 50th percentiles, respectively).

Table 11. Annual AAP rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	102,817	125,325	82.04	81.83	82.25	N/A
	Caretakers	3,087	3,461	89.19	88.10	90.20	
	Parents	121,714	139,219	87.43	87.25	87.60	
2015	AX Adults	131,336	165,773	79.23	79.03	79.42	N/A
	Caretakers	3,577	4,025	88.87	87.85	89.82	
	Parents	118,697	136,832	86.75	86.57	86.93	
2016	AX Adults	117,639	139,310	84.44	84.25	84.63	80.54
	Caretakers	3,609	4,038	89.38	88.37	90.30	
	Parents	114,814	131,307	87.44	87.26	87.62	
2017	AX Adults	129,031	157,317	82.02	81.83	82.21	80.02
	Caretakers	4,041	4,585	88.14	87.16	89.05	
	Parents	113,530	131,802	86.14	85.95	86.32	
2018	AX Adults	123,546	150,913	81.87	81.67	82.06	79.80
	Caretakers	4,083	4,576	89.23	88.28	90.10	
	Parents	113,627	131,711	86.27	86.08	86.46	

Figure 8. Annual AAP rates of caretaker adults and comparison groups.



CCS Rates.

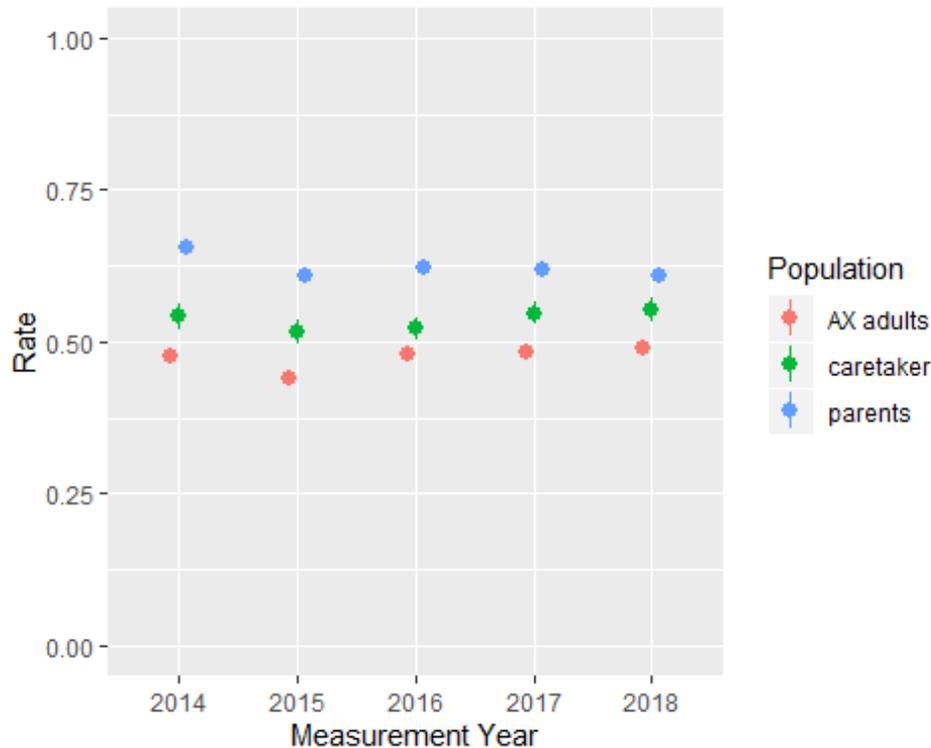
As can be seen in table 12, CCS rates were generally stable across years and overlapping confidence intervals suggest these changes were not significant for the caretaker group. On the other hand, group differences do appear to be significant given non-overlapping confidence intervals (see figure 9). Indeed, tests for the equality of proportions were conducted separately for each year and all met the statistical significance criterion set prior to analysis. Specifically, in each year caretaker rates were about 4-7% higher than the adults without children rates and about 6-11% lower than the parent rates (all pairwise comparisons involving caretakers were statistically significant).

In the years for which NCQA average rates were available, the CCS rate for caretakers was lower than the NCQA benchmark. In fact, the caretakers group ranked near the 33rd percentile in 2016, 2017, and 2018 (33% = 52.07, 55.23, and 56.45, respectively) on this measure (parents and adults without children ranked near the 67th and 25th percentiles, respectively).

Table 12. Annual CCS rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	22,354	46,993	47.57	47.12	48.02	N/A
	Caretakers	1,218	2,250	54.13	52.05	56.21	
	Parents	58,380	89,271	65.40	65.08	65.71	
2015	AX Adults	27,687	62,770	44.11	43.72	44.50	N/A
	Caretakers	1,331	2,580	51.59	49.64	53.53	
	Parents	54,019	88,595	60.97	60.65	61.29	
2016	AX Adults	26,127	54,311	48.11	47.69	48.53	55.85
	Caretakers	1,363	2,614	52.14	50.21	54.07	
	Parents	52,939	85,088	62.22	61.89	62.54	
2017	AX Adults	28,939	60,026	48.29	47.89	48.69	58.00
	Caretakers	1,576	2,881	54.70	52.86	56.53	
	Parents	52,197	84,467	61.80	61.47	62.12	
2018	AX Adults	27,657	56,583	48.88	48.47	49.29	59.39
	Caretakers	1,541	2,789	55.25	53.38	57.11	
	Parents	52,263	85,637	61.03	60.70	61.36	

Figure 9. Annual CCS rates of caretaker adults and comparison groups.



CDC Rates.

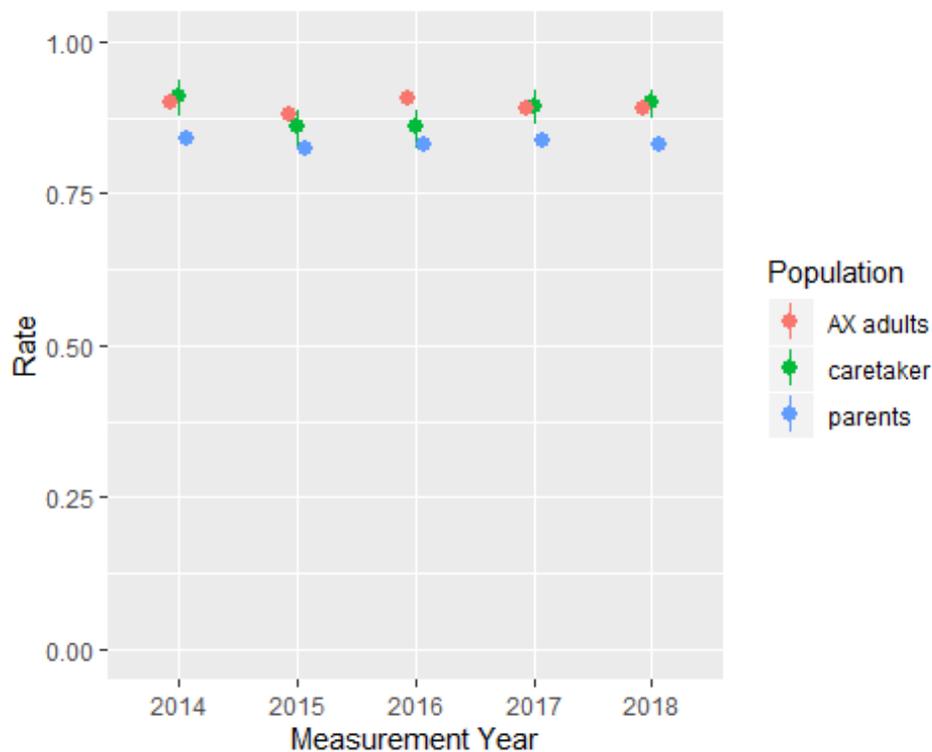
As can be seen in table 13, caretaker CDC rates were generally stable across all years with exception of a dip in 2015 and 2016; however, overlapping confidence intervals suggest these changes were not significant. On the other hand, group differences do appear to be significant in some years (see figure 10). Specifically, in each year caretaker rates were about 3-7% higher than the parent rates; however, rate differences between caretakers and adults without children were smaller and less consistent (caretaker rates ranged from 4.5% below to 1% above those of adults without children). Tests for the equality of proportions were conducted separately for each year and met the statistical significance criterion set prior to analysis for all years. With exception of 2016, results of pairwise comparisons suggest that caretakers and adults without children did not have significantly different rates. On the other hand, both groups had significantly larger rates than those of parents in 2014, 2017, and 2018.

In the years for which NCQA average rates were available, the CDC rate for caretakers was equal to or greater than the NCQA benchmark. In fact, the caretakers group ranked in the 50th percentile in 2016 (50% = 85.95) and just under the 75th percentile in 2017 and 2018 (75% = 90.06, 90.45, respectively) on this measure (parents and adults without children ranked near the 25th and 75th percentiles, respectively).

Table 13. Annual CDC rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	9,649	10,717	90.03	89.45	90.59	N/A
	Caretakers	364	400	91.00	87.65	93.53	
	Parents	6,586	7,837	84.04	83.20	84.84	
2015	AX Adults	11,661	13,259	87.95	87.38	88.49	N/A
	Caretakers	429	499	85.97	82.54	88.84	
	Parents	6,413	7,769	82.55	81.68	83.38	
2016	AX Adults	11,453	12,634	90.65	90.13	91.15	85.94
	Caretakers	440	512	85.94	82.55	88.77	
	Parents	6,456	7,756	83.24	82.38	84.06	
2017	AX Adults	12,359	13,873	89.09	88.55	89.60	86.65
	Caretakers	485	542	89.48	86.52	91.88	
	Parents	6,582	7,852	83.83	82.99	84.63	
2018	AX Adults	12,136	13,635	89.01	88.47	89.52	87.54
	Caretakers	578	642	90.03	87.38	92.19	
	Parents	6,811	8,212	82.94	82.10	83.74	

Figure 10. Annual CDC rates of caretaker adults and comparison groups.



FUH 7-Day Sub-Measure Rates.

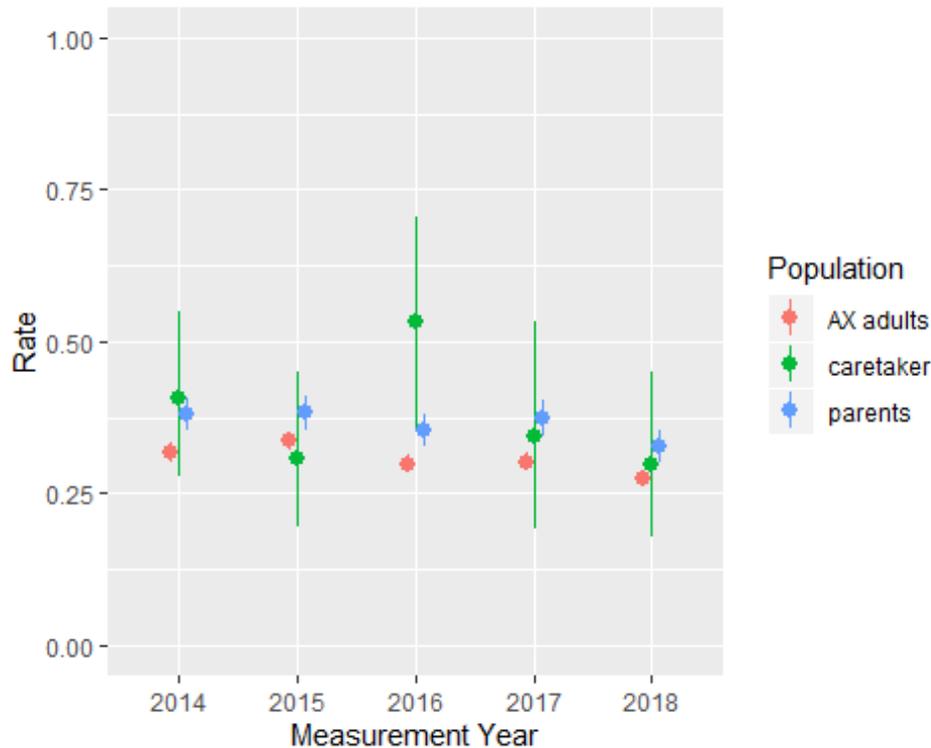
As can be seen in table 14, FUH 7-Day sub-measure rates for caretakers varied widely across the years (from a low of 30% to a high of 53%) but overlapping confidence intervals suggest these changes were not significant. Likewise, group differences do not appear to be significant (see figure 11) given the confidence intervals. On one hand, tests for the equality of proportions were conducted separately for each year and all met the statistical significance criterion set prior to analysis. On the other hand, none of the pairwise comparisons involving caretakers were significant at $p < 0.05$; differences were significant only between parents and adults without children. Over the years caretaker rates ranged from about 7% below to 18% above the parent rates, and from about 3% below to 23% above the adults without children rates.

NCQA average rates were available for years 2016 and 2018 for the FUH 7-Day sub-measure; this rate for caretakers was higher than the NCQA benchmark in 2016 but not in 2018. In fact, the caretakers group ranked above the 67th percentile (67% = 51.44) on this measure in 2016 but just above the 25th percentile in 2018 (25% = 29.61); parents and adults without children ranked above the 25th and 10th percentiles, respectively, in both years.

Table 14. Annual FUH 7-Day rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	1,105	3,481	31.74	30.20	33.32	N/A
	Caretakers	22	54	40.74	27.86	54.94	
	Parents	504	1,323	38.10	35.48	40.78	
2015	AX Adults	1,190	3,538	33.63	32.08	35.22	N/A
	Caretakers	17	55	30.91	19.52	44.97	
	Parents	481	1,258	38.24	35.55	40.99	
2016	AX Adults	1,112	3,730	29.81	28.35	31.31	43.71
	Caretakers	17	32	53.12	35.03	70.49	
	Parents	415	1,174	35.35	32.62	38.17	
2017	AX Adults	1,204	3,996	30.13	28.71	31.58	N/A
	Caretakers	11	32	34.38	19.17	53.23	
	Parents	423	1,134	37.30	34.49	40.20	
2018	AX Adults	1,138	4,140	27.49	26.14	28.88	37.01
	Caretakers	14	47	29.79	17.79	45.08	
	Parents	407	1,246	32.66	30.08	35.36	

Figure 11. Annual FUH 7-Day rates of caretaker adults and comparison groups.



FUH 30-Day Sub-Measure Rates.

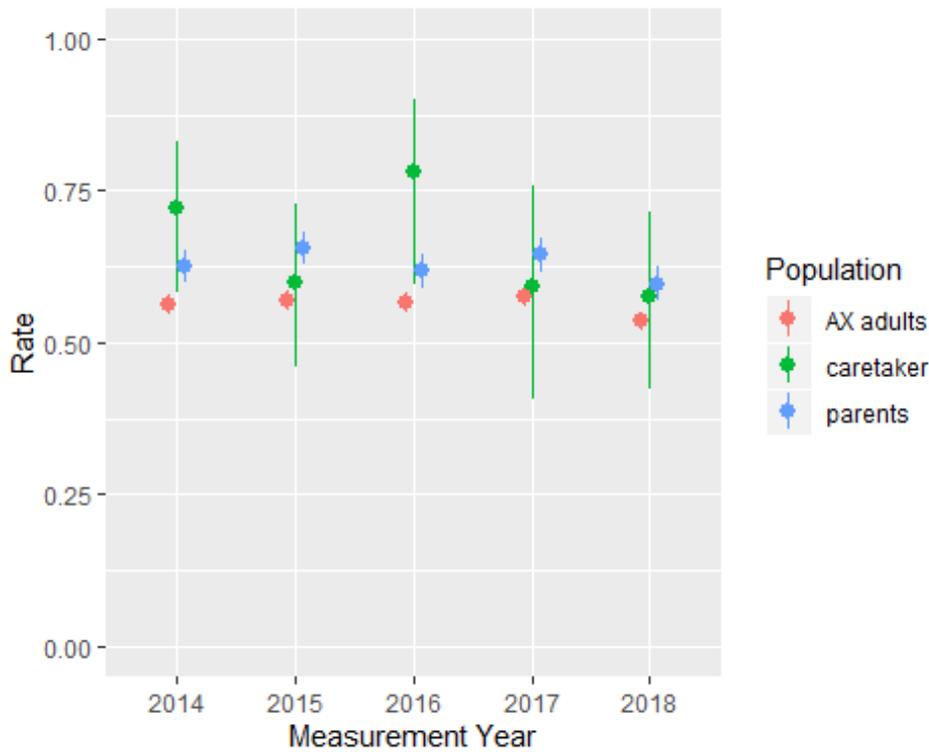
As can be seen in table 15, FUH 30-Day sub-measure rates for caretakers varied widely across the years (from a low of 57% to a high of 78%) but overlapping confidence intervals suggest these changes were not significant. On the other hand, in a few instances group differences do appear to be significant given non-overlapping confidence intervals (see figure 12). Tests for the equality of proportions were conducted separately for each year and all met the statistical significance criterion set prior to analysis. However, none of the pairwise comparisons involving caretakers were significant at $p < 0.05$; differences were significant only between parents and adults without children. Specifically, caretaker rates ranged from about 6% lower to 16% higher than parent rates and from about 2% to 21% higher than adults without children rates.

NCQA average rates were available for years 2016 and 2018 for the FUH 30-Day sub-measure rate; this rate for caretakers was higher than the NCQA benchmark in 2016 and about the same as the benchmark in 2018. In fact, the caretakers group ranked at about the 90th percentile (90% = 78.52) in 2016 and just under the 50th percentile in 2018 (50% = 59.66; parents and adults without children ranked near the 50th and 33rd percentiles, respectively).

Table 15. Annual FUH 30-Day rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	1,959	3,481	56.28	54.61	57.93	N/A
	Caretakers	39	54	72.22	58.14	83.14	
	Parents	826	1,323	62.43	59.75	65.04	
2015	AX Adults	2,013	3,538	56.90	55.24	58.53	N/A
	Caretakers	33	55	60.00	45.92	72.68	
	Parents	824	1,258	65.50	62.79	68.12	
2016	AX Adults	2,114	3,730	56.68	55.07	58.27	61.29
	Caretakers	25	32	78.12	59.56	90.06	
	Parents	725	1,174	61.75	58.90	64.53	
2017	AX Adults	2,295	3,996	57.43	55.88	58.97	N/A
	Caretakers	19	32	59.38	40.79	75.78	
	Parents	732	1,134	64.55	61.68	67.32	
2018	AX Adults	2,215	4,140	53.50	51.97	55.03	57.95
	Caretakers	27	47	57.45	42.26	71.43	
	Parents	744	1,246	59.71	56.92	62.44	

Figure 12. Annual FUH 30-Day rates of caretaker adults and comparison groups



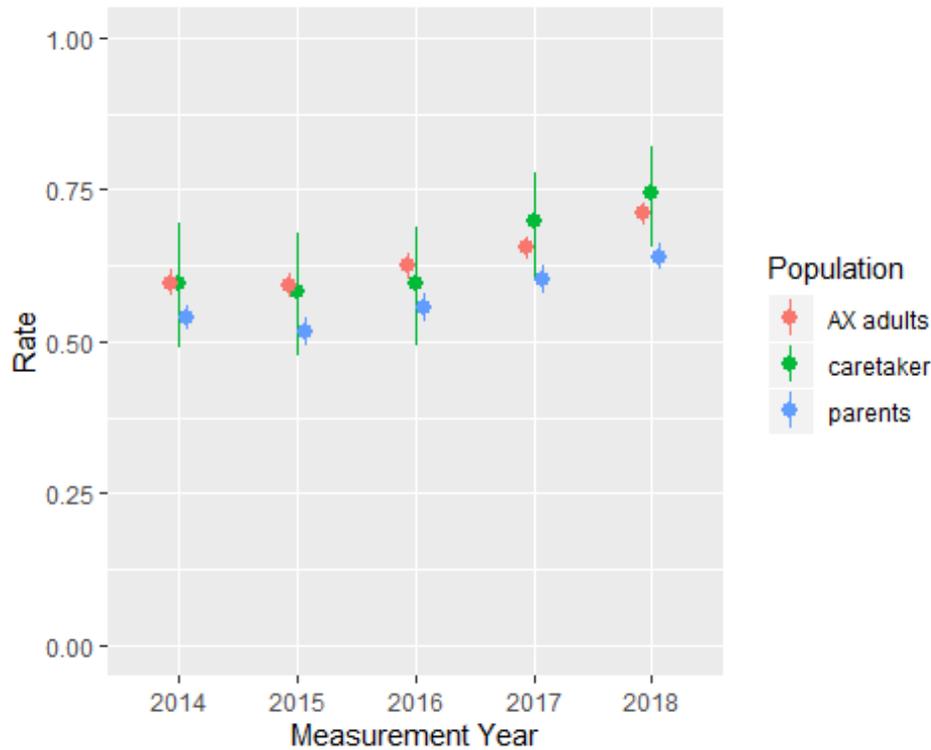
MMA 50% Compliance Sub-Measure Rates.

As can be seen in table 16, MMA 50% Compliance sub-measure rates for caretakers were stable from 2014 to 2016 and then increased by about 10% in 2017 and another 5% in 2018, but overlapping confidence intervals suggest these changes were not significant from year to year. Group differences also do not appear to be significant given overlapping confidence intervals (see figure 13). However, tests for the equality of proportions were conducted separately for each year and all met the statistical significance criterion set prior to analysis. At the same time, none of the pairwise comparisons involving caretakers were significant at $p < 0.05$; differences were significant only between parents and adults without children. Specifically, in each year caretaker rates ranged from 4-10% higher than parent rates and from 3% lower to 5% higher than the adults without children rates. Unfortunately, NCQA Quality Compass rates are not available for the 50% compliance sub-measure.

Table 16. Annual MMA 50% Compliance rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	1,256	2,103	59.72	57.59	61.82	N/A
	Caretakers	56	94	59.57	48.94	69.42	
	Parents	1,225	2,271	53.94	51.86	56.00	
2015	AX Adults	1,500	2,527	59.36	57.41	61.28	N/A
	Caretakers	57	98	58.16	47.76	67.92	
	Parents	1,065	2,063	51.62	49.44	53.80	
2016	AX Adults	1,335	2,139	62.41	60.32	64.46	N/A
	Caretakers	60	101	59.41	49.16	68.93	
	Parents	994	1,789	55.56	53.22	57.88	
2017	AX Adults	1,635	2,500	65.40	63.49	67.26	N/A
	Caretakers	83	119	69.75	60.55	77.65	
	Parents	1,150	1,908	60.27	58.03	62.47	
2018	AX Adults	1,651	2,321	71.13	69.23	72.96	N/A
	Caretakers	85	114	74.56	65.39	82.05	
	Parents	1,145	1,789	64.00	61.72	66.22	

Figure 13. Annual MMA 50% Compliance rates of caretaker adults and comparison groups.



MMA 75% Compliance Sub-Measure Rates.

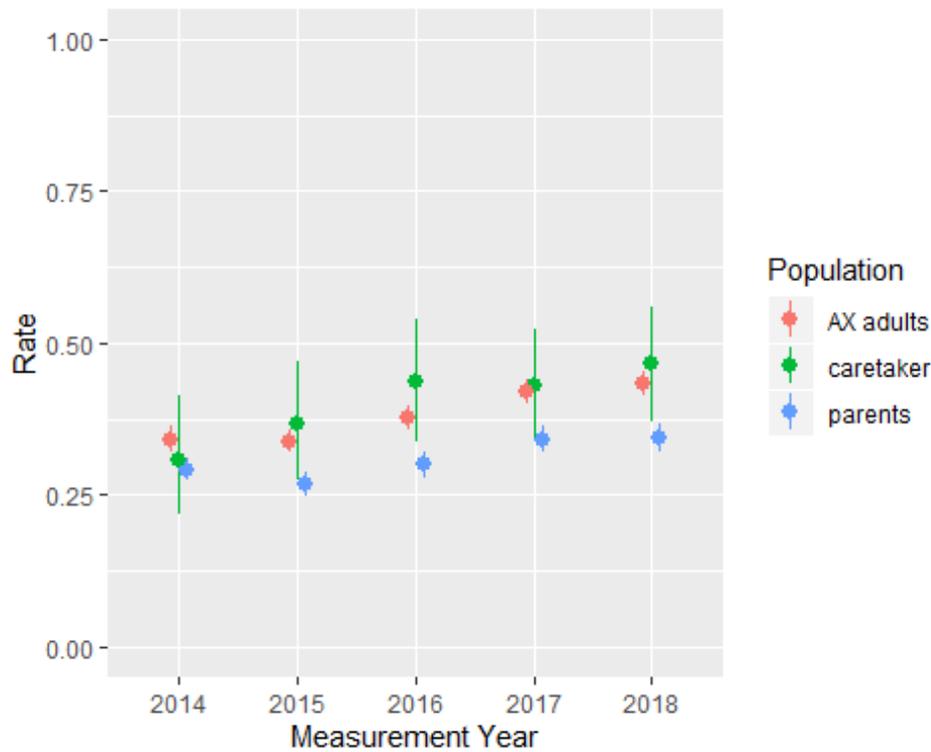
As can be seen in table 17, MMA 75% Compliance sub-measure rates for caretakers steadily increased from 2014 to 2018; however, overlapping confidence intervals suggest these changes were not significant. On the other hand, a test for the equality of proportions across years suggests that the overall change from 2014 to 2018 was indeed significant ($p = 0.016$). Most group differences do not appear to be significant given overlapping confidence intervals (see figure 14). However, tests for the equality of proportions were conducted separately for each year and all met the statistical significance criterion set prior to analysis (though only two pairwise comparisons involving caretakers were significant at $p < 0.05$: caretaker rates were greater than parent rates in 2016 and 2018). Specifically, in each year caretaker rates ranged from 2-14% higher than parent rates and from 3% below to 6% above adults without children rates.

In the years for which NCQA average rates were available, the MMA 75% Compliance sub-measure rate for caretakers was higher than the NCQA benchmark. In fact, the caretakers group ranked near the 75th percentile in 2016, 2017, and 2018 (75% = 43.08, 42.83, and 45.95, respectively) on this measure (parents ranked between the 10th and 33rd percentiles and adults without children ranked near the 67th percentile across years).

Table 17. Annual MMA 75% Compliance rates of caretaker adults and comparison groups.

Year	Population	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	AX Adults	719	2,103	34.19	32.17	36.27	N/A
	Caretakers	29	94	30.85	21.95	41.34	
	Parents	663	2,271	29.19	27.34	31.12	
2015	AX Adults	855	2,527	33.83	32.00	35.72	N/A
	Caretakers	36	98	36.73	27.39	47.13	
	Parents	553	2,063	26.81	24.91	28.78	
2016	AX Adults	806	2,139	37.68	35.63	39.78	37.72
	Caretakers	44	101	43.56	33.84	53.78	
	Parents	537	1,789	30.02	27.91	32.21	
2017	AX Adults	1,053	2,500	42.12	40.18	44.09	38.85
	Caretakers	51	119	42.86	33.93	52.25	
	Parents	650	1,908	34.07	31.95	36.25	
2018	AX Adults	1,008	2,321	43.43	41.40	45.48	41.01
	Caretakers	53	114	46.49	37.18	56.04	
	Parents	614	1,789	34.32	32.13	36.58	

Figure 14. Annual MMA 75% Compliance rates of caretaker adults and comparison groups



Limitations and Conclusions

In no case (year or measure) were the rates of both the parents and adults without children significantly larger than those of caretakers; in fact, for measures ADV and AAP the caretakers rated the best. For CCS the caretakers rated in the middle (better than the adults without children group) and for CDC the caretakers also rated in the middle (better than the parents group). For FUH and MMA, rates did not follow a consistent pattern across years and were not significantly different between the caretakers and the other two groups. This suggests no consistent difference in access or quality of care between caretakers and other MN adults on Medicaid, supporting the first hypothesis.

With exception of the measure CCS (for which Minnesota ranked at about the 33rd percentile across 2016-2018) and the FUH 7-Day sub-measure (for which Minnesota ranked at about the 25th percentile in 2018), all rates for caretakers placed Minnesota in at least in the 50th percentile for the available comparison years (and in some cases as high as the 90th or 95th percentiles). This suggests that caretaker adults are mostly receiving the same quality of care as other adults in MA population, supporting the second hypothesis. Unfortunately, benchmarks were unavailable for some measures and sub-measures or were based on slightly different age criteria (e.g., MMA 75% compliance benchmark limited to ages 19-50 where state calculations included adults of all ages), which limits the conclusions we can make for such measures.

Pregnant Women

Methodology

For the following analysis, utilization patterns/rates of Medicaid-covered prenatal and postpartum care of pregnant women in Minnesota covered under the waiver were compared to utilization patterns/rates of pregnant women enrolled in Medicaid on a national level (i.e., NCQA Quality Compass benchmark rates). The NCQA HEDIS measure Prenatal and Postpartum Care (PPC), sub-measures Timeliness of Prenatal Care and Postpartum Care, were calculated for the pregnant women waiver population.

Hypotheses

Providing health care coverage to the pregnant women waiver population will result in

- a) Access to and quality of prenatal care for this population that is comparable to other adults enrolled in public health care programs; specifically, Minnesota will rank near the 50th percentile or higher for the HEDIS PPC sub-measure Timeliness of Prenatal Care.
- b) Access to and quality of postnatal care for this population that is comparable to other adults enrolled in public health care programs; specifically, Minnesota will rank near the 50th percentile or higher for the HEDIS PPC sub-measure Postnatal Care.

Results

Table 18 displays the number of distinct enrollees meeting criteria for the PMAP+ waiver population of pregnant women during calendar years 2014 to 2018; it reflects growth from 2014 to 2016 and then a decrease through 2018. Still, the number of enrollees in 2018 was larger than that of 2014.

Table 18. Annual enrollment of PE pregnant women.

Year	Number of Enrollees
2014	298
2015	397
2016	444
2017	430
2018	337

Tables 19 and 20 present numerators, denominators, and rates (with confidence intervals) of HEDIS PPC sub-measures for pregnant women across years 2014 to 2018. Complementary figures (15 and 16) are included to emphasize changes across the years. Additionally, the average national rates obtained from NCQA's Quality Compass are included for comparison purposes (when available).

As can be seen in table 19, after a sharp decrease from 2014 to 2015, PPC Timeliness of Prenatal Care sub-measure rates declined steadily across years. Confidence intervals suggest

these changes were not significant, presumably at least in part because of small denominator sizes. Visual representation of these rates is available in figure 15.

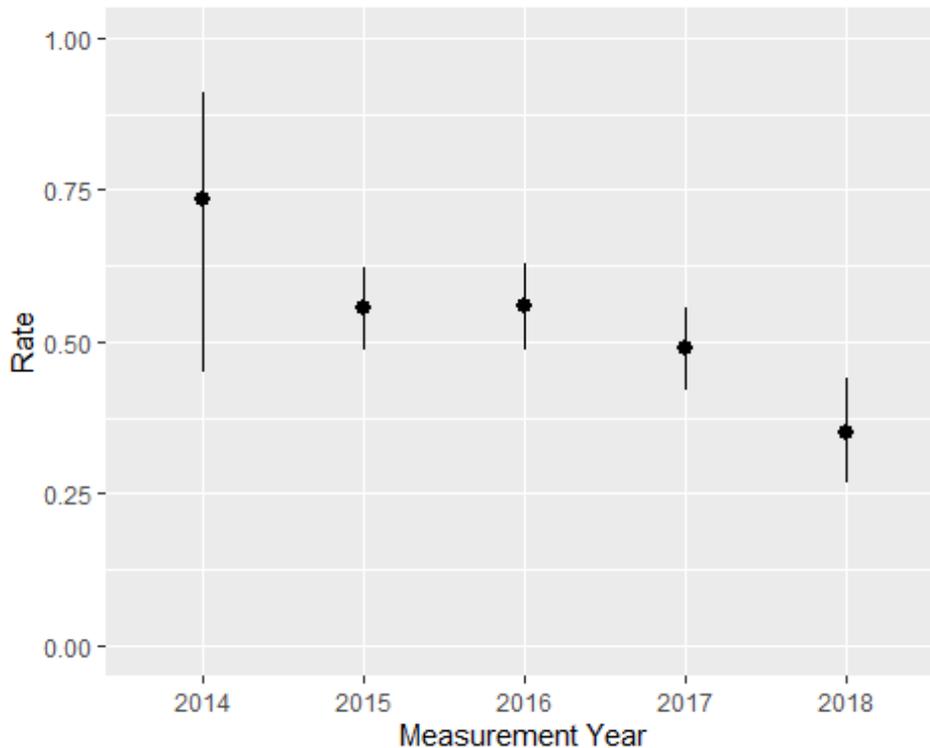
In the years for which NCQA average rates were available, MN’s rate was largely different from the NCQA benchmark (on average about 40 percentage points lower). Considering the rates associated with each percentile listed in Quality Compass, it appears that Minnesota ranks below the 5th percentile in 2016, 2017, and 2018 (5% = 63.56, 64.48, and 64.59, respectively) for this sub-measure.

PPC Results.

Table 19. Annual PPC Timeliness of Prenatal Care rates of PE pregnant women.

Year	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	11	15	73.33	44.83	91.09	N/A
2015	119	214	55.61	48.68	62.33	N/A
2016	114	204	55.88	48.78	62.76	80.03
2017	104	213	48.83	41.96	55.73	81.67
2018	43	123	34.96	26.73	44.14	81.13

Figure 15. Annual PPC Timeliness of Prenatal Care rates of PE pregnant women.



As can be seen in table 20, after a moderate increase from 2014 to 2015, PPC Postpartum Care sub-measure rates decreased from 2016-2017 and then increased again in 2018. Confidence intervals suggest these changes were not significant, again presumably at least partially

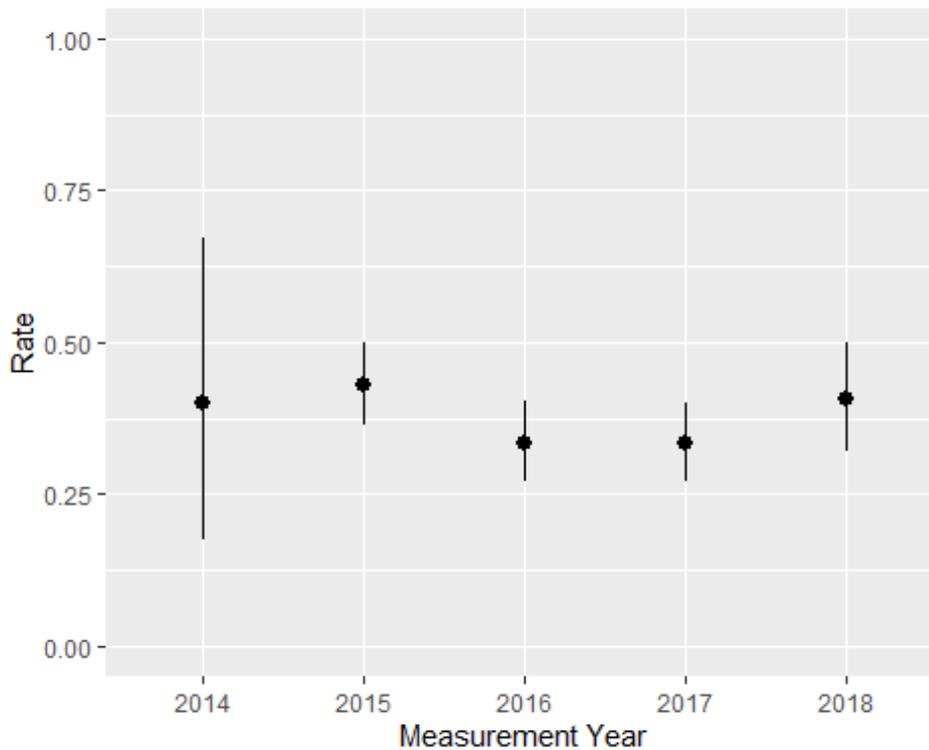
because of small denominator sizes. Visual representation of these rates is available in figure 16.

In the years for which NCQA average rates were available, MN’s rate was largely different from the NCQA benchmark (about 25 percentage points lower on average). Considering the rates associated with each percentile listed in Quality Compass, it appears that Minnesota ranks below the 5th percentile (5% = 43.64, 45.76, and 49.06, respectively) for this sub-measure.

Table 20. Annual PPC Postpartum Care rates of PE pregnant women.

Year	Numerator	Denominator	Rate	LBound	UBound	NCQA Average Rate
2014	6	15	40.00	17.46	67.11	N/A
2015	92	214	42.99	36.31	49.92	N/A
2016	68	204	33.33	27.00	40.31	60.93
2017	71	213	33.33	27.13	40.15	63.75
2018	50	123	40.65	32.00	49.89	64.35

Figure 16. Annual PPC Postpartum Care rates of PE pregnant women.



Limitations and Conclusions

For both sub-measures, rates were substantially below the national average from 2016 to 2018; in fact, Minnesota ranked below the 5th percentile in all cases. Thus, comparisons of Minnesota’s pregnant women in a period of presumptive eligibility and NCQA benchmarks

suggest that this waiver population is not receiving the same access to and quality of care as the rest of the country's MA population, which fails to support both proposed hypotheses. However, upon exploration of PPC rates in the wider MA population of Minnesota, we learned that these lower rates are not exclusive to pregnant women in a period of presumptive eligibility but rather a product of lower rates in general in Minnesota. A limitation relevant to this particular quality measure lies in how prenatal and postnatal services are sometimes billed in Minnesota. Often, prenatal services are bundled together on one claim that is not submitted until the delivery date; there is no way of knowing when the initial service occurred and thus no way of determining whether a prenatal visit occurred within the necessary time frame. If a person has no other prenatal claims prior to delivery, that individual may still be included in the denominator but not in the numerator thus lowering the rate for timeliness of prenatal care. Similarly, bundled codes sometimes include postpartum care so the rate for postpartum care may also be lower than expected.

MERC Analyses

Evaluation Questions

Another goal of this demonstration is to support training opportunities for medical education, especially in rural areas, so that new providers will be attracted to serve low-income and underserved regions of Minnesota. This is achieved via the Medical Education and Research Costs (MERC) Trust Fund, which grants funds to medical care providers who serve the Medicaid population and offer opportunities for clinical training. Through expenditure authority granted under the PMAP+ waiver, MERC Trust Fund grant payments are eligible for federal financial participation and thus are the basis of this report.

While a goal of the grant is to fund those professions where shortages exist, funding is not based on type of training but rather each site's grant amount is determined by a specific formula that takes into account 1) the total Medicaid revenue pool across all eligible clinical training sites and 2) the percentage of the total revenue pool each clinical training site contributed. Grants are further determined by the number of Full-Time Equivalent hours (FTEs) a site hosted; specifically, sites must host at least 0.1 FTEs (208 clinical hours) and have at least \$5,000 in clinical training expenditures in order to be eligible to receive grant funds. Another caveat is that amount of funds received by clinical training sites cannot exceed the site's reported clinical training expenditures nor can they exceed the 95th percentile grant per FTE cap.

Evaluation questions are as follows:

- a) Was the number of students and residents at clinical training sites receiving MERC grant funds maintained or increased during the current waiver period compared to the previous waiver period for rural and urban areas of the state?
- b) How did the MERC fund grantees use the payments?

- c) Was the ratio of primary care providers (PCPs) in rural Minnesota to PCPs in urban Minnesota maintained or improved during this waiver period compared to the previous waiver period?
- d) Was the ratio of rural PCPs per 10,000 rural beneficiaries maintained or improved during this waiver period compared to the previous waiver period?
- e) Was the ratio of urban PCPs per 10,000 urban beneficiaries maintained or improved during this waiver period compared to the previous waiver period?

Methodology

MERC program data were used to describe how funds were distributed during the years of interest while Medicaid provider and beneficiary enrollment data were used to identify PCPs and beneficiaries in rural and urban areas of the state. In all of the tables presented, the current waiver period includes state fiscal years 2016 to 2019 and the previous waiver period includes state fiscal years 2014 and 2015. Urban Minnesota was defined as the seven-county metro area (additionally, for those data addressing evaluation questions c-e “urban” included the Shakopee Mdewakanton Sioux reservation in Scott county) while all other counties (and reservations) were considered rural Minnesota.

The number of students and residents at training sites were compared across waiver periods by examining the number of FTEs hosted by training sites in rural and urban areas of the state. Additionally, program data were used to identify the percentage of funds used to support training during the current waiver period for the following professional groups: medical (including residents and students), dental providers (including dental residents/students, dental therapists, and advanced dental therapists), psychologists, pharmacists (including PharmD residents and students), community paramedics, and other professionals (e.g., clinical social workers, physician assistants, etc.).

To address the remaining questions, populations of PCPs were compared between waiver periods. PCPs were defined as physicians, physician assistants, nurse practitioners, nurse midwives, clinical nurse specialists, and primary care clinics; only those that were Medicaid-enrolled and active during the relevant waiver periods were included. MMIS data were used to identify these providers and determine county location, and those located out of state were excluded. Similarly, MMIS data were used to identify beneficiaries residing in rural versus urban areas; those eligible must have been enrolled in a Medicaid program and have lived in state during the relevant waiver period. County of financial responsibility was used to determine rural versus urban status rather than county of residence as MMIS maintains historical records only for the former. If individuals fit into both rural and urban designations within the same fiscal year, they were counted in both; otherwise, beneficiaries were de-duplicated within waiver periods to obtain a count of unique individuals.

First, we compared the proportions of total providers that were rural versus urban across waiver periods to determine whether or not there was substantial change over time. Second, we calculated provider to beneficiary ratios across waiver periods to determine whether or not there was substantial change over time (separately for rural and urban locations). Because the

waiver periods are of different duration (two versus four years), it is more appropriate to de-duplicate beneficiaries and providers within fiscal year rather than within waiver periods (this is because the number of new beneficiaries will grow substantially more than the number of new PCPs each year thus inflating the denominators). In order to compare waiver periods directly, average ratios for each period were calculated based on the yearly ratios.

Hypotheses

Providing a dedicated trust fund for graduate medical education will

- a) Maintain or increase training opportunities at facilities statewide to support the care of the Medicaid population in Minnesota. Specifically:
 - 1. The number of students and residents at training sites in rural Minnesota will be maintained or increase between waiver periods.
 - 2. The number of students and residents at training sites in urban Minnesota will be maintained or increase between waiver periods.

- b) Support training activities which help to maintain or increase the number of PCPs serving the Medicaid population in Minnesota. Specifically:
 - 1. The ratio of rural PCPs to urban PCPs will be maintained or improve between waiver periods.
 - 2. The ratio of rural PCPs to rural beneficiaries will be maintained or improve between waiver periods.
 - 3. The ratio of urban PCPs to urban beneficiaries will be maintained or improve between waiver periods.

Results

Table 1 displays the number of FTE hours paid for with MERC funds in both rural and urban areas of Minnesota while table 2 displays the percentages of FTE hours paid for in rural versus urban areas. It appears that the ratio of rural to urban training hours has remained consistent across waiver periods.

Table 1. FTEs rural vs. urban receiving MERC funds.

Payment Year	Medicaid Utilization Year	Clinical Training Year	Rural	Urban	Total
2014 (DY19)	2011	2011	1,310.9	1,810.1	3,121.0
2015 (DY20)	2012	2012	1,340.6	1,914.2	3,254.8
2016	2013	2013	1,374.3	1,900.3	3,274.6
2016	2014	2014	1,343.8	1,718.7	3,062.5

Payment Year	Medicaid Utilization Year	Clinical Training Year	Rural	Urban	Total
2017	2015	2015	1,322.9	1,689.0	3,011.9
2018	2016	2016	1,343.9	1,717.8	3,061.7
2019	2017	2017	1,328.6	1,696.6	3,025.2

Table 2. Percent rural vs. urban FTEs receiving MERC funds.

Payment Year	Medicaid Utilization year	Clinical Training Year	Rural	Urban
2014 (DY19)	2011	2011	42.0%	58.0%
2015 (DY20)	2012	2012	41.2%	58.8%
2016	2013	2013	42.0%	58.0%
2016	2014	2014	43.9%	56.1%
2017	2015	2015	43.9%	56.1%
2018	2016	2016	43.9%	56.1%
2019	2017	2017	43.9%	56.1%

Table 3 displays the percent of funds used to support clinical training in different health professions across years in the current waiver period. The greatest proportion of funds was utilized for training physicians, followed by ‘other’ professionals (a diverse group of nurses, PAs, etc.), pharmacists, dentists, psychologists, and finally, community paramedics. These proportions did not appear to change from 2016 to 2019 except for a small increase in allocated funds to physicians (4-7%) with a corresponding decrease to other professionals.

Table 3. Percent of funds used to support clinical training.

Payment Year	2016	2017	2018	2019
Medicaid Utilization Year	2013/2014	2015	2016	2017
Clinical Training Year	2013/2014	2015	2016	2017
Physicians	63.0%	69.6%	69.9%	67.3%
Dentists	1.3%	1.4%	1.8%	1.6%
Psychologists	0.4%	0.7%	0.9%	0.9%
Pharmacists	12.4%	13.0%	11.5%	14.5%
Community Paramedics	0.0%	0.0%	0.0%	0.0%
Other	22.9%	15.3%	15.9%	15.8%

Table 4 displays the counts of distinct rural and urban PCPs across waiver periods as well as their corresponding percentages of total PCPs. The total number of PCPs increased between the previous and current waiver periods by a little over 6,000; both rural and urban PCPs increased

in number by about 3,000. Moreover, the percentages of rural and urban PCPs did not appear to change substantially across waiver periods.

Table 4. Percentages of rural and urban PCPs across waiver periods.

Waiver Period	Number of Rural PCPs	Number of Urban PCPs	Total Number of PCPs	Percent Rural	Percent Urban
Previous	13,829	16,392	30,221	45.76	54.24
Current	16,912	19,791	36,703	46.08	53.92

Table 5 displays the de-duplicated counts of rural and urban beneficiaries across state fiscal years as well as the corresponding ratios of PCPs to beneficiaries; also provided is an average ratio for the overall waiver periods (i.e., previous versus current). Though the number of urban beneficiaries was greater than the number of rural beneficiaries in both waiver periods, the pattern of change in number of beneficiaries across fiscal years was similar. Furthermore, the ratio of PCPs per 10,000 beneficiaries declined very slightly from the previous to the current waiver period for both rural and urban areas; thus there was no between-group difference in ratio change over time.

Table 5. Ratios of PCPs to 10,000 beneficiaries in rural and urban areas of MN across waiver periods.

Waiver Period (SFY)	Number of Rural Beneficiaries	Number of Urban Beneficiaries	Number of Rural PCPs per 10,000 Rural Beneficiaries	Number of Urban PCPs per 10,000 Urban Beneficiaries
Previous				
2014	523,361	608,555	245.24	253.42
2015	578,700	671,669	232.99	239.84
Average			239.11	246.63
Current				
2016	610,767	716,975	230.87	233.90
2017	630,381	737,937	232.34	236.92
2018	630,642	736,475	243.18	249.35
2019	634,488	738,971	250.71	257.30
Average			239.27	244.37

Note. The numbers of beneficiaries and PCPs are de-duplicated within fiscal year.

Limitations and Conclusions

The first hypothesis was addressed by the number of FTE hours receiving MERC funds across the waiver periods. Regarding rural areas, the number of hours did not appear to differ between the first two fiscal years (1,310.9 and 1,340.6 hours, respectively) and the subsequent four fiscal years (which ranged from 1,322.9 to 1,374.3 hours). On the other hand, the number

of hours paid via MERC in urban areas appears to have declined somewhat from the first two fiscal years (1,810.1 and 1,914.2, respectively) to the last four years (ranging from 1,689.0 to 1,914.2). This accounts for the change in percentage of MERC spending allocated to rural facilities from about 42% to about 44% across the waiver periods (due to a lower total number of MERC-funded FTEs). Such results support the hypothesis that the number of training opportunities has been maintained or increased across waiver periods in rural areas but that the number of opportunities in urban areas has declined to a small degree.

Regarding the subsequent hypotheses, we have demonstrated the following: although the percentage of rural PCPs was smaller than that of urban PCPs, it may be expected given the population distribution of the state. Furthermore, the ratio of rural to urban PCPs was maintained from the previous to the current waiver period. These results support the first component of the second hypothesis.

Similarly, the ratio of PCPs per 10,000 beneficiaries was maintained from the previous to the current waiver period for both rural and urban areas of the state. These results support the second and third components of the second hypothesis. Furthermore, the change in PCP to beneficiary ratios across waiver periods was not different between rural and urban geographic areas. This suggests that although there may have been some small decline in the overall number of PCPs per 10,000 Medicaid beneficiaries, that decline was not worse in rural areas.

An important limitation of these data is that historical addresses are unavailable for providers. That is, only the most recent location of each provider could be used to determine rural versus urban status. If PCPs relocated from one waiver period to the next, it could not be tracked. However, many of the providers considered in these analyses are clinics and as such seem unlikely to change locations between these relatively short waiver periods. Furthermore, it seems reasonable to expect that even if PCPs relocated over the years they would most likely remain in the same geographic area—moving within-county or from one rural county to another (or one urban county to another)—which would not affect the results of these analyses.

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

Evaluation Plan 2021 to 2025

1. Introduction

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

2. PMAP+ Section 1115 Waiver Extension in 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.

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

MA One-Year-Olds

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

Caretaker Adults with 18-Year-Old

The PMAP+ waiver provides expenditure authority for Medicaid coverage for Caretaker Adults who live with and assume responsibility for a youngest or only child who is age 18 and is not enrolled full time in secondary school. PMAP+ waiver authority allows Minnesota to waive the requirement to track the full-time student status of children age 18 living with a caretaker. Beginning in 2014, Minnesota covers both adults without children and caretaker adults to 133% of the FPL under the state plan. Adults without children and caretaker adults are eligible for the

full MA benefit set. Without waiver authority, a caretaker adult with a youngest child or only child turning 18 would need to be re-determined under an “adult without children” basis of eligibility. This exercise is meaningless because Minnesota covers adults and parents to the same income level. Health care coverage and cost sharing are the same.

The household size for the parent is independent of the required tracking of the child’s full-time student status. For non-tax filing families, Minnesota has chosen age 19 as the age at which a child is no longer in the household. In a tax filing household, the parent’s household size would depend on whether they expect to claim the child as a dependent, regardless of age. By waiving the requirement to track the full-time student status, Minnesota avoids requesting private data that will not be consequential to the consumer’s eligibility for health care. In addition to relieving the burden on consumers and not requesting personal information that is not relevant to eligibility, coverage, or cost-sharing, Minnesota expects the waiver to result in administrative efficiency by simplifying the procedures that case workers need to follow.

MERC

Through expenditure authority granted under the PMAP+ waiver, payments made through the Medical Education and Research Costs (MERC) Trust Fund through sponsoring institutions to medical care providers are eligible for federal financial participation.

Pregnant Women

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

4. Hypotheses, Research Questions and Evaluation Metrics

4.1 MA One-Year-Olds

Goal/Objective

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

Research Question

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

Hypothesis

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

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

4.2 Medicaid Caretaker Adults with 18 –Year- Old

Goal/Objective

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

Research Questions

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

Hypothesis

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

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

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

Statistical Methods

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

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

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

5.3 Medical Education and Research Costs (MERC) Trust Fund

Goal/Objective

There is an on-going need to support training opportunities for medical education in Minnesota. For nearly two decades, Minnesota has taken a unique approach to this issue through its section

1115 waiver authority under PMAP+. This authority is necessary to continue a grant payment structure for facilities accepting trainees to support the care of the Medicaid population. Without this grant program, many facilities, especially in rural areas, may not be able to participate in training activities for medical education, which help attract new providers ready to serve low-income and underserved areas of the state.

Through Minnesota’s PMAP+ waiver, the MERC program supports the objectives of the Medicaid program by strengthening the state’s provider network through residency grants to facilities serving the Medicaid population that accept trainees who will support patient care. This program also serves a variety of health professions, including training for professions where shortages exist for the Medicaid population. The amount of the grant available to the facility is relative to their Medicaid-patient volume, providing an incentive for these facilities to serve a higher volume of the Medicaid population.

The key advantage of this approach is that MERC allows for a broader set of facilities to participate than just teaching hospitals, helping the state reach a larger portion of the state. Under the traditional fee-for-service system, medical education payments to teaching facilities are higher than those to non-teaching facilities. This is done in an effort to offset a portion of the higher costs faced by facilities that provide clinical medical education.

Hypothesis A

Providing a dedicated trust fund for graduate medical education will maintain or increase training opportunities at facilities statewide to support the care of the Medicaid population in Minnesota.

Research Questions

1. Were the number of students and residents at clinical training sites receiving MERC grant funds maintained or increased during this waiver period compared to the previous waiver period for rural and urban areas of the state?
2. How did the MERC fund grantees use the payments?

Hypothesis A

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

¹ Comparison Years are based on State Fiscal Years.

<p>compared to the previous waiver period for rural and urban areas of the state?²</p>	<p>Demonstration Year (DY) 24³ and DY 25⁴.</p> <p>b. Urban: Number of students or residents at training sites in urban areas of the state for DY 24 and DY 25.</p>	<p>2021 through 2025 to the number of students and residents at training sites in rural Minnesota for DY 24 and DY 25.</p> <p>b. Urban: Compare the number of students and residents at training sites in urban areas of the state for the current waiver period to the number of students and residents at training sites in urban areas of the state in DY 24 and DY 25.</p>		
<p>2. How did the MERC-funded grantees use the payments?</p>	<p>N/A</p>	<p>Of the total grant distribution for years 2021 through 2025, identify the percentage of funds that were used to support training in the following health professions:</p> <ul style="list-style-type: none"> a. Medical training (physicians) b. Dental providers (including dental therapists) c. Psychologists d. Pharmacists e. Community Paramedics f. Other health professionals 	<p>MY 2021-2025</p>	<p>MERC Program Data</p>

Hypothesis B

Providing a dedicated trust fund for graduate medical education will support training activities which help to maintain or increase the number of primary care providers serving the Medicaid population in Minnesota.

² Urban areas of the state include the seven-county metro area which includes the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Washington and Scott. The rural areas of the state include the remaining 80 counties in Minnesota.

³ PMAP demonstration year 24 covers the period of July 1, 2018 through June 30, 2019.

⁴ PMAP demonstration year 25 covers the period of July 1, 2019 through June 30, 2020.

Research Question

1. Was the ratio of primary care providers in rural Minnesota to primary care providers in urban Minnesota maintained or improved during this waiver period compared to the previous waiver period?
2. Was the ratio of rural primary care providers per 10,000 rural beneficiaries maintained or improved during this waiver period compared to the previous waiver period?
3. Was the ratio of urban primary care providers per 10,000 urban beneficiaries maintained or improved during this waiver period compared to the previous waiver period?

Hypothesis B

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

		10,000 urban beneficiaries for DY 24 and DY 25		
--	--	--	--	--

¹ Comparison Years are based on State Fiscal Years.

Statistical Methods

The evaluation will use MERC program data to compare the annual number of students and residents at training sites in rural and urban areas of the state across the two waiver periods. The comparison will determine whether or not the number of students and residents change significantly over time or if they remain relatively constant. Grant fund distributions will be analyzed to determine utilization rates across health professions. The analysis will evaluate provider to beneficiary ratios within geographical regions of the state to determine if MERC has impacted ratios between the two waiver periods.

5.4 Pregnant Women in a Presumptive Eligibility Period

Goal/Objective

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

Research Question

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

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

Statistical Methods

The evaluation will use selected HEDIS performance measures to evaluate care for the waiver population compared to national averages. A comparison and stratification of the selected

HEDIS and other performance measures will be made between the waiver population and national Medicaid averages for pregnant women to show the ongoing improvement in care for pregnant women enrolled in MA in Minnesota. Minnesota Managed Care HEDIS Hybrid data will also be utilized to determine differences in administrative versus hybrid rates for this measure.

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

5. Qualifications of Staff Conducting Evaluation

The qualifications of the staff conducting the evaluation include but are not limited to the following key personnel.

Kevan Edwards has been with DHS for five years and is currently the Research Director of Health Care Research and Quality Division/Research and Data Analysis Section. Dr. Edwards has a Ph.D. in Sociology, Health Services Research Supporting area from the University of Minnesota. Prior to his work at DHS, he was the Research Director, Health Economics Program at the Minnesota Department of Health working with the All Payer Claims Database. Areas of expertise include data visualization, risk adjustment of cost and quality measures, and disparities in health status, health access, and health care utilization.

Titilope Adeniyi has been with DHS since July 2013 and is currently the Research and Data Analysis Supervisor of Health Care Research and Quality Division/Research and Data Analysis Section. Dr. Adeniyi has a Ph.D. in Health Services Research from the University of Minnesota. Areas of experience include SAS and Stata programming, multivariate regression analysis, and health care utilization.

Lindsay Burr, Senior Health Care Researcher in Health Care Research and Quality Division/Research and Data Analysis Section, has been with DHS since December 2017. Graduated from the University of Minnesota (UMN) with a Masters and PhD in psychology in 2016. Dissertation incorporated longitudinal and multilevel modeling as well as genetic analyses. Taught research methods courses at the University of Wisconsin-River Falls as well as UMN where instruction focused on generating publishable research, including research methodology, statistics, and writing scientific papers. Has over 10 years' experience programming in R, SPSS, and SAS.

Monica Patrin, Senior Health Care Researcher in Health Care Research and Quality Division/Research and Data Analysis Section, has been with DHS since December 2016. After graduating from the University of Minnesota with a Masters in Statistics in 2013, she worked in education research and assessment as a data analyst/R programmer for almost three years. She has experience working with a variety of models used as the basis for teacher evaluations— (random effects models, error in variables models, multinomial logistic regression models, etc).

Diane Reger, State Program Administrator – Coordinator, has been with MDH since 2000. She has administered the MERC grant program for sixteen years. Prior to coming to MDH, she worked in the insurance industry for ten years, in underwriting and sales and marketing analysis.

Zora Radosevich, MPA, is Director of the Office of Rural Health and Primary Care at the Minnesota Department of Health. She has over 30 years of experience in nonprofit, legislative and state government policy development and analysis, program management and evaluation. She manages a portfolio of health care safety net and workforce development programs, which includes the MERC program.

6. Evaluation Implementation Strategy and Timeline

Waiver Populations under Sections 5.1, 5.2, and 5.4

Beginning in 2026, performance measurement data will be extracted from DHS' managed care encounter and fee-for-service database to allow for a sufficient encounter/claim run-out period. Performance measurement rates for the baseline period (CY 2019 and 2020) will be calculated for the targeted populations and compared to CY 2021, 2022, 2023, 2024, and 2025. In addition, national benchmarks will be obtained from NCQA's Medicaid Quality Compass to compare performance of Minnesota's populations with national and other states' performance.

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

Below is an overview of evaluation activities and timelines:

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

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

October 2026: HEDIS results will be reviewed and evaluated.

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

March 2027: CMS submits feedback to DHS.

May 2027: DHS incorporates CMS feedback. Final report is submitted to CMS.

Waiver Authority under Sections 5.3

The Minnesota Department of Health and DHS will conduct this component of the waiver evaluation. MERC Program data for the baseline period (DY 24 and DY 25) will be compiled and compared to state fiscal year 2021, 2022, 2023, 2024, and 2025. Medicaid provider enrollment data for state fiscal year 2021 through 2025 will be extracted and analyzed. The results will be incorporated into the draft final report.

	A	B	C	D	E	F	G	H	I	J
1	5 YEARS OF HISTORIC DATA									
2										
3	SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:									
4		SFY2015	SFY2016	SFY2017	SFY2018	SFY2019				
5	Medicaid Pop 1	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS		MA Children Age 1	
6	TOTAL EXPENDITURES	\$ 58,172	\$ 61,985	\$ 65,918	\$ 81,493	\$ 81,109	\$ 348,678			
7	ELIGIBLE MEMBER MONTHS	527	614	601	642	650				
8	PMPM COST	\$ 110.38	\$ 100.95	\$ 109.68	\$ 126.94	\$ 124.78				
9	TREND RATES						5-YEAR			
10				ANNUAL CHANGE			AVERAGE			
11	TOTAL EXPENDITURE		6.55%	6.34%	23.63%	-0.47%	8.66%			
12	ELIGIBLE MEMBER MONTHS		16.51%	-2.12%	6.82%	1.25%	5.38%			
13	PMPM COST		-8.54%	8.64%	15.73%	-1.70%	3.11%			
14										
15	Medicaid Pop 2	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS		MA CARETAKER 18 YR OLD	
16	TOTAL EXPENDITURES	\$ 8,088,905	\$ 9,958,119	\$ 11,533,431	\$ 14,748,896	\$ 14,860,429	\$ 59,189,781			
17	ELIGIBLE MEMBER MONTHS	20,093	21,101	24,678	29,447	29,236				
18	PMPM COST	\$ 402.57	\$ 471.93	\$ 467.36	\$ 500.86	\$ 508.29				
19	TREND RATES						5-YEAR			
20				ANNUAL CHANGE			AVERAGE			
21	TOTAL EXPENDITURE		23.11%	15.82%	27.88%	0.76%	16.42%			
22	ELIGIBLE MEMBER MONTHS		5.02%	16.95%	19.32%	-0.72%	9.83%			
23	PMPM COST		17.23%	-0.97%	7.17%	1.48%	6.00%			
24										
25	Medicaid Pop 3	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS			
26	TOTAL EXPENDITURES						\$ -			
27	ELIGIBLE MEMBER MONTHS									
28	PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!				
29	TREND RATES						5-YEAR			
30				ANNUAL CHANGE			AVERAGE			
31	TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
32	ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
33	PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
34										
35	Other Data	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS			
36	TOTAL EXPENDITURES						\$ -			
37	ELIGIBLE MEMBER MONTHS									
38	PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!				
39	TREND RATES						5-YEAR			
40				ANNUAL CHANGE			AVERAGE			
41	TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
42	ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
43	PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

	A	B	C	D	E	F	G	H	I	J	K
1	DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
2											
3						SFY2022	SFY2023	SFY2024	SFY2025	Jul-Dec 2025	
4	ELIGIBILITY	TREND	MONTHS	BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
5	GROUP	RATE 1	OF AGING	DY 00	RATE 2	DY 01	DY 02	DY 03	DY 04	DY 05	WOW
6											
7	Medicaid Pop 1										
8	Pop Type:	Medicaid									
9	Eligible Member Months	5.4%	24	722	5.4%	761	802	845	890	469	
10	PMPM Cost	3.1%	24	\$ 132.67	3.1%	\$ 136.80	\$ 141.05	\$ 145.44	\$ 149.96	\$ 154.62	
11	Total Expenditure					\$ 104,057	\$ 113,062	\$ 122,853	\$ 133,486	\$ 72,520	\$ 545,979
12											
13	Medicaid Pop 2										
14	Pop Type:	Medicaid									
15	Eligible Member Months	9.8%	24	35,266	9.8%	38,733	42,540	46,722	51,315	56,359	
16	PMPM Cost	6.0%	24	\$ 571.12	6.0%	\$ 605.39	\$ 641.71	\$ 680.21	\$ 721.02	\$ 764.28	
17	Total Expenditure					\$ 23,448,557	\$ 27,298,619	\$ 31,780,876	\$ 36,999,099	\$ 43,074,209	\$ 162,601,359
18											
19	Medicaid Pop 3										
20	Pop Type:	Medicaid									
21	Eligible Member Months	#DIV/0!	24	#DIV/0!	#DIV/0!						
22	PMPM Cost	#DIV/0!	24	#DIV/0!	#DIV/0!						
23	Total Expenditure					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24											
25	Hypo 1										
26	Pop Type:	Hypothetical									
27	Eligible Member Months										
28	PMPM Cost										
29	Total Expenditure					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
30											
31	Hypo 2										
32	Pop Type:	Hypothetical									
33	Eligible Member Months										
34	PMPM Cost										
35	Total Expenditure					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			SFY2022 DY 01	SFY2023 DY 02	SFY2024 DY 03	SFY2025 DY 04	Jul-Dec 2025 DY 05	
Medicaid Pop 1								
Pop Type: Medicaid								
Eligible Member								
Months	722	5.4%	761	802	845	890	469	
PMPM Cost	\$ 132.67	3.1%	\$ 136.80	\$ 141.05	\$ 145.44	\$ 149.96	\$ 154.62	
Total Expenditure			\$ 104,057	\$ 113,062	\$ 122,853	\$ 133,486	\$ 72,520	
							\$ 545,979	
Medicaid Pop 2								
Pop Type: Medicaid								
Eligible Member								
Months	35,266	9.8%	38,733	42,540	46,722	51,315	56,359	
PMPM Cost	\$ 571.12		\$ 605.39	\$ 641.71	\$ 680.21	\$ 721.02	\$ 764.28	
Total Expenditure			\$ 23,448,557	\$ 27,298,619	\$ 31,780,876	\$ 36,999,099	\$ 43,074,209	
							\$ 162,601,359	
Medicaid Pop 3								
Pop Type: Medicaid								
Eligible Member								
Months	#DIV/0!	#DIV/0!						
PMPM Cost	#DIV/0!							
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	
							\$ -	
Hypo 1								
Pop Type: Hypothetical								
Eligible Member								
Months			-	-	-	-	-	
PMPM Cost			\$ -	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	
							\$ -	
Hypo 2								
Pop Type: Hypothetical								
Eligible Member								
Months			-	-	-	-	-	
PMPM Cost			\$ -	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	
							\$ -	
Exp Pop 1								
Pop Type: Expansion								
Eligible Member								
Months								
PMPM Cost								
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	
							\$ -	
Exp Pop 2								
Pop Type: Expansion								
Eligible Member								
Months								
PMPM Cost								
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	
							\$ -	

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS					
	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS						
	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS						
	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Allotment Diverted (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS						
	DY 01	DY 02	DY 03	DY 04	DY 05	
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Population Status Drop-Down

Medicaid

Hypothetical

Expansion

Department of Human Services

Health Care Administration

Request for Comments on the Prepaid Medical Assistance Project Plus Section 1115

Medicaid Waiver Extension Request

DHS is announcing a 30-day comment period on the proposed extension of the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver.

The PMAP+ waiver provides federal authority to:

- Cover children 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)
- 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;
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility; and
- Fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

The current waiver ends December 31, 2020.

DHS invites public comment on the PMAP+ waiver extension request. Comments received will be posted on the DHS website. A copy of the waiver renewal request can be found at http://www.dhs.state.mn.us/dhs16_171635.

Written comments may be submitted to the following email mailbox: Section1115WaiverComments@state.mn.us. DHS would like to provide copies of comments received in a format that is accessible for people with disabilities. Therefore, we request that comments be submitted in Microsoft Word format or incorporated within the email text. If you

would also like to provide a signed copy of the comment letter, you may submit a second copy in Adobe PDF format. Comments must be received by June 25, 2020.

In addition to the opportunity to submit written comments during the 30-day public comment period, two teleconferences will be held to provide stakeholders and other interested persons the opportunity to comment on the waiver request. The dates and times of the two conferences are provided below.

Teleconference #1

Date: Monday, June 1, 2020

Time: 9:00 a.m.

Teleconference #2

Date: Wednesday, June 3, 2020

Time: 4:00 p.m.

If you would like to attend a teleconference please send an email request to Section1115WaiverComments@state.mn.us to obtain the call-in information. If you plan to testify during the conference, please send an email to Section1115WaiverComments@state.mn.us indicating that you will testify.



Minnesota Department of Human Services
Health Care Administration
540 Cedar Street
PO Box 64983
St Paul, MN 55164-0983

May 26, 2020

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

Dear Tribal Leader,

This letter is to inform you that the Minnesota Department of Human Services (DHS) is announcing a 30-day comment period on a request to extend the Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver.

The current PMAP+ waiver provides federal authority to:

- Cover children 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);
- 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;
- Provide Medical Assistance benefits to pregnant women during the period of presumptive eligibility; and
- Fund graduate medical education through the Medical Education Research Costs (MERC) trust fund.

DHS is proposing to extend the waiver for an additional five-year period from January 1, 2021 through December 31, 2025.

We invite you to comment on the proposed waiver extension. A copy of the PMAP+ waiver extension request and information on the public input process is available at [PMAP+ Waiver](#) web page.

Questions or comments regarding this notification or the waiver extension are welcome at any time within the next 30 days and should be submitted to Jan.Kooistra@state.mn.us. Thank you.

Sincerely,

A handwritten signature in black ink that reads 'Jan Kooistra'.

Jan Kooistra
Federal Relations
Minnesota Department of Human Services