Minnesota Department of **Human Services**

September 30, 2016

Ms. Ruth Hughes, Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services
233 No. Michigan Avenue #600
Chicago, IL 60601-5519

RE: Minnesota's Access Monitoring Review Plan

Dear Ms. Hughes:

I am pleased to submit the Access Monitoring Review Plan for Minnesota's Medical Assistance Program, as required by 42 C.F.R. § 447.203.

This report represents a baseline of information regarding access to certain categories of services. Although the baseline data has some limitations, as we explain in the plan, this as an important step in better understanding the factors that influence access to care, and to improving access to appropriate and high quality health care.

If you require additional information, please contact Stacie Weeks at 651/431-2151.

Sincerely,

Marie Zimmerman
Medicaid Director

MINNESOTA
ACCESS MONITORING
REVIEW PLAN

Minnesota Department of Human Services

42 C.F.R. § 447.203(b); Methods for Assuring Access to Covered Medicaid Services, Final Rule

Contents

I. Overview

The Centers for Medicare & Medicaid (CMS) recently issued a final rule with comment, revising rules that implement section 1902(a)(30)(A) of the Social Security Act (SSA). This law requires states to "assure that payments are consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available [to beneficiaries] under the [state Medicaid] plan at least to the extent that such care and services are available to the general population in the geographic area."

The rule sets forth new requirements for states to create a data-driven process and plan to monitor and review access to services for beneficiaries enrolled in MA under a fee-for-service (FFS) arrangement as compared to the general population. In accordance with this rule, specifically 42 C.F.R. § 447.203, the Minnesota Department of Human Services (DHS) developed an "access review monitoring plan" for the following categories of service:

1. Primary care
2. Dental care
3. Physician specialist
4. Pre- and post-natal obstetric services (includes labor and delivery)
5. Behavioral health services (includes both mental health and substance use disorder)
6. Home health (as defined in 42 C.F.R. § 440.70)

As required in 42 C.F.R. § 447.203 (b)(1), Minnesota's plan considers the following for each of the listed categories of service:

1. The extent to which beneficiary needs are fully met;
2. The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;
3. Changes in utilization of covered services by Medicaid beneficiaries in each geographic area;
4. The characteristics of the beneficiary population; and
5. Actual or estimated levels of provider payment available from other payers, including Medicare and the state's employee health insurance program, by provider type and site of service.

The plan was developed during the months of March through August of 2016, and it received public feedback from the Minnesota Medicaid Advisory Committee, a stakeholder forum, and the general public. It was posted on the state's public website for public comment from September 1, 2016 through September 30, 2016. DHS plans to use public feedback received to inform and shape efforts to improve its access metrics in future updates to the plan.

As required by the rule, the Minnesota Department of Human Services (DHS) will regularly monitor (at least annually) trends or changes in access based on the measures in this report. DHS will also submit an updated access review monitoring plan to CMS at least every three years, or earlier if payment rates are reduced or restructured by the state in such a way that could result in reduced access for beneficiaries. This includes adding other service categories to assure any future rate changes are assessed and monitored for their impact on access to care.

II. Standards and Methodologies

The federal standard for determining whether provider access is sufficient compares the experience of the Medicaid FFS population to that of the general public in the same geographic area. However, like some other states, there is a general lack of available or relevant data for DHS to make direct and valid comparisons of the Medical Assistance FFS population ("MA-FFS population") to the general population for the purposes of determining provider availability, utilization rates, and beneficiary satisfaction or experience with provider access. While Minnesota has an all-payer-claims database, state law currently prohibits DHS from accessing this database. Therefore, for this analysis, DHS is relying on data from national sources, Medicare, and the state's employee health plan for comparison purposes, when applicable and reasonable to make comparisons to the MA-FFS population.

The Medicaid-related data used in this report is based on calendar year (CY) 2014 in order to match other available data sources as necessary for utilization measurements and for assessing whether beneficiary needs were met.[1]

For required geographical comparisons in this report, DHS has divided the state into two regions—metro and non-metro.[2] In future updates, DHS plans to provide a more refined analysis for comparing access within different geographic areas of the state.

Data Sources

- Provider and individual enrollment, service agreement, and claims data from the DHS Medicaid Management Information System (MMIS)
- Call center data from the Minnesota Health Care Programs Help Desk
- Payment rate data from the Minnesota State Employee Group Insurance Plan (SEGIP)
- Payment rate data from Medicare
- Survey data from the Minnesota Health Care Access Survey

Methodologies

As required, DHS developed and applied the following methodologies to establish baselines for monitoring access:

1. **Beneficiary Population Characteristics (See Section III)**
   Fulfills 42 C.F.R. § 447.203(b)(1)(iv)

   Demographic Information: These measures provide information on the characteristics of the MA-FFS population that can be used to inform the analysis of the other measures in the report.

[1] Using CY2014 as a baseline may distort some of the results for the following reasons: 1) Minnesota experienced an increase of approximately 300,000 additional enrollees in Medicaid with the implementation of the Affordable Care Act and the Medicaid expansion; 2) Significant enrollment shifts in MinnesotaCare (as it transitioned from a 1115 waiver in 2014 to becoming the state's basic health plan) and Medical Assistance; and 3) challenges with the state's new eligibility system that impacted enrollment, including referrals for non-MAGI groups to the state's legacy eligibility system and the timing of enrollment into managed care. The state will need to further assess how these significant changes may have impacted the baseline year results in future updates to this plan.

[2] The metropolitan region of Minnesota is comprised of the following 7 counties: Ramsey, Hennepin, Anoka, Carver, Scott, Dakota, and Washington.

2. **Provider Availability Measures (See Section IV)**
Fulfills 42 C.F.R. § 447.203(b)(1)(ii)

a. Provider Enrollment and Participation Baselines: The metrics outlined in this report will set baselines for monitoring trends in provider availability and changes after reductions in rates or restructuring of provider payments. Specifically, this will allow the state to monitor trends, longitudinally, in MA provider enrollment and participation in the MA-FFS system by provider type, location, and site of service.

Location, metro or non-metro, for purposes of this measure is based on the county listed in the provider enrollment file, not where the service was provided.

b. Provider-to-Enrollee Ratios: This ratio allows for monitoring trends in provider availability at the enrollee level. This ratio represents the ratio of active providers in a location to the enrolled MA-FFS population for that geographic region per 1000 person-years. In other words, it represents the average number of providers per 1000 MA-FFS enrollees during CY2014.

Location, metro or non-metro, for purposes of this measure is based on the county listed in the provider enrollment file, not where the service was provided.

3. **Beneficiary Utilization Measures (See Section IV)**
Fulfills 42 C.F.R. § 447.203(b)(1)(iii)

Annual Risk-Adjusted Utilization Rates: This metric provides a baseline measure for monitoring changes over time in beneficiary utilization rates. The "utilization rate" reflects the average number of claims per 1000 person-years, meaning the average number of claims per 1000 people for one full year, by length of enrollment, geographic area, age, and disability status.[3] It also provides a risk-adjusted utilization rate with a risk score based on the Adjusted Clinical Groups (ACG®) Case-Mix System as a way to account for differences in the MA-FFS population's case mix and acuity.[4] The ACG® Case Mix "risk score" applied in this analysis represents the risk score for Minnesota's entire MA-FFS population and includes an assessment of their health status across the entire reporting year which may include experience in both managed care and MA-FFS programs.[5]

[3] Utilization Rate: The number of fee for service claims provided to a FFS recipient for qualified medical procedures or services that occur per 1,000 person years. A person year is defined as a measurement combining the number of persons and their time contribution in a study. Person year measure is being used in this study as a population denominator in this report to measure recipients' FFS enrolled period. It is the sum of individual units of time that the persons in the study population have been observed to the conditions of interest.

[4] Risk-Adjusted Utilization Rate: The unadjusted utilization rate multiplied by the ratio of the average ACG® risk score for the entire FFS population (i.e., 1.09) over the average ACG® risk score for each specific population subdivision (e.g., Long-term, Metro Long-term, or 0-20 Short-term etc.). One might think of this as the "expected" utilization rate for this population subdivision if that group's morbidity burden was closer to the expected morbidity burden of all FFS recipients.

[5] ACG® is a proprietary grouper system from Johns Hopkins University that measures the morbidity burden of patient populations based on disease patterns, age and gender. It relies on the diagnostic and/or pharmaceutical information found in insurance claims or other medical data over an individual's utilization history. The ACG® risk score for each specific population subdivision is the result of a relative comparison of that subgroup to all individuals enrolled in Minnesota Health Care Programs (MHCP) regardless of payment status, i.e., FFS or Managed Care. As an example, since the average risk score for all MHCP individuals is standardized to 1.0, the 1.09 for all FFS recipients indicates the FFS population is estimated to carry a 9% additional morbidity burden than the MHCP population as a whole

Location, metro or non-metro, for purposes of this measure was based on the service recipient's county of residence.

4. **Beneficiary Needs Assessment (See Section V)**
   Fulfills 42 C.F.R. § 447.203(b)(1)(i)

   a. Health Care Effectiveness Data and Information Set (HEDIS®)[6] Measure: The HEDIS® measures used in this report for each benefit category allow the state to evaluate the performance of the MA-FFS program in meeting recognized health and quality outcomes for enrollees as compared to national Medicaid averages as well as the performance of the state's managed care program. In the past, the state's HEDIS® measures completed by DHS were only applied to the managed care population.

      All benefit categories, except home health, specialty care, and obstetric have at least one associated HEDIS® measure that the state will use to monitor trends in beneficiary outcomes. For home health, the state identified an alternative metric which is explained in more detail later in this report. For obstetrics and specialty care, the state plans to include alternative measures in future updates to this report.

   b. Comparison of Call Logs: This metric compares the data related to access from the call logs of the DHS Provider and Member Help Desk (the DHS Help Desk) for the FFS population to the managed care population in MA program.[7] To improve the state's ability to measure beneficiary satisfaction with accessing services and providers in future updates to this plan, DHS plans to improve its efforts to track access within the call log system and to expand its use of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to the MA-FFS population. Currently, it is only used for the managed care population in MA.[8]

   c. Minnesota Health Access Survey: Every other year, the Minnesota Department of Health and the University of Minnesota's School of Public Health conduct a statewide telephone survey to collect information related to health insurance and access. The results of survey questions regarding access to providers have been included in this report.

5. **Comparative Payment Rate Review (See Appendix A)**
   Fulfills 42 C.F.R. § 447.203(b)(1)(v)

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)."

[7] There is insufficient qualitative information in DHS' call log data to assess whether a call entry with the "access" identifier is associated with a specific benefit or whether the caller was unable to access a service provider. Some calls may be related to questions about whether a service is a covered service, and, therefore, accessible or inaccessible to the enrollee. DHS plans to update its call-log process to allow for more accurate reporting of access issues to providers.

[8] Since 2008, the MN DHS has conducted a consumer satisfaction survey on its Managed Care population. The survey is designed to assess the satisfaction of enrollees in managed care Minnesota health care programs (MHCP). The survey is administered by DHS on an annual basis utilizing the standardized survey instrument from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Medicaid core survey. The 2015 Consumer Satisfaction Survey (based on 2014 consumer experiences) was conducted by DataStat, Inc., an NCQA-certified CAHPS® vendor, under contract with the MN DHS.

a. Medicare Aggregate Payment Rate Comparison: This metric compares Medicaid payment rates to Medicare payment rates for primary care, obstetrics, specialty care, mental health, and home health.

b. Rate Comparison to the state's health benefit program for state employees, also known as "State Employee Group Insurance Plan" (SEGIP): This metric provides the percentage comparison of Medicaid payment rates to payment rates for dental care in SEGIP.

c. Substance use disorder (SUD) rates: At this time, DHS does not have a reasonable or similar rate comparison for SUD services provided by another payer that provides an accurate or fair comparison to Medicaid rates for SUD services in Minnesota. DHS plans to further research SUD services and rates provided in other states to determine whether there are comparable options for comparison purposes in future updates made to this report.

III. Beneficiary Population

Medical Assistance (MA) is Minnesota's Medicaid program. It is the largest of Minnesota's publicly funded health care programs, providing coverage for more than one million low-income Minnesotans, or one out of every five Minnesotans. About three-fourths of those enrolled in MA are children, parents, pregnant women and adults without children. One-fourth are people 65 or older and people with disabilities. Most Minnesotans enrolled in MA receive services through the state's managed care system—prepaid health plans and county-based purchasing plans. The remainder receive services through the traditional fee-for-service (FFS) system, where providers receive a payment from DHS for each service they provide and enrollees are free to choose from any provider enrolled in the MA program.

In a given year, a portion of enrollees in the MA-FFS system who were determined eligible for managed care are temporarily enrolled through the MA-FFS system until the selection of their health plan is final. Those who remain in FFS primarily consist of those who are not required to enroll in managed care, or who have chosen to opt out of managed care. In general, these individuals include:

- Individuals with disabilities;
- "Medically needy" individuals;
- People with "cost-effective" health insurance as defined under Title XIX of the SSA;
- Children with adoption assistance; and
- American Indians who live on a reservation.

A. Demographics

The tables below provide demographic information about the characteristics of the MA-FFS population in CY2014. This includes details about differences in age groups, location, race, disability status, third-party coverage, and duration of enrollment.

In CY2014, about 280,000 people were enrolled in the FFS system in any given month.

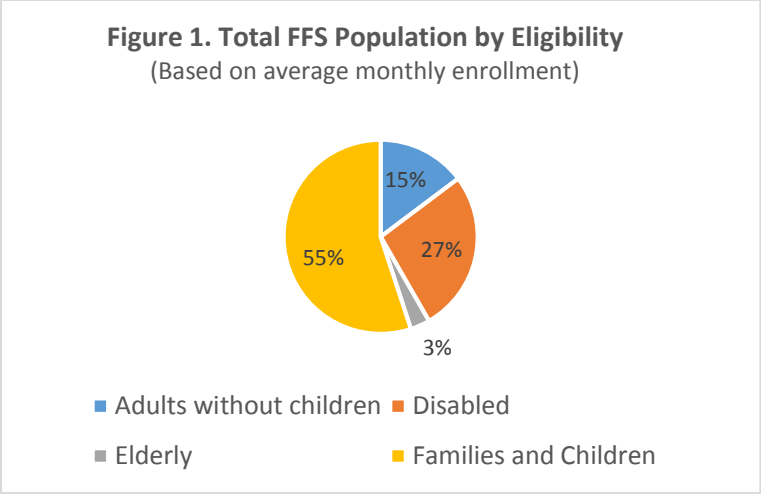


Figure 1 provides a snapshot of average monthly MA-FFS population by eligibility category for CY2014.

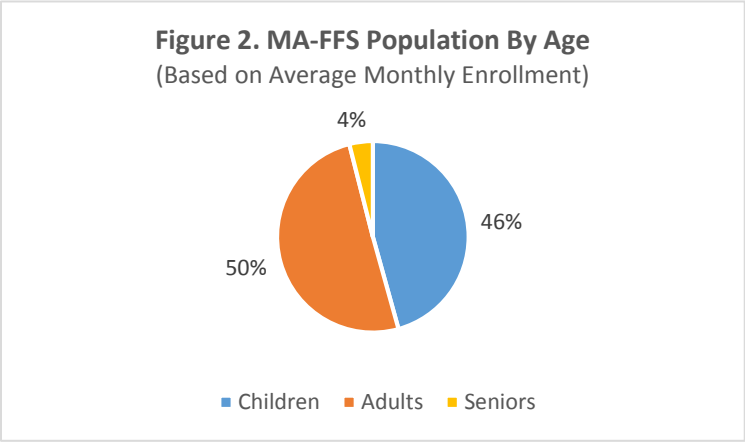


Figure 2 illustrates the enrolled MA-FFS population on an average monthly basis by age. The category for "children" includes enrollees who are 20 years of age and younger; the category for "adults" includes those 21-to-64 years of age; and the category for "seniors" includes those age 65 and older.

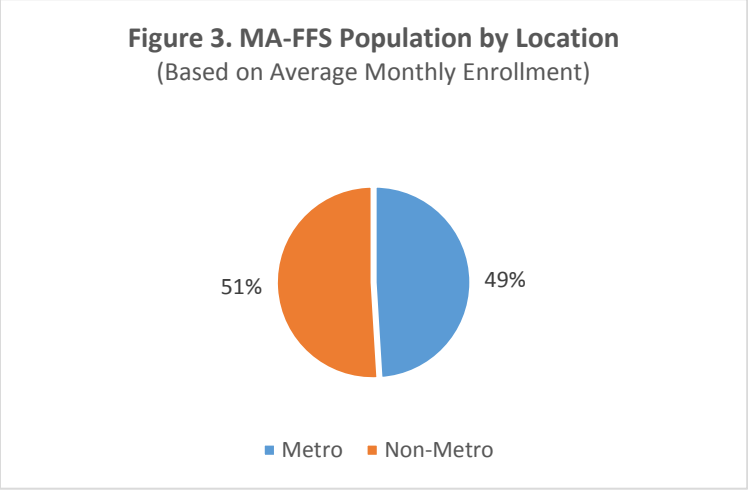


Figure 3 divides the average monthly FFS population into two geographical regions. The metro region is comprised of Ramsey, Hennepin, Anoka, Carver, Scott, Dakota, and Washington counties. The non-metro region includes the remaining 80 counties in Minnesota.[9]

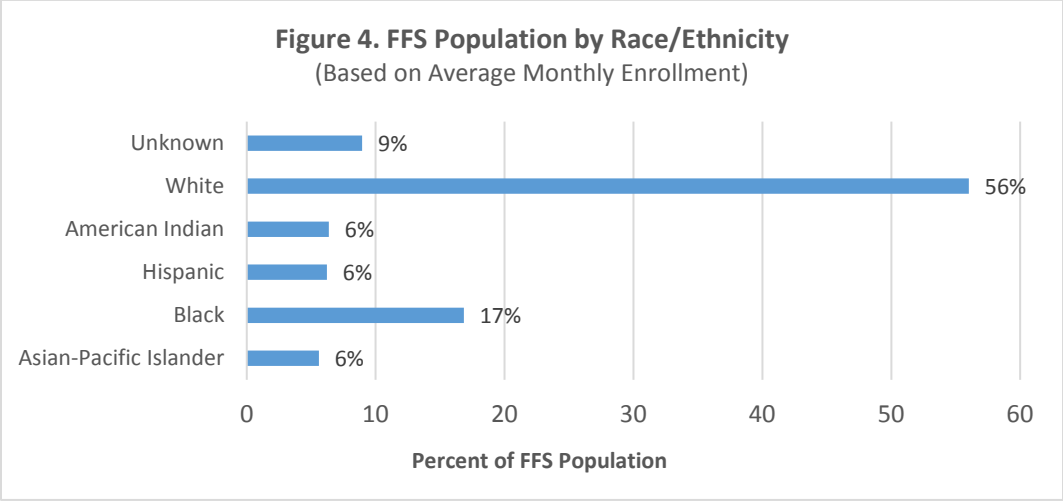
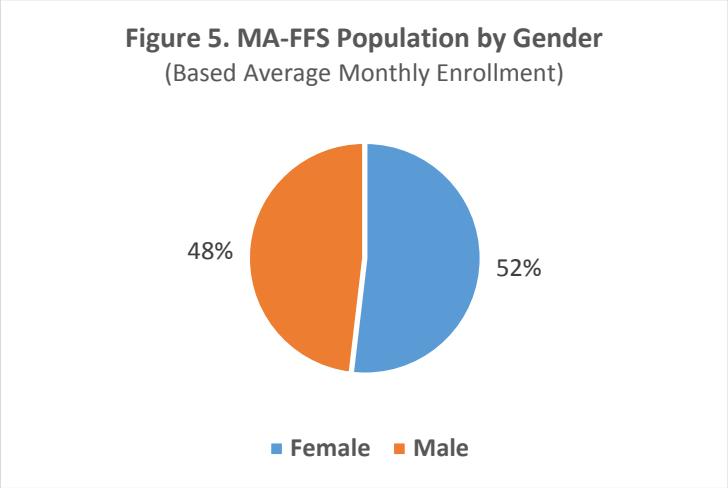


Figure 4 represents the average monthly FFS population by race/ethnicity in Minnesota.[10]



[9] The use of metro region in this report does not include all urban areas of the state. For example, Duluth and Rochester are two urban areas that fall within the non-metro category for purposes of geographical comparisons in this report.

[10] This is the order of assignmen for race/ethnicity indicatorst:

1. If the Ethnicity Flag is "Yes" then race is Hispanic
2. If no race is listed then the race category is 'unknown'
3. If only one race is listed then: Asian and Pacific Islander/Native Hawaii is collapsed into Asian-Pacific Islander. The rest are as listed (Black, American Indian, and White)
4. If more than one race is listed then the priority of order to assign to a race category is:
    1) American Indian
    2) Asian-Pacific Islander
    3) Black
    4) White

Figure 5 compares the average monthly population in FFS by gender.

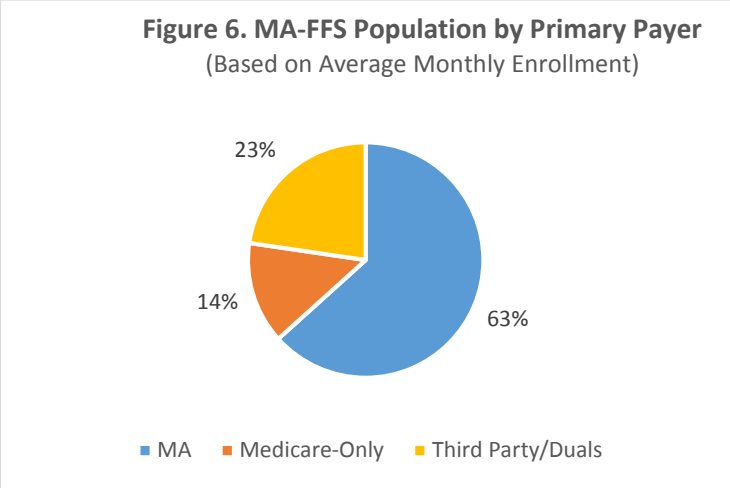


Figure 6 shows the percentage of the MA-FFS population with Medicaid as their primary payer, as compared to those with a third party insurer as their primary source of coverage. As indicated, about 37 percent of enrollees had some form of third party coverage during CY2014.

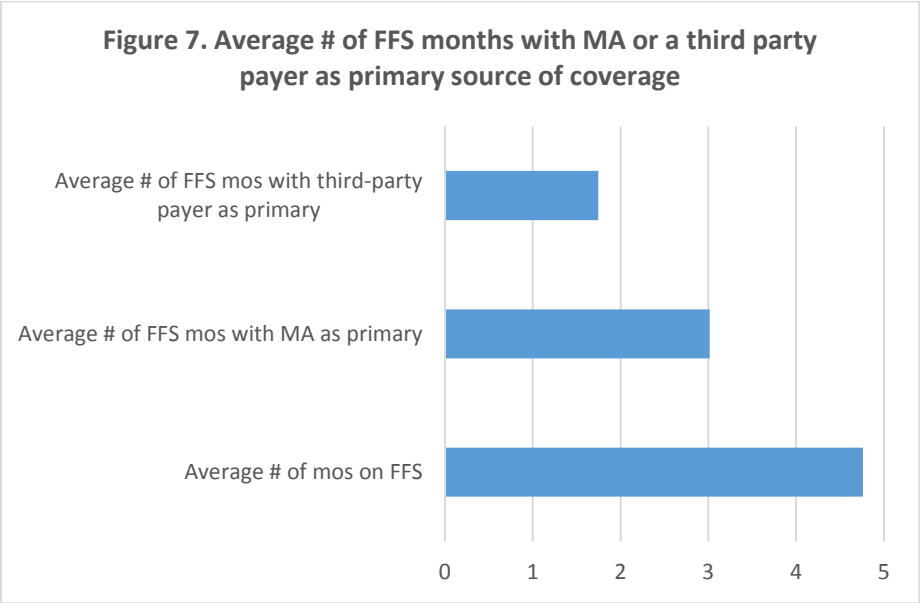


Figure 7 above shows the average number of FFS months a recipient had in CY2014 was less than 5 months. However, the MA program was the primary payer for the average recipient for only 3 of those months. (The average number of months a FFS recipient had a third party payer as a primary source of coverage in 2014 was almost 2 months (1.75 months average).

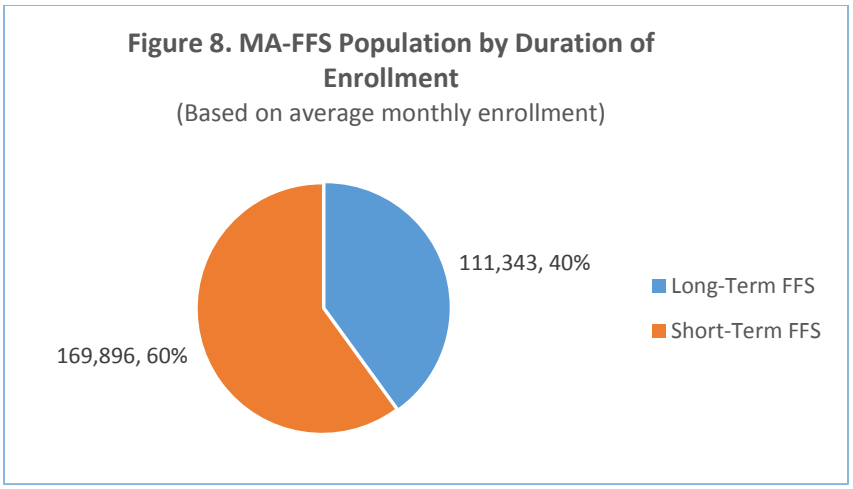


Figure 8 compares the number of people who were enrolled for a short period of time in FFS to those who were enrolled on a longer-term basis (i.e. 12 months of enrollment) in CY2014. As previously explained, a portion of the MA-FFS population is comprised of those who have been determined eligible for managed care but who are temporarily enrolled into FFS until selection of their health plan is complete. As indicated above in Figure 8**,** two-thirds of the total MA-FFS population (about 170,000 people) are enrolled on a temporary or short-term basis, and the remaining one-third (about 110,000 people) are enrolled for a longer duration in the FFS program.

Typically this short-term enrollment into FFS for this managed care population lasts a couple of months. **Figure 9** illustrates the variations in duration of enrollment by month for the ever-enrolled, MA-FFS population in CY 2014.

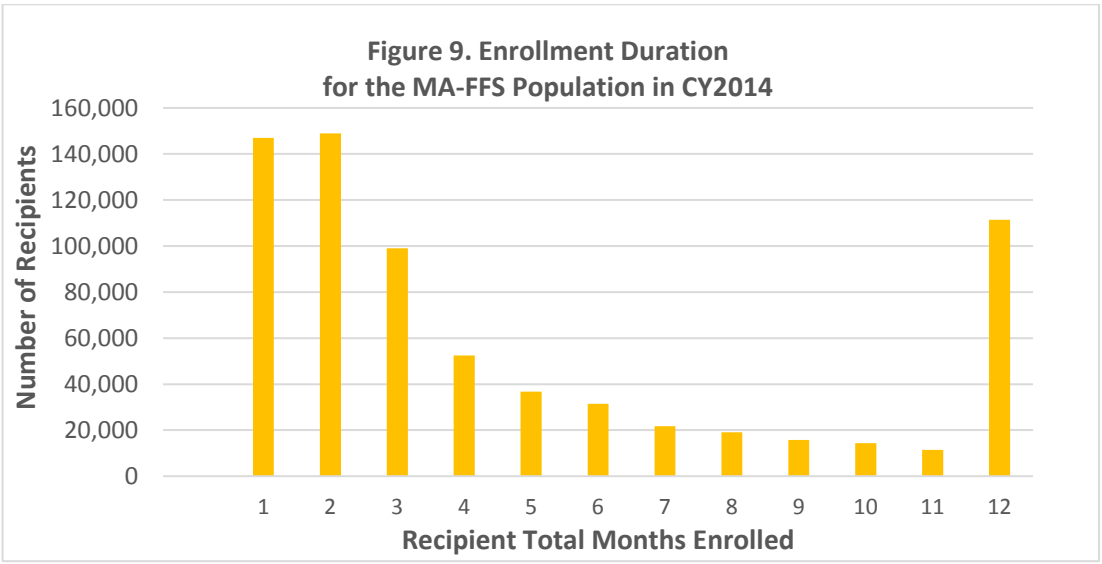


Figure 10 compares the long-term FFS population (approximately 110,000 people) by age and disability status, based on average monthly enrollment figures. The category for "children" includes enrollees who are 20 years of age and younger; the category for "adults" includes those 21-to-64 years of age; and the category for "seniors" includes those 65 years of age and older.

When compared to Figure 1, the long-term FFS population is comprised of a greater number of individuals with disabilities, as compared to the total MA-FFS population. Fifty-four percent of those in the long-term FFS population have a disabled status, whereas only 27 percent of the total FFS population has a disabled status.

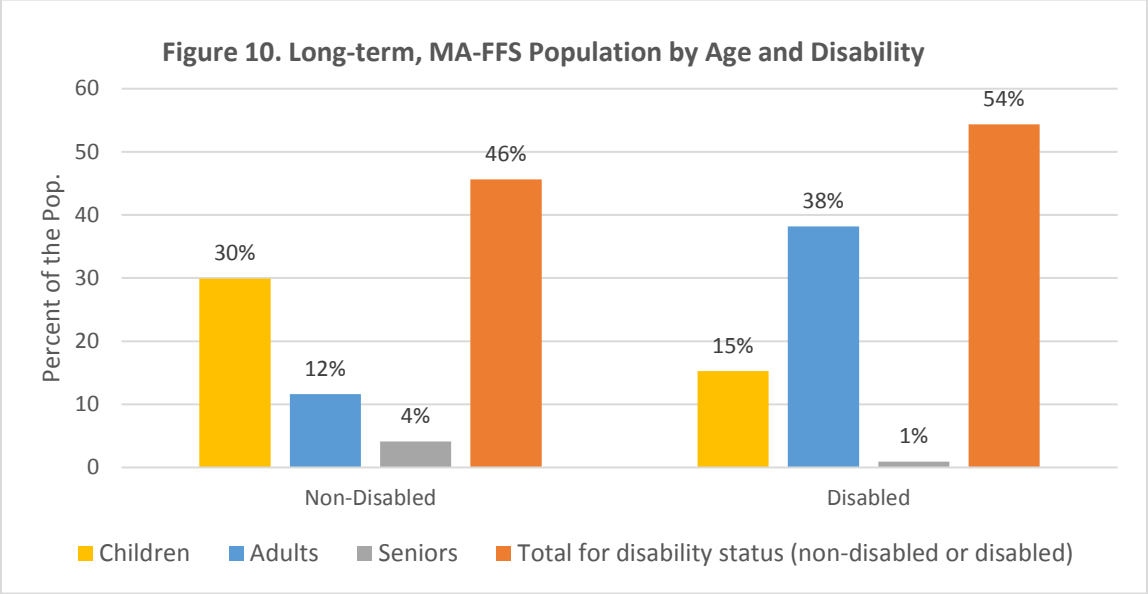


Figure 11 shows the percentage of enrollees in the long-term FFS population by race/ethnicity on an average monthly basis. The distribution is similar for the entire MA-FFS population as shown in Figure 4.

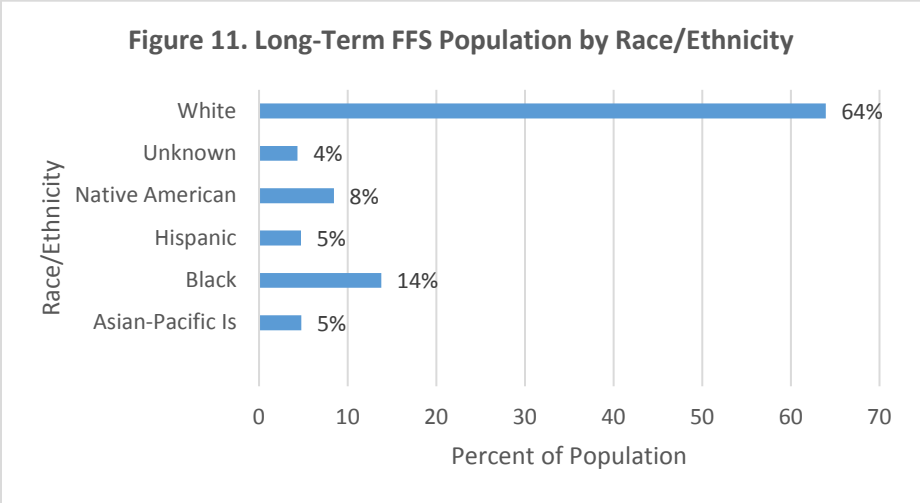


Figure 12 divides the long-term FFS population into two geographical areas. The metro region is comprised of Ramsey, Hennepin, Anoka, Carver, Scott, Dakota, and Washington counties.

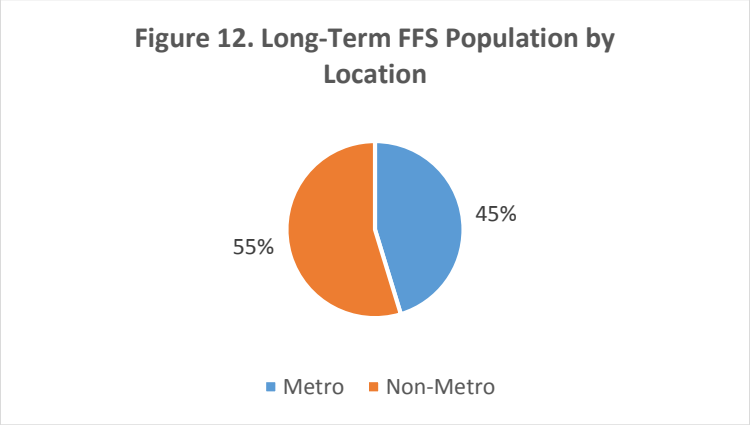


Figure 13 shows the primary sources of coverage for the long-term FFS population in CY2014. Nearly 60 percent of this long-term FFS population had a third party payer as their primary source of coverage during CY2014, as compared to about 40 percent for the total FFS population.

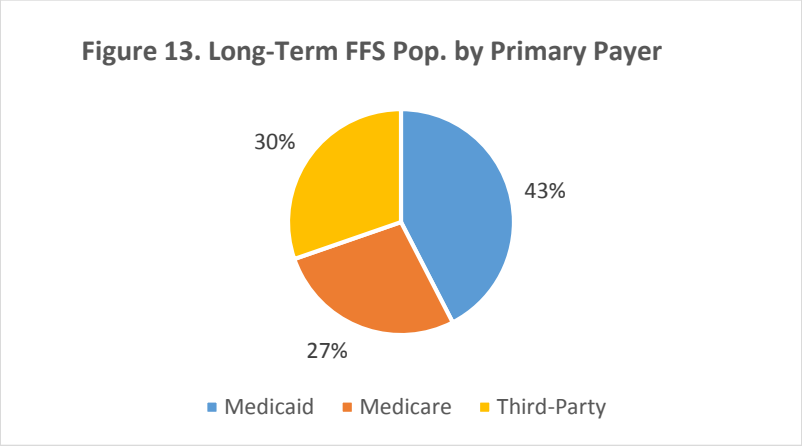
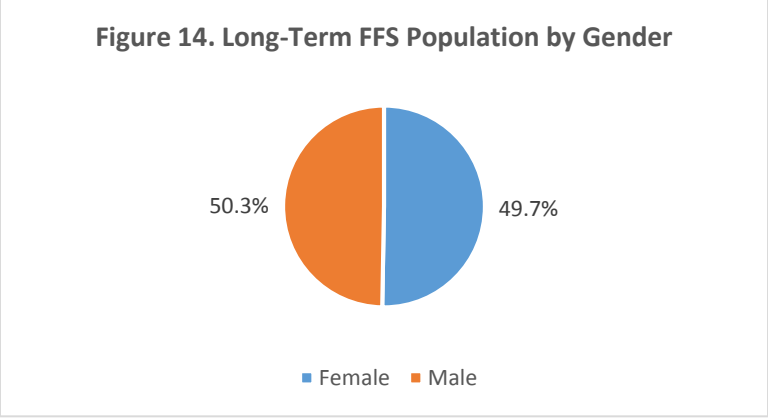


Figure 14 compares the long-term FFS population by gender based on average monthly enrollment figures, showing almost an even split between female and male in the long-term FFS population.



IV. Baselines for Provider Availability and Utilization

Applying the methodology described in section II, this section sets forth the state's baselines for monitoring the availability of care through MA-enrolled providers and changes in beneficiary utilization of covered services for primary care, dental, physician specialty (cardiology, oncology, and orthopedics), obstetric care, behavioral health (substance use disorder and mental health), and home health.

A. Primary Care

Primary care in this report includes general practice, internal medicine, family medicine, pediatrics, and obstetrics/gynecology.[11]

Provider Availability

The state's baselines for monitoring the availability of primary care providers for the FFS population in CY 2014 are presented below.

Data Sources

- Enrollment data from the MMIS
- Claims data from the MMIS

Table IV.A.1. Primary care providers enrolled in MA program by location for CY2014.

Primary Care: MA-Enrolled Provider	Metro	Non-Metro	Statewide (TOTALS)
Physician	5,461	6,483	**11,944**
Non-physician	3,071	3,747	**6,818**
TOTAL ENROLLED PRIMARY CARE PROVIDERS	**8,532**	**10,230**	**18,762**

Table IV.A.1 provides a baseline for the total number of enrolled providers, stratified by provider type and location. Primary care providers—physician and non-physician—include those who practice in the areas of medicine listed above. Primary care providers identified as "non-physicians" are limited to nurse practitioners, clinical nurse specialists, and physician assistants.

Table IV.A.2. Primary care providers active in MA-FFS program by location for CY2014.

Primary Care: Active Provider	Metro	Non-Metro	Statewide (TOTALS)
Physician	4,830	4,549	**9,379**
Non-physician	2,601	2,791	**5,392**
TOTAL ACTIVE PRIMARY CARE PROVIDERS	**7,431**	**7,340**	**14,771**

Table IV.A.2 provides a baseline of active MA providers for the FFS population. To be included in this "active" provider measurement, a primary care provider must have provided at least one service to a FFS enrollee in CY2014.

As illustrated in the figure below, these baselines show that nearly 80 percent of primary care providers in the MA program provided at least one primary care service to a FFS enrollee in CY2014. For the metro

[11] Pre- and post-natal services are not included in this analysis of primary care, because they are included under the analysis of obstetrics later in the report. Other preventative or primary-care related services for OB, are included in this analysis of primary care.

region, this provider-participation rate was closer to 88 percent with the non-metro region being lower at 72 percent.

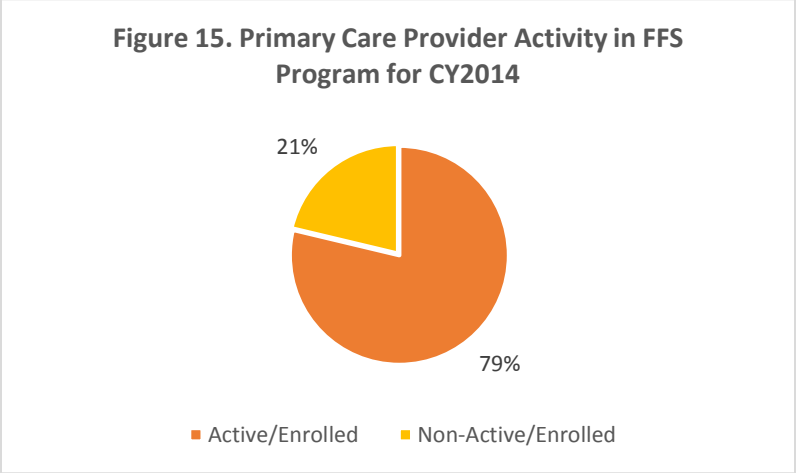


Table IV.A.3. Provider-to-enrollee ratios for primary care for the MA-FFS system in CY2014.

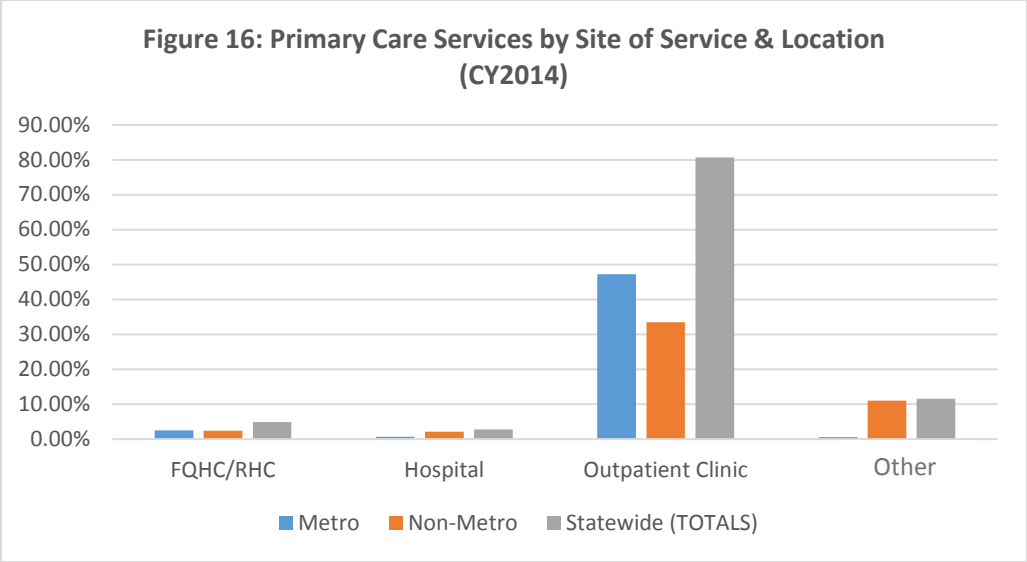
	Primary Care Providers per 1,000 person-years
Metro Region	53.8
Non-Metro Region	51.2
Statewide	52.5

Table IV.A.3, above, represents a comparison of the provider-to-enrollee ratios for the FFS system in Minnesota with respect to primary care. A provider must have supplied at least one service within the appropriate classification of primary care services to be considered an active provider for the purposes of this analysis. This baseline represents the average number of primary care providers per 1,000 enrollees over a 12-month period. Based on this information, on average, statewide, there was at least one active MA primary care provider for every 19 enrollees in CY2014.

Table IV.A.4. Primary care services provided to the MA-FFS pop. by site of service and location.

Primary Care: Site of Service	Metro	Non-Metro	Statewide (TOTALS)
FQHC/RHC	2.47%	2.43%	**4.89%**
Hospital	0.65%	2.16%	**2.81%**
Outpatient Clinic	47.25%	33.46%	**80.72%**
Other	0.55%	11.03%	**11.58%**
TOTAL Frequency of services	50.92%	49.08	**100.00%**

Both table IV.A.4 and figure 16 show the proportion of primary care services provided to FFS enrollees by site of service and location in CY2014. The majority of primary care services received by MA-FFS enrollees occurred in an outpatient clinic setting in both metro and non-metro regions of the state.



Beneficiary Utilization

The table below represents the state's baselines for monitoring changes in utilization of primary care services. The baselines reflect utilization rates for the long-term and short-term FFS population in the MA program, stratified by location, age, and disability status.

The baselines also provide a raw utilization rate per 1000 person years (i.e. the average number of claims per 1000 people over 12 months of enrollment), and a risk-adjusted rate based on the case mix or acuity of the population using the ACG® Case-Mix System. For more information or details regarding this analysis, see Appendix B.

Data sources:

- Enrollment data from the MMIS
- Claims data from the MMIS

Table IV.A.5. Primary Care: Utilization Analysis for MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
Total FFS Population		Long-term: 12 mos	8,640	5,209	1.81
		Short-term: < 12 mos	8,444	9,851	0.94
		Total FFS Population	**8,522**	**N/A[12]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	10,332	5,575	2.02
		Short-term: < 12 mos	8,979	10,801	0.91
		Total FFS Population	**9,474**	**9,601**	**1.08**
	Non-Metro	Long-term: 12 mos	7,240	4,835	1.63
		Short-term: < 12 mos	7,875	8,863	0.97
		Total FFS Population	**7,605**	**7,493**	**1.11**

[12] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

By Age Group	**0-20 years**	Long-term: 12 mos	6,657	8,632	0.84
		Short-term: < 12 mos	7,738	19,446	0.43
		Total FFS Population	**7,315**	**15,824**	**0.50**
	21-64 years	Long-term: 12 mos	10,311	4,458	2.52
		Short-term: < 12 mos	9,020	7,688	1.28
		Total FFS Population	**9,525**	**6,933**	**1.50**
	65 and older	Long-term: 12 mos	9,918	3,149	3.44
		Short-term: < 12 mos	9,450	3,031	3.40
		Total FFS Population	**9,685**	**3,097**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	6,290	7,406	0.93
		Short-term: < 12 mos	7,912	10,353	0.83
		Total FFS Population	**7,512**	**9,728**	**0.84**
	Disabled	Long-term: 12 mos	10,613	4,572	2.53
		Short-term: < 12 mos	14,060	5,419	2.83
		Total FFS Population	**11,287**	**4,697**	**2.62**

B. Dental Care

Provider Availability

The state's baselines for monitoring the availability of dental care providers for the FFS population in CY 2014 are presented below. In order to include all of the providers who provided dental care to the FFS population in CY2014, DHS reviewed all of the claims related to dental care, regardless of the provider type. Therefore, these measures only include a baseline for active MA providers for dental services by location and site of service.

Data Sources

- Claims data from the MMIS

Table IV.B.1. Dental care providers active in the MA-FFS program in CY2014.

Dental Care: Active Provider	Metro	Non-Metro	Statewide (TOTALS)
Dentists/Physicians	1,087	897	**1,984**
Other Dental Care Providers	7	18	**25**
TOTAL ACTIVE DENTAL CARE PROVIDERS	**1,094**	**915**	**2,009**

Table IV.B.1 shows active MA providers who provided dental care to the FFS population, stratified by provider type and location. To be included in this "active" MA-provider measurement, a dental care provider must have provided at least one dental service to a FFS enrollee in CY2014. The provider types are divided into two categories—dentists/physicians and other dental care professionals. Other dental care professionals include physician assistants, nurse practitioners, and allied health professionals.

Figure 17 below further illustrates the distribution of active dental care providers by geographic region, serving the MA-FFS population in CY2014.

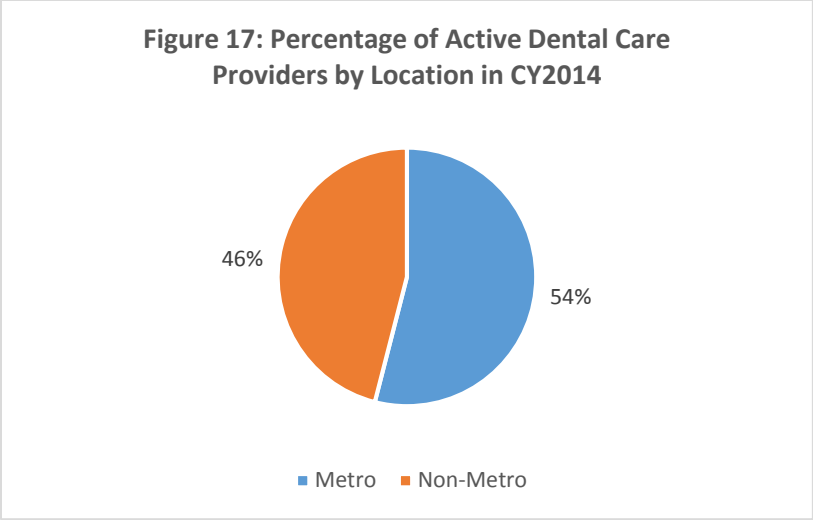


Table IV.B.2. Provider-to-enrollee ratios for dental services for the MA-FFS system in CY2014.

	Dental Care Providers per 1,000 person-years
Metro Region	7.9
Non-Metro Region	6.4
Statewide	7.1

Table IV.B.2 represents a geographical comparison of the provider-to-enrollee ratios for the FFS system in Minnesota. A provider must have supplied at least one service within the appropriate classification of services for dental care to be considered an active provider for the purposes of this analysis. This baseline represents the average number of providers per 1,000 enrollees over a 12-month period. Based on this information, on average, statewide, there was at least one active dental care provider for every 142 enrollees in CY2014.

Table IV.B.3. Percentage of dental care services provided to the MA-FFS pop. by site of service and location in CY2014.

Primary Care: Site of Service	Metro	Non-Metro	Statewide (TOTALS)
Clinic Setting	52%	46%	**98%**
Hospital/Other	1.2%	.8%	**2%**

Table IV.B.3 shows the proportion of dental care services provided to FFS enrollees by site of service and location of the treating provider in CY2014. Based on the information in this table, the clinic setting was the primary site of service.

Beneficiary Utilization

The table below represents the state's baselines for monitoring changes in utilization of dental care services. The baselines reflect utilization rates for the long-term and short-term FFS population, along with the total FFS population, in the MA program, stratified by location, age, and disability status.

The baselines also provide a raw utilization rate per 1000 person years (i.e. the average number of claims per 1000 people over 12 months of enrollment), and a risk-adjusted rate based on the case mix or

acuity of the population using the ACG® Case-Mix System. For more information or details regarding this analysis, see Appendix B.

Data sources:

- Enrollment data from the MMIS
- Claims data from the MMIS

Table IV.B.4. Dental Care: Utilization Analysis for MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
Total FFS Population		Long-term: 12 mos	2,535	1,528	1.81
		Short-term: < 12 mos	1,381	1,610	0.94
		Total FFS Population	**1,838**	**N/A[13]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	2,463	1,329	2.02
		Short-term: < 12 mos	1,343	1,616	0.91
		Total FFS Population	**1,752**	**1,776**	**1.08**
	Non-Metro	Long-term: 12 mos	2,595	1,733	1.63
		Short-term: < 12 mos	1,420	1,598	0.97
		Total FFS Population	**1,920**	**1,891**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	2,386	3,094	0.84
		Short-term: < 12 mos	1,402	3,523	0.43
		Total FFS Population	**1,787**	**3,867**	**0.50**
	21-64 years	Long-term: 12 mos	2,727	1,179	2.52
		Short-term: < 12 mos	1,373	1,170	1.28
		Total FFS Population	**1,903**	**1,385**	**1.50**
	65 and older	Long-term: 12 mos	1,971	626	3.44
		Short-term: < 12 mos	1,191	382	3.40
		Total FFS Population	**1,583**	**506**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	1,943	2,288	0.93
		Short-term: < 12 mos	1,289	1,687	0.83
		Total FFS Population	**1,450**	**1,878**	**0.84**
	Disabled	Long-term: 12 mos	3,032	1,306	2.53
		Short-term: < 12 mos	2,344	903	2.83
		Total FFS Population	**2,898**	**1,206**	**2.62**

C. Physician Specialist

For purposes of this report, the analysis of physician specialists includes the following three practice areas of medicine:

- Cardiology
- Oncology

[13] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

- Orthopedics

Provider Availability

The state's baselines for monitoring the availability of cardiology, oncology, and orthopedic providers for the FFS population in CY2014 are presented below. It should be noted that this analysis only includes licensed physicians for each specialty area, and does not include other non-physician providers who also provide specialty care in cardiology, oncology, and orthopedics, such as physician assistants and nurse practitioners.

Data Sources

- Enrollment data from the MMIS
- Claims data from the MMIS

Table IV.C.1. Specialty providers enrolled in MA program by provider type and location for CY2014.

Specialty: MA-Enrolled Provider	Metro	Non-Metro	Statewide (TOTALS)
Cardiologists	323	425	**748**
Oncologists	179	209	**388**
Orthopedists	319	389	**708**

Table IV.C.1, above, provides a baseline for the total number of enrolled providers for each specialty area, stratified by provider type and location.

Table IV.C.2. Specialty providers active in MA program by location for CY2014.

Specialty: Active Provider	Metro	Non-Metro	Statewide (TOTALS)
Cardiologists	279	254	**533**
Oncologists	161	148	**309**
Orthopedic	280	267	**547**

Table IV.C.2, above, sets forth a measure of active MA providers for the FFS population by each specialty area. To be included in this "active" provider measurement, the provider must have provided at least one specialty service to a FFS enrollee in CY2014.

As illustrated in the Figure 18 below, these baselines show that over 70 percent of specialty physicians provided at least one primary care service to a FFS enrollee in CY2014.

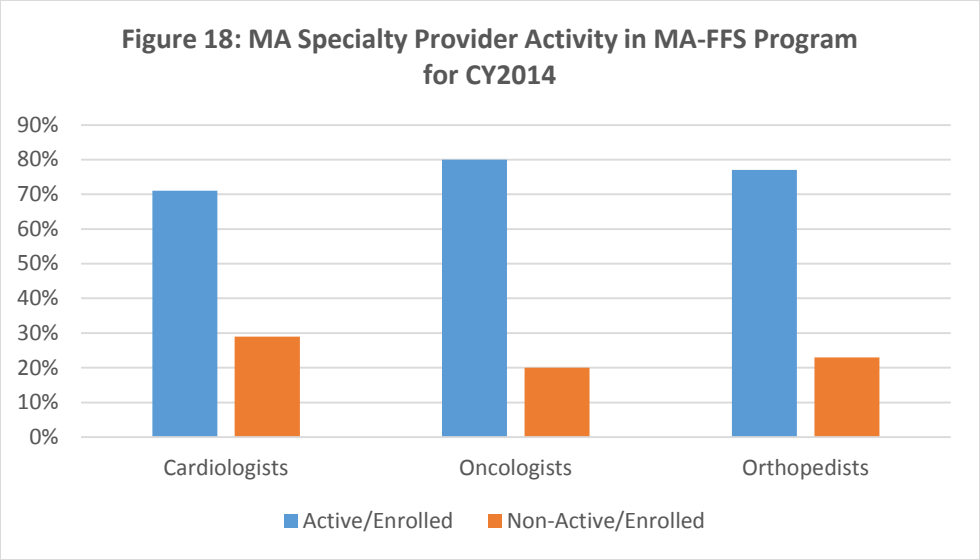


Table IV.C.3. Provider-to-enrollee ratios for specialty care for the MA FFS system in CY2014.

	Cardiologists per 1,000 person-years	Oncologists per 1,000 person-years	Orthopedists per 1,000 person-years
Metro Region	2.0	1.2	2.0
Non-Metro Region	1.8	1.0	1.9
Statewide (TOTALS)	**1.9**	**1.1**	**1.9**

Table IV.C.3, above, represents a geographical comparison of the provider-to-enrollee ratios for the FFS system in Minnesota for each of the three specialty areas. A physician must have supplied at least one service within the appropriate classification of services to be considered an active provider for the purposes of this measure. This baseline represents the average number of providers per 1,000 enrollees over a 12-month period. Based on this information, on average, statewide, there was at least one active specialty care provider in cardiology and orthopedics for every 500 enrollees. For oncology, on average, statewide, there was at least one active specialty care provider for every 1,000 FFS enrollees.

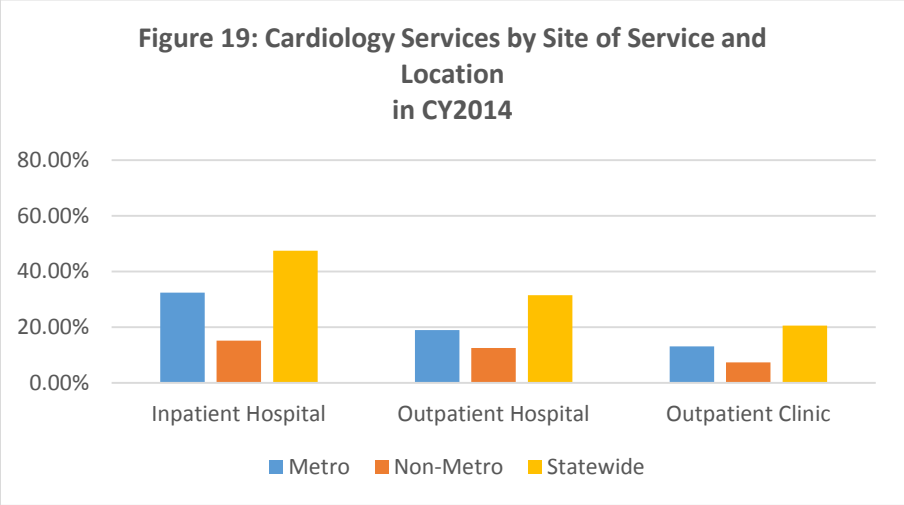
Given the nature of these services, we would expect to see fewer providers for the number of patients than other categories of service, like primary care. However, as previously mentioned, there are other non-physician providers who provide these services who are not included in this analysis. In future reports, DHS intends to assess whether these other providers should be included as part of this analysis to better inform our baselines and future decisions regarding access to specialty care.

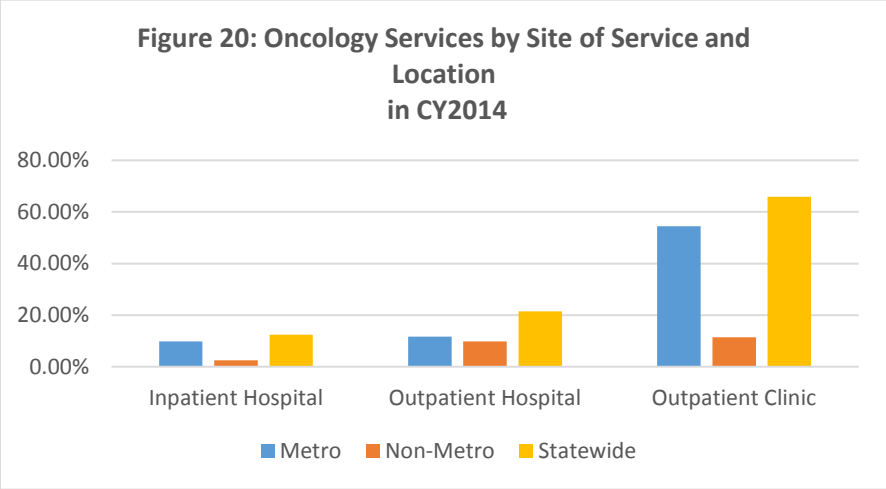
Table IV.C.4. Percent of specialty care services provided to the MA-FFS population by site of service and location in CY2014.

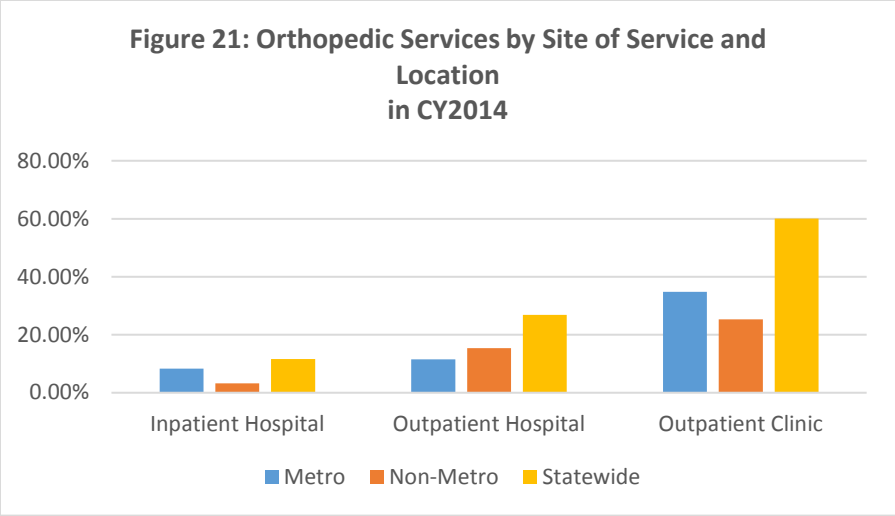
	Site of service	Metro	Non-Metro	Statewide
Cardiology services	Inpatient Hospital	32.40%	15.16%	**47.56%**
	Outpatient Hospital	18.96%	12.62%	**31.58%**
	Outpatient Clinic	13.16%	7.41%	**20.57%**
Oncology	Inpatient Hospital	9.87%	2.50%	**12.37%**

services	Outpatient Hospital	11.73%	9.79%	**21.52%**
	Outpatient Clinic	54.54%	11.4%	**65.94%**
Orthopedic services	Inpatient Hospital	8.34%	3.25%	**11.59%**
	Outpatient Hospital	11.54%	15.32%	**26.86%**
	Outpatient Clinic	34.85%	25.26%	**60.11%**

Table IV.C.4 and the figures below show the proportion of specialty services provided to FFS enrollees by service site and location of the treating provider in CY2014.







Beneficiary Utilization

The tables below represent the state's baselines for monitoring changes in utilization of cardiology, oncology, and orthopedic services. The baselines reflect utilization rates for the long-term and short-term FFS population, along with the total FFS population, in the MA program, stratified by location, age, and disability status.

The baselines also below provide a raw utilization rate per 1000 person years (i.e. the average number of claims per 1000 people over a full 12 months of enrollment), and a risk-adjusted rate based on the case mix or acuity of the population using the ACG® Case-Mix System. For more information or details regarding this analysis, see Appendix B.

Data sources:

- Enrollment data from the MMIS
- Claims data from the MMIS

Table IV.C.5. Cardiology: Utilization Analysis for MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population		Long-term: 12 mos	286	173	1.81
		Short-term: < 12 mos	234	273	0.94
		Total FFS Population	**255**	**N/A[14]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	358	193	2.02
		Short-term: < 12 mos	250	300	0.91
		Total FFS Population	**289**	**293**	**1.08**
	Non-Metro	Long-term: 12 mos	227	151	1.63
		Short-term: < 12 mos	218	245	0.97
		Total FFS Population	**221**	**218**	**1.11**

[14] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

By Age Group	**0-20 years**	Long-term: 12 mos	106	137	0.84
		Short-term: < 12 mos	81	204	0.43
		Total FFS Population	**91**	**196**	**0.50**
	21-64 years	Long-term: 12 mos	407	176	2.52
		Short-term: < 12 mos	339	289	1.28
		Total FFS Population	**366**	**266**	**1.50**
	65 and older	Long-term: 12 mos	708	225	3.44
		Short-term: < 12 mos	753	242	3.40
		Total FFS Population	**730**	**234**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	134	158	0.93
		Short-term: < 12 mos	185	242	0.83
		Total FFS Population	**172**	**223**	**0.84**
	Disabled	Long-term: 12 mos	414	178	2.53
		Short-term: < 12 mos	755	291	2.83
		Total FFS Population	**480**	**200**	**2.62**

Table IV.C.6. Oncology: Utilization Analysis for MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	**Utilization Rate (per 1000 PY)**	**Risk-Adjusted Utilization Rate**	**ACG® Score**
FFS Population		Long-term: 12 mos	191	115	1.81
		Short-term: < 12 mos	135	157	0.94
		Total FFS Population	**157**	**N/A[15]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	296	159	2.02
		Short-term: < 12 mos	170	205	0.91
		Total FFS Population	**216**	**219**	**1.08**
	Non-Metro	Long-term: 12 mos	104	70	1.63
		Short-term: < 12 mos	97	109	0.97
		Total FFS Population	**100**	**99**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	32	41	0.84
		Short-term: < 12 mos	16	41	0.43
		Total FFS Population	**22**	**48**	**0.50**
	21-64 years	Long-term: 12 mos	303	131	2.52
		Short-term: < 12 mos	219	187	1.28
		Total FFS Population	**252**	**183**	**1.50**
	65 and older	Long-term: 12 mos	513	163	3.44
		Short-term: < 12 mos	494	158	3.40
		Total FFS Population	**503**	**161**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	152	179	0.93
		Short-term: < 12 mos	83	108	0.83
		Total FFS Population	**100**	**129**	**0.84**
	Disabled	Long-term: 12 mos	224	96	2.53
		Short-term: < 12 mos	681	263	2.83
		Total FFS Population	**313**	**130**	**2.62**

[15] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

Table IV.C.7. Orthopedics: Utilization Analysis for MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population		Long-term: 12 mos	218	132	1.81
		Short-term: < 12 mos	161	188	0.94
		Total FFS Population	**184**	**N/A[16]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	246	133	2.02
		Short-term: < 12 mos	145	175	0.91
		Total FFS Population	**182**	**184**	**1.08**
	Non-Metro	Long-term: 12 mos	195	130	1.63
		Short-term: < 12 mos	178	200	0.97
		Total FFS Population	**185**	**182**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	123	159	0.84
		Short-term: < 12 mos	71	179	0.43
		Total FFS Population	**91**	**197**	**0.50**
	21-64 years	Long-term: 12 mos	297	128	2.52
		Short-term: < 12 mos	238	203	1.28
		Total FFS Population	**261**	**190**	**1.50**
	65 and older	Long-term: 12 mos	299	95	3.44
		Short-term: < 12 mos	230	74	3.40
		Total FFS Population	**265**	**85**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	137	161	0.93
		Short-term: < 12 mos	142	185	0.83
		Total FFS Population	**141**	**182**	**0.84**
	Disabled	Long-term: 12 mos	286	123	2.53
		Short-term: < 12 mos	364	140	2.83
		Total FFS Population	**301**	**125**	**2.62**

D. Obstetrics

The service category of obstetrics in this report covers pre- and post-natal services related to pregnancy and childbirth for women under the age of 65 who were covered under the MA-FFS system in CY2014. In order to include all of the providers who provided obstetric care (pre- and post-natal services) to the MA-FFS population in CY2014, DHS reviewed all of the claims related to these services, regardless of the provider type. Therefore, these measures provide only a baseline for active obstetric providers by location and site of service.

Provider Availability

The state's baselines for monitoring the availability of obstetric providers for the FFS population in CY 2014 are presented below.

Data Sources

[16] *See footnote above.*

- Claims data from the DHS MMIS

Table IV.D.1. Obstetric providers active in MA-FFS program by location for CY2014.

Obstetric Care: MA-Enrolled Provider	Metro	Non-Metro	Statewide (TOTAL)
Physician	972	962	1,934
Midwife/Nurse	200	139	339
Physician Assistant	24	28	52
TOTAL ENROLLED OBSTETRIC PROVIDERS	**1,196**	**1,129**	**2,325**

Table IV.D.1, above, sets forth a measure of active MA providers who provided obstetric care to the FFS population, stratified by provider type and location. To be included in this "active" provider measurement, an obstetric provider must have provided at least one obstetric service to a female FFS enrollee under the age of 65 in CY2014. The provide-type category for "physician" includes both family practice physicians and obstetricians/gynecologists (OB/GYNs). The provider-type category for "midwife/nurse" includes nurse practitioners, nurse midwives, certified nurse anesthetists, and certified professional midwives.

Note, that out of the 1,934 physicians indicated above, 597 (31 percent) were family physicians who provided at least one obstetric service in CY2014. The figure below further illustrates the distribution of active and enrolled obstetric care providers by location.

Figure 22: Percentage of Active Obstetric Care Providers by Location (CY2014)

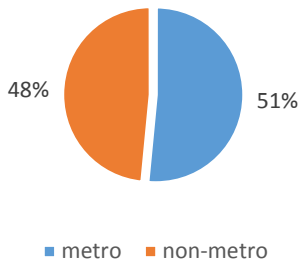


Table IV.D.2. Provider-to-enrollee ratios for obstetric care for the MA-FFS system in CY2014.

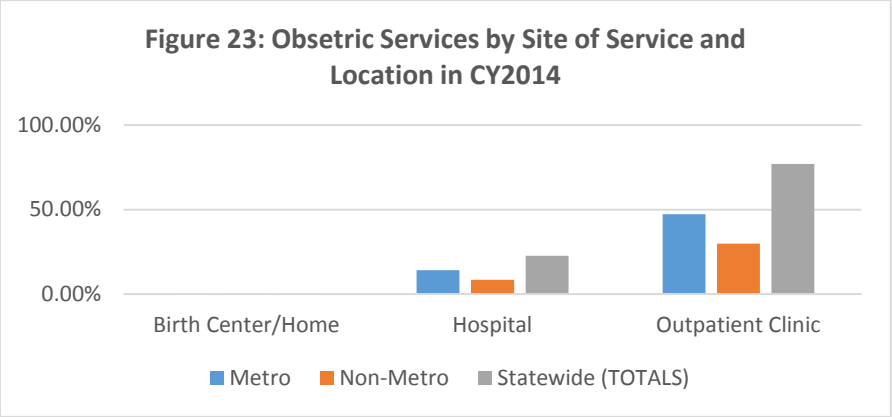
	Obstetric Care Providers per 1,000 person-years
Metro Region	17.9
Non-Metro Region	15.7
Statewide	16.8

Table IV.D.2 represents a comparison of the provider-to-enrollees ratios. An obstetric provider must have supplied at least one service within the appropriate classification of services for obstetrics to be considered an active provider for the purposes of this analysis. This baseline represents the average number of providers per 1,000 enrollees over a 12-month period. Based on this information, on average, statewide, there was at least one active obstetric provider for every 59 female FFS enrollees under the age of 65 in CY2014.

Table IV.D.3. Percentage of obstetric services provided to the MA-FFS pop. by site of service and location in CY2014.

Obstetric Care: Site of Service	Metro	Non-Metro	Statewide (TOTALS)
Birth Center/Home	0.08%	0.2%	**0.3%**
Hospital	14.2%	8.5%	**22.7%**
Outpatient Clinic	47.2%	29.8%	**77.0%**

Table IV.D.3 and figure 23 show the proportion of obstetric care services provided to FFS enrollees by service site and location of the treating provider in CY2014. As shown, the primary site of service for obstetric services was at an outpatient clinic in both the metro and non-metro regions of the state in CY2014.



Beneficiary Utilization

The tables below represent the state's baselines for monitoring changes in utilization of obstetric services among female FFS beneficiaries. The baselines reflect utilization rates for the long-term and short-term female FFS population under the age of 65, along with the total female FFS population under the age of 65, in the MA program, stratified by location, age, and disability status.

The baselines also provide a raw utilization rate per 1000 person-years (i.e. the average number of claims per 1000 people over a full 12 months of enrollment), and a risk-adjusted rate based on the case mix or acuity of the population using the ACG® Case-Mix System. For more information or details regarding this analysis, see Appendix B.

Data sources:

- Enrollment data from the MMIS
- Claims data from the MMIS

Table IV.D.4. Obstetric Care: Utilization Analysis for Female FFS Population under age 65 in CY2014.

	Female FFS Pop. (< age 65) by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FEMALE; <age 65 FFS Population	Long-term: 12 mos	128	77	1.81
	Short-term: < 12 mos	536	626	0.94

		Total FFS Population	**382**	**N/A[17]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	127	68	2.02
		Short-term: < 12 mos	592	712	0.91
		Total FFS Population	**434**	**439**	**1.08**
	Non-Metro	Long-term: 12 mos	129	86	1.63
		Short-term: < 12 mos	479	539	0.97
		Total FFS Population	**335**	**330**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	47	61	0.84
		Short-term: < 12 mos	155	391	0.43
		Total FFS Population	**116**	**251**	**0.50**
	21-64 years	Long-term: 12 mos	186	81	2.52
		Short-term: < 12 mos	847	722	1.28
		Total FFS Population	**590**	**429**	**1.50**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	238	280	0.93
		Short-term: < 12 mos	572	748	0.83
		Total FFS Population	**492**	**637**	**0.84**
	Disabled	Long-term: 12 mos	27	12	2.53
		Short-term: < 12 mos	99	38	2.83
		Total FFS Population	**40**	**17**	**2.62**

E. Behavioral Health

Behavioral health has been divided into two subcategories—substance use disorder (SUD) and mental health.

1. Substance Use Disorders (SUD)

SUD services in MA consist of individual and group therapy services provided as residential and non-residential treatment, as well as medication assisted therapy.

Facility Availability

The state's metrics and baselines for monitoring the availability of SUD providers for the FFS population in CY2014 are presented below. Because providers of SUD services are licensed and billed at the facility level, this analysis includes enrolled 'facilities' according to their billing provider type as a facility, and not the individual providers serving MA enrollees within those facilities.

Data Sources

- Enrollment data from the MMIS
- Claims data from the DHS MMIS

Table IV.E1.1. SUD Facilities enrolled in MA program by type and location in CY2014.

SUD services: MA-Enrolled Facilities	Metro	Non-Metro	Statewide (TOTAL)

[17] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

Residential SUD Facilities	Chemical Dependency Facility	38	69	107
	Indian Health Facility	0	6	6
TOTAL NUMBER OF RESIDENTIAL FACILITIES		**38**	**75**	**114**
SUD services: MA-Enrolled Facilities		**Metro**	**Non-Metro**	**Statewide (TOTAL)**
Non-Residential SUD Facilities	Chemical Dependency Facility	131	183	314
	Indian Health Facility	3	49	52
TOTAL NUMBER OF NON-RESIDENTIAL FACILITIES		**134**	**232**	**366**
TOTAL NUMBER OF ALL SUD FACILITIES		**172**	**307**	**479**

Table IV.E1.1, above, provides a baseline for the total number of facilities providing SUD services that are enrolled in MA program, stratified by facility type and location.

Table IV.E1.2. SUD Facilities active in the MA-FFS program by type and location in CY2014.

SUD services: Active Facilities		**Metro**	**Non-Metro**	**Statewide (TOTAL)**
Residential SUD facilities	Chemical Dependency Facility	36	65	101
	Indian Health Facility	0	5	5
TOTAL NUMBER OF RESIDENTIAL FACILITIES		**36**	**70**	**106**
SUD services: Active Facilities		**Metro**	**Non-Metro**	**Statewide (TOTAL)**
Non-Residential SUD faciliies	Chemical Dependency Facility	103	145	248
	Indian Health Facility	0	21	21
TOTAL NUMBER OF NON-RESIDENTIAL FACILITIES		**103**	**166**	**269**
TOTAL NUMBER OF ALL SUD FACILITIES		**139**	**236**	**375**

Table IV.E1.2 sets forth a measure of active MA facilities that delivered SUD services to the MA-FFS population in CY2014. To be included in this "active" measurement, an MA-enrolled facility must have provided at least one SUD service to a FFS enrollee in CY2014.

As illustrated in figure 24, these baselines show that 78 percent of MA-enrolled, SUD facilitates, statewide, provided at least one SUD service to a FFS enrollee in CY2014. For the metro region, this provider-participation rate was closer to 81 percent, with the non-metro region rate at about 77 percent.

Figure 24: MA-Enrolled, SUD Facility Activity by Location in CY2014

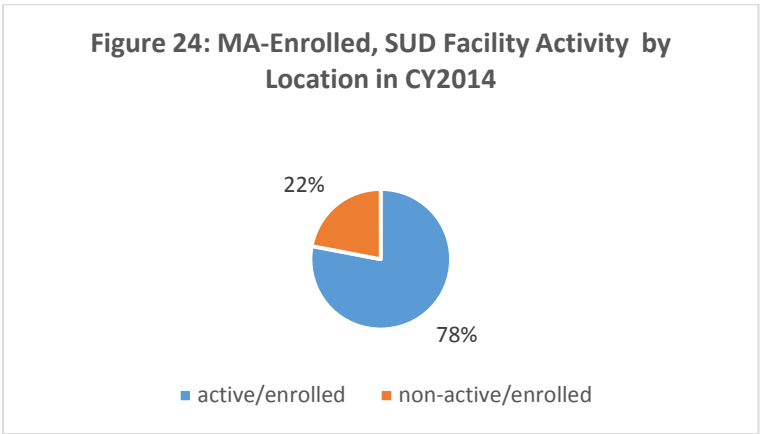


Table IV.E1.3. Facility-to-enrollee ratios for SUD services for the MA-FFS program in CY2014.

	SUD facilities per 1,000 person-years
Metro Region	1.0
Non-Metro Region	1.6
Statewide	1.3

Table IV.E1.3, above, represents a comparison of the facility-to-enrollee ratios with respect to SUD services. A facility must have supplied at least one service within the appropriate classification of services for SUD to be considered an active provider for the purposes of this analysis. This baseline represents the average number of SUD facilities per 1,000 enrollees over a 12-month period. Based on this information, on average, statewide, there was at least one active SUD facility for every 1,000 FFS enrollees in CY2014.

Table IV.E1.4. Percent of SUD services provided to the MA-FFS population by site of service and location in CY2014.

SUD services: Site of Service (frequency)	Metro	Non-Metro	Statewide (TOTAL)
Chemical Dependency Facility	63.87%	27.15%	91.02%
Indian Health Facility	0.00%	8.98%	8.98%
TOTAL % of Services Provided by Site (frequency)	**63.87%**	**36.13%**	**100%**

Table IV.E1.4 shows the proportion of SUD services provided to FFS enrollees by service site and location of the facility in CY2014. As indicated above, the primary site for SUD services in CY2014 was at a chemical dependency facility in both the metro and non-metro regions of the state**.**

Beneficiary Utilization

The tables below represent the state's baselines for monitoring changes in utilization of SUD services. The baselines reflect utilization rates for the long-term and short-term FFS population, along with the total FFS population, in the MA program, stratified by location, age, and disability status.

The baselines below provide a raw utilization rate per 1000 person years (i.e. the average number of claims per 1000 people over a full 12 months of enrollment), and a risk-adjusted rate based on the case mix or acuity of the population using the ACG® Case-Mix System. For more information or details regarding this analysis, see Appendix B.

Data sources:

- Enrollment data for the MMIS
- Claims data for the DHS MMIS

Table IV.E1.5. SUD Services: Utilization Analysis for the MA-FFS Population in CY2014.

	FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population	Long-term: 12 mos	262	158	1.81
	Short-term: < 12 mos	367	428	0.94

		Total FFS Population	**326**	**N/A[18]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	368	198	2.02
		Short-term: < 12 mos	392	472	0.91
		Total FFS Population	**383**	**388**	**1.08**
	Non-Metro	Long-term: 12 mos	175	117	1.63
		Short-term: < 12 mos	341	383	0.97
		Total FFS Population	**270**	**266**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	53	68	0.84
		Short-term: < 12 mos	41	103	0.43
		Total FFS Population	**45**	**98**	**0.50**
	21-64 years	Long-term: 12 mos	453	196	2.52
		Short-term: < 12 mos	683	582	1.28
		Total FFS Population	**593**	**432**	**1.50**
	65 and older	Long-term: 12 mos	256	81	3.44
		Short-term: < 12 mos	50	16	3.40
		Total FFS Population	**154**	**49**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	184	217	0.93
		Short-term: < 12 mos	333	435	0.83
		Total FFS Population	**296**	**383**	**0.84**
	Disabled	Long-term: 12 mos	328	141	2.53
		Short-term: < 12 mos	732	282	2.83
		Total FFS Population	**407**	**169**	**2.62**

2. Mental Health

For purposes of this report, the mental health includes, but is not limited to, diagnostic assessments, medication management, psychotherapy, adult rehabilitative mental health services (ARMHS), children therapeutic support services (CTSS), inpatient mental health psychiatry, and other mental health services provided to the MA-FFS population in Minnesota.

Provider Availability

The state's baselines for monitoring the availability of providers for mental health services for the FFS population in CY 2014 are presented below.

Data Sources

- Enrollment data from the MMIS
- Claims data from the DHS MMIS

Table IV.E2.1. Mental health providers enrolled in MA program by location for CY2014.

Mental Health: MA-Enrolled Provider	Metro	Non-Metro	Statewide (TOTAL)
Mental Health Professionals	4,205	2,547	6,752
Psychiatrists	439	497	936
TOTAL ENROLLED MENTAL HEALTH PROVIDERS	**4,644**	**3,044**	**7,688**

[18] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

Table IV.E2.1, above, provides a baseline for the total number of enrolled providers, stratified by provider type and location. The provider-type category for "mental health professionals" includes nurse practitioners, clinical nurse specialists, psychologists, licensed social workers, marriage and family therapists, and licensed professional clinical counselors.

Table IV.E2.2. Mental health providers active in MA-FFS program by location in CY2014.

Primary Care: Active Provider	Metro	Non-Metro	Statewide
Mental Health Professionals	3,161	1,979	5,140
Psychiatrists	364	352	716
TOTAL ACTIVE MENTAL HEALTH PROVIDERS	**3,525**	**2,331**	**5 ,856**

Table IV.E2.2 sets forth a measure of active MA providers who delivered mental health services to the FFS population in CY2014. To be included in this "active" provider measurement, a provider must have provided at least one mental health service to a MA-FFS enrollee in CY2014. As illustrated in the figure below, these baselines show that 76 percent of MA-enrolled, mental health providers statewide provided at least one mental health service to a FFS enrollee in CY2014. For the metro and non-metro region, this provider-participation rate was the same at 76 percent.

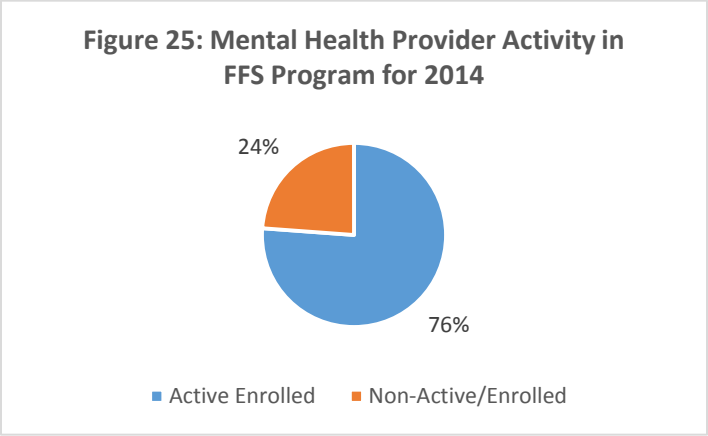


Table IV.E2.3. Provider-to-enrollee ratios for mental health services for the MA-FFS program in CY2014.

	Mental Health Providers per 1,000 person-years
Metro Region	25.5
Non-Metro Region	16.2
Statewide	20.8

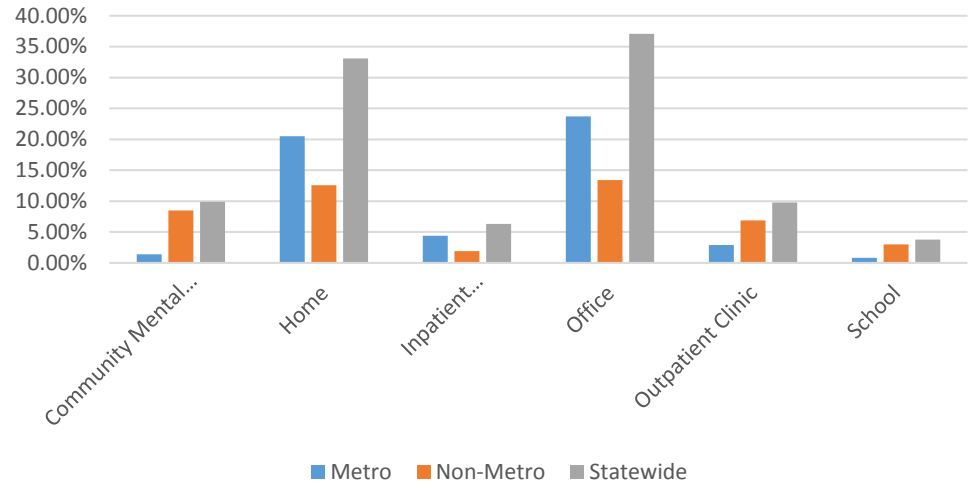
Table IV.E2.3, above, represents a comparison of the provider-to-enrollee ratios with respect to mental health. A provider must have supplied at least one service within the appropriate classification of services for mental health to be considered an active provider for the purposes of this analysis. This baseline represents the average number of providers per 1,000 enrollees over a 12-month period. Based on this information, on average, statewide, there was at least one active mental health provider for every 48 FFS enrollees in CY2014.

Table IV.E2.4. Percentage of mental health services provided to MA-FFS population by site of service and location in CY2014.

Mental Health: Site of Service	Metro	Non-Metro	Statewide
Community Mental Health Center	1.4%	8.5%	**9.9%**
Home	20.5%	12.6%	**33.1%**
Inpatient Hospital/Residential Facility	4.4%	1.9%	**6.3%**
Office	23.7%	13.4%	**37.1%**
Outpatient Clinic	2.9%	6.9%	**9.8%**
School	0.8%	3.0%	**3.8%**

Table IV.E2.4 and figure 26 show the proportion of mental health services provided to FFS enrollees by site and location of the treating provider in CY2014. The primary site of service for mental health services in CY2014 was at an office or home setting in both the metro and non-metro regions of the state.

Figure 26: Mental Health Services by Site of Service & Location in CY2014



Beneficiary Utilization

The tables below represent the state's baselines for monitoring changes in utilization of mental health services. The baselines reflect utilization rates for the long-term and short-term FFS population, along with the total FFS population, in the MA program, stratified by location, age, and disability status.

The baselines also provide a raw utilization rate per 1000 person-years (i.e. the average number of claims per 1000 people over a full 12 months of enrollment), and a risk-adjusted rate based on the case mix or acuity of the population using the ACG® Case-Mix System. For more information or details regarding this analysis and additional separate analyses for medication management and telemedicine for mental health, see Appendix B.

Data sources:

- Enrollment data from the MMIS
- Claims data from the DHS MMIS

Table IV.E2.5. Mental Health Services: Utilization Analysis for the MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population		Long-term: 12 mos	6,260	3,774	1.81
		Short-term: < 12 mos	1,687	1,968	0.94
		Total FFS Population	**3,497**	**N/A[19]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	6,737	3,635	2.02
		Short-term: < 12 mos	1,540	1,852	0.91
		Total FFS Population	**3,439**	**3,485**	**1.08**
	Non-Metro	Long-term: 12 mos	5,866	3,917	1.63
		Short-term: < 12 mos	1,843	2,074	0.97
		Total FFS Population	**3,554**	**3,501**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	7,191	9,325	0.84
		Short-term: < 12 mos	1,396	3,508	0.43
		Total FFS Population	**3,665**	**7,929**	**0.50**
	21-64 years	Long-term: 12 mos	5,835	2,523	2.52
		Short-term: < 12 mos	2,008	1,711	1.28
		Total FFS Population	**3,506**	**2,552**	**1.50**
	65 and older	Long-term: 12 mos	2,111	670	3.44
		Short-term: < 12 mos	792	254	3.40
		Total FFS Population	**1,456**	**465**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	3,303	3,889	0.93
		Short-term: < 12 mos	1,195	1,563	0.83
		Total FFS Population	**1,715**	**2,220**	**0.84**
	Disabled	Long-term: 12 mos	8,742	3,766	2.53
		Short-term: < 12 mos	6,879	2,651	2.83
		Total FFS Population	**8,378**	**3,486**	**2.62**

F. Home Health

For purposes of this report, home health is comprised of those services, primarily provided by home health agencies, as defined in 42 CFR § 440.70. This is consistent with the description provided by CMS in its supplementary section of the final rule.

Provider Availability

The state's baselines for monitoring the availability of home health for the FFS population in CY2014 are presented below.

Data Sources

- Enrollment data from the MMIS

[19] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

- Claims data from the DHS MMIS

Table IV.F.1. Home health agencies enrolled versus active in MA-FFS program by location in CY2014.

Home Health Agencies: MA-Enrolled v. Active	Metro	Non-Metro	Statewide (TOTAL)
Enrolled Home Health Agencies	86	113	**199**
Active Home Health Agencies	73	98	**171**

Table IV.F.1, above, provides a baseline for the total number of enrolled home health agencies in MA. It also provides a baseline for the number of "active" home health agencies for the FFS population in CY2014 which includes those agencies that provided at least one service to a FFS enrollee in CY2014.

As illustrated in the figure below, these baselines show that 86 percent of MA-enrolled, home health agencies statewide provided at least one home health service to a FFS enrollee in CY2014.This provider-participation rate was similar in both the metro and non-metro regions of the state.

Figure 27: Home Health Agency Activity in FFS (CY2014)

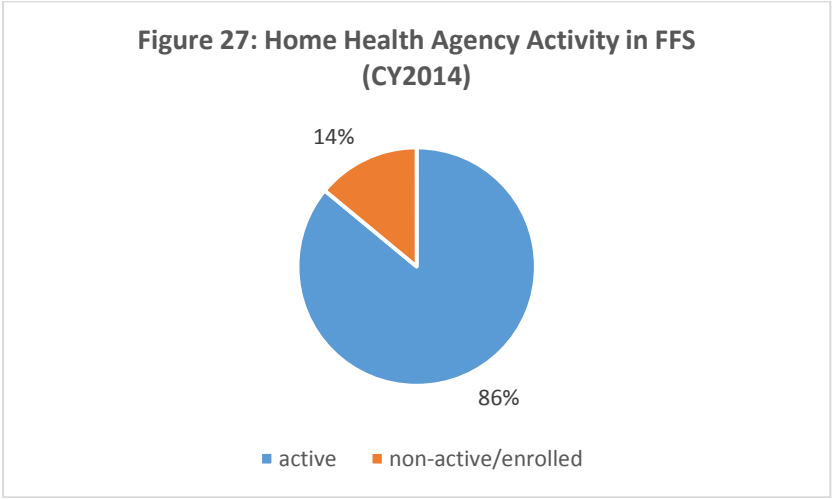


Table IV.F.2. Percentage of home health services provided by provider site to the MA-FFS population in CY2014.

Home Health Service	Agency/Entity Type	Metro	Non-Metro	Statewide
Home health aide	Home Health Agency	28.1%	44.9%	73.0%
	Hospital	0.0%	4.9%	4.9%
	Indian Health Facility	0.0%	0.5%	0.5%
	Other	6.5%	15.1%	21.6%
Nursing care	Home Health Agency	31.3%	42.2%	73.5%
	Hospital	0.0%	5.2%	5.2%
	Indian Health Facility	0.0%	0.9%	0.9%
	Other	4.8%	15.7%	20.4%
Occupational, physical, respiratory, speech therapy (OT/PT/RT/ST)	Home Health Agency	35.1%	50.7%	85.8%
	Hospital	0.0%	3.7%	3.7%
	Indian Health Facility	0.0%	0.7%	0.7%
	Other	2.2%	7.5%	9.7%
	Home Health Agency	0.1%	0.0%	0.1%

Durable medical equipment and medical supplies	Hospital	1.7%	12.8%	14.5%
	Indian Health Facility	0.0%	0.6%	0.6%
	Medical Supplier	6.5%	13.5%	20.0%
	Pharmacy	28.4%	36.0%	64.4%
	Other	0.2%	0.3%	0.4%

Table IV.F.2, above, sets forth a baseline for the proportion of provider sites for each geographic region, where home health services, as defined under 42 CFR § 440.70, were provided in CY 2014.

As illustrated in the table above, the majority of home health services, including OT/PT/RT/ST, provided to FFS enrollees in CY2014 were delivered by home health agencies in both metro and non-metro regions of the state. With respect to durable medical equipment (DME) and medical supplies, the majority of services were provided by a pharmacy.

Table IV.F.3. Provider-to-enrollee ratios for home health services for the MA-FFS system in CY2014.

	Unique Entities for Home Health Services per 1,000 person-years	**Unique Entities for DME/Medical Supplies per 1,000 person-years**
Metro Region	**2.8**	**4.9**
Non-Metro Region	**3.7**	**8.0**
Statewide	**3.3**	**6.5**

Table IV.F.3, above, represents a comparison of the provider-to-enrollee ratios for the FFS system for entities providing home health services in Minnesota. An entity must have supplied at least one service within the appropriate classification of services to be considered an active provider for the purposes of this measure. This baseline represents the average number of entities per 1,000 enrollees over a 12-month period. Based on this information, on average, statewide, there was at least one active entity providing home health services for every 303 FFS enrollees in CY2014. As for DME and medical supplies, there was at least one entity for every 153 enrollees.

Beneficiary Utilization

The tables below represent the state's baselines for monitoring changes in utilization of home health services. The baselines reflect utilization rates for the long-term and short-term FFS population, along with the total FFS population, in the MA program, stratified by location, age, and disability status.

The baselines also below provide a raw utilization rate per 1000 person years (i.e. the average number of claims per 1000 people over a full 12 months of enrollment), and a risk-adjusted rate based on the case mix or acuity of the population using the ACG® Case-Mix System. For more information or details regarding this analysis, see Appendix B.

Data sources:

- Enrollment data from the MMIS
- Claims data from the DHS MMIS

Table IV.F.4. Home Health Aide: Utilization Analysis for the MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population		Long-term: 12 mos	108	65	1.81
		Short-term: < 12 mos	14	17	0.94
		Total FFS Population	**51**	**N/A[20]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	80	43	2.02
		Short-term: < 12 mos	10	12	0.91
		Total FFS Population	**35**	**35**	**1.08**
	Non-Metro	Long-term: 12 mos	132	88	1.63
		Short-term: < 12 mos	19	21	0.97
		Total FFS Population	**67**	**66**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	4	5	0.84
		Short-term: < 12 mos	0	0	0.43
		Total FFS Population	**2**	**3**	**0.50**
	21-64 years	Long-term: 12 mos	172	74	2.52
		Short-term: < 12 mos	15	13	1.28
		Total FFS Population	**76**	**55**	**1.50**
	65 and older	Long-term: 12 mos	417	132	3.44
		Short-term: < 12 mos	205	66	3.40
		Total FFS Population	**312**	**100**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	41	48	0.93
		Short-term: < 12 mos	7	10	0.83
		Total FFS Population	**16**	**20**	**0.84**
	Disabled	Long-term: 12 mos	165	71	2.53
		Short-term: < 12 mos	87	33	2.83
		Total FFS Population	**149**	**62**	**2.62**

Table IV.F.5. Home Health Nursing Care: Utilization Analysis for the MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population		Long-term: 12 mos	582	351	1.81
		Short-term: < 12 mos	92	107	0.94
		Total FFS Population	**286**	**N/A[21]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	706	381	2.02
		Short-term: < 12 mos	98	118	0.91
		Total FFS Population	**320**	**324**	**1.08**
	Non-Metro	Long-term: 12 mos	479	320	1.63
		Short-term: < 12 mos	86	96	0.97
		Total FFS Population	**253**	**249**	**1.11**
	0-20 years	Long-term: 12 mos	55	71	0.84
		Short-term: < 12 mos	34	86	0.43

[20] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

[21] *See footnote above.*

By Age Group		**Total FFS Population**	**42**	**91**	**0.50**
	21-64 years	Long-term: 12 mos	984	426	2.52
		Short-term: < 12 mos	118	101	1.28
		Total FFS Population	**457**	**333**	**1.50**
	65 and older	Long-term: 12 mos	1,329	422	3.44
		Short-term: < 12 mos	495	159	3.40
		Total FFS Population	**915**	**292**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	136	160	0.93
		Short-term: < 12 mos	44	57	0.83
		Total FFS Population	**67**	**86**	**0.84**
	Disabled	Long-term: 12 mos	955	412	2.53
		Short-term: < 12 mos	600	231	2.83
		Total FFS Population	**886**	**369**	**2.62**

Table IV.F.6. Therapy Services: Utilization Analysis for the MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population		Long-term: 12 mos	45	27	1.81
		Short-term: < 12 mos	12	14	0.94
		Total FFS Population	**25**	**N/A[22]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	72	39	2.02
		Short-term: < 12 mos	16	19	0.91
		Total FFS Population	**36**	**37**	**1.08**
	Non-Metro	Long-term: 12 mos	22	14	1.63
		Short-term: < 12 mos	8	9	0.97
		Total FFS Population	**14**	**14**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	18	24	0.84
		Short-term: < 12 mos	2	5	0.43
		Total FFS Population	**8**	**18**	**0.50**
	21-64 years	Long-term: 12 mos	62	27	2.52
		Short-term: < 12 mos	15	13	1.28
		Total FFS Population	**33**	**24**	**1.50**
	65 and older	Long-term: 12 mos	107	34	3.44
		Short-term: < 12 mos	110	35	3.40
		Total FFS Population	**109**	**35**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	13	15	0.93
		Short-term: < 12 mos	6	8	0.83
		Total FFS Population	**8**	**10**	**0.84**
	Disabled	Long-term: 12 mos	71	31	2.53
		Short-term: < 12 mos	71	27	2.83
		Total FFS Population	**71**	**30**	**2.62**

[22] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

Table IV.F.7. DME/Medical Supply Services: Utilization Analysis for the MA-FFS Population in CY2014.

		FFS Population by Enrollment Duration	Utilization Rate (per 1000 PY)	Risk-Adjusted Utilization Rate	ACG® Score
FFS Population		Long-term: 12 mos	4,533	2,733	1.81
		Short-term: < 12 mos	1,000	1,167	0.94
		Total FFS Population	**2,399**	**N/A[23]**	**1.09**
By Location	**Metro**	Long-term: 12 mos	5,234	2,824	2.02
		Short-term: < 12 mos	994	1,195	0.91
		Total FFS Population	**2,543**	**2,577**	**1.08**
	Non-Metro	Long-term: 12 mos	3,953	2,640	1.63
		Short-term: < 12 mos	1,007	1,133	0.97
		Total FFS Population	**2,260**	**2,226**	**1.11**
By Age Group	**0-20 years**	Long-term: 12 mos	2,486	3,223	0.84
		Short-term: < 12 mos	392	984	0.43
		Total FFS Population	**1,212**	**2,621**	**0.50**
	21-64 years	Long-term: 12 mos	5,851	2,530	2.52
		Short-term: < 12 mos	1,279	1,090	1.28
		Total FFS Population	**3,069**	**2,233**	**1.50**
	65 and older	Long-term: 12 mos	9,869	3,133	3.44
		Short-term: < 12 mos	5,249	1,683	3.40
		Total FFS Population	**7,573**	**2,421**	**3.41**
By Disability Status	**Non-Disabled**	Long-term: 12 mos	1,632	1,922	0.93
		Short-term: < 12 mos	699	914	0.83
		Total FFS Population	**929**	**1,203**	**0.84**
	Disabled	Long-term: 12 mos	6,968	3,001	2.53
		Short-term: < 12 mos	4,181	1,611	2.83
		Total FFS Population	**6,423**	**2,673**	**2.62**

V. Needs Assessment

To assess whether beneficiary needs have been met, DHS applied the performance standards of the Healthcare Effectiveness Data and Information System (HEDIS®) to the long-term, MA-FFS population (i.e. enrolled continuously for 12 months) for the categories of service in this report, except home health, obstetrics, and specialty care.[24] DHS currently uses this tool to measure performance and outcomes for care and services for the managed care population in MA. This measure sets a baseline of performance that the state can use to monitor, longitudinally, patient experience and standards of care for the MA-FFS population. For home health, the state applied an alternative method which is further

[23] The risk score for this group is the reference point or comparison group for all risk adjusted (i.e. expected) rates in this table, hence the use of "N/A".

[24] No HEDIS® measurement is available to the state for assessing home health services, at this time. As for specialty care, the use of an available HEDIS® measure for this benefit would have resulted in an insufficient denominator for conducting a valid HEDIS measurement comparison for this report. For obstetrics, the HEDIS® measure available to the state was based on a hybrid measure which we believe is an invalid measurement of the experience of this population given our lack of capacity to do a medical record review to identify whether claims were made for the service being measured.

described below. For obstetrics and specialty care, the state plans to include an alternative method in future updates to this report.

This section also includes data metrics related to provider access for MA enrollees from DHS' call log data from the DHS Help Desk and survey data from the Minnesota Health Access Survey from the Minnesota Department of Health and the University of Minnesota. In future years, DHS has plans to improve its ability to use call center data for assessing beneficiary and provider feedback on access to services. DHS also has plans to explore opportunities for future use of targeted surveying of MA-FFS enrollees regarding their satisfaction with provider access and services, similar to the state's approach for monitoring outcomes for the MA population in managed care with the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) survey. There is also discussion regarding a separate survey for assessing enrollee satisfaction and experience with access to dental providers and care in both managed care and FFS systems.

HEDIS® Measurements

The HEDIS® measures used for assessing whether beneficiary needs have been met represented in the tables below for each benefit category, except home health, specialty care, and obstetrics.

Data sources:

- Claims data for the DHS MMIS
- DHS HEDIS® measures for enrollees in managed care in MA[25]
- National HEDIS® measures rates reported in Quality Compass® for enrollees in health maintenance organizations[26]

A. Primary Care

The table, below, represents the HEDIS® metric for measuring the percentage of enrollees who were continuously enrolled and who had one of the primary care visits or services listed below during the measurement year of CY2014. The table compares the MA-FFS population to the MA population in managed care and to national Medicaid averages.

Table V.A.1. HEDIS ® Measures for Primary Care Services (CY2014).

HEDIS® Measure	MA-FFS	MA-MCO	National Medicaid
Adult Access to Preventive & Ambulatory	87.39%	89.80%	82.03%
Breast Cancer Screening	43.74%	60.58%	60.22%
Children/Adolescent Access to Primary Care Practitioner[27]	83.94%	92.59%	N/A

[25] DHS measures did not include review of the medical records to verify claims. Only administrative claims data was used for these measures.

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

[27] Total rates for age groups can be found in Appendix C.

B. Dental Care

The table, below, represents the HEDIS metric for measuring the percentage of enrollees ages two through 21 who were continuously enrolled and who had an annual dental exam during the measurement year of CY2014. The table compares the MA-FFS population to the MA population in managed care and to national Medicaid averages.

Table V.B.1. HEDIS® Measure for Dental Care (CY2014).

HEDIS® Measure: Annual Dental Visit	MA-FFS	MA-MCO	National Medicaid
2-3 years	19.57%	33.23%	35.58%
4-6 years	40.18%	60.69%	56.95%
7-10 years	43.88%	64.83%	59.72%
11-14 years	41.85%	61.14%	54.80%
15-18 years	37.83%	52.28%	46.84%
19-21 years	32.61%	39.07%	31.95%
Total	**38.43%**	**55.31%**	**48.74%**

C. Behavioral Health

The table, below, represents the HEDIS® metric for measuring the percentage of enrollees who were continuously enrolled and who had one of the behavioral health visits or services listed below during the measurement year of CY2014. The table compares the MA-FFS population to the MA population in managed care and to national Medicaid averages.

Table V.D.1. HEDIS® Measures for Behavioral Health (CY2014).

HEDIS® Measure	MA-FFS	MA-MCO	National Medicaid
Antidepressant Medication Management (Effective Acute Phase Treatment)	48.93%	50.53%	52.25%
Antidepressant Medication Management (Effective Continuation Phase Treatment)	34.01%	36.60%	36.99%
Follow Up After Hospitalization for Mental Illness (within 7 days of discharge)	22.10%	24.79%	43.95%
Follow Up After Hospitalization for Mental Illness (within 30 days of discharge)	44.75%	45.98%	63.09%
Initiation & Engagement of Alcohol & Other Drug Dependence (Engagement: those who had ≥ 2 services for dependence within 30 days of initial treatment)	13.62%	11.28%	11.24%
Initiation & Engagement of Alcohol & Other Drug Dependence (Initiation: treatment within 14 days of diagnosis)	45.77%	36.20%	38.25%

VI. Other Access-Related Metrics

As mentioned previously, given the limitation in available data, the state included additional metrics to set forth initial thresholds for assessing whether beneficiary needs are being met as set forth below.

DHS is exploring future opportunities to refine these metrics to better identify opportunities for improvement in FFS beneficiary satisfaction and experience to provider access.

A. Home Health Services

Below represents a baseline measurement for assessing whether beneficiaries had their needs met with respect to home health services. This metric uses "service agreements" to identify FFS beneficiaries who were authorized as having a need for a home health service by a provider and provides the percentage of these beneficiaries who received such a service during their service agreement period.

Data sources:

- Claims and service agreement data from the MMIS

Table V1.A.1. Beneficiary Needs Assessment for Home Health Services

Home Health Service	Percentage of FFS Enrollees Who Received A Service During Service-Agreement Period for CY2014
Home Health Aide	71%
Home Nursing Care	82%

B. Beneficiary & Provider Feedback Mechanisms

DHS maintains a call log from our service center that tracks calls from MA providers and enrollees. As indicated earlier in the methodologies section, this tracking system is currently limited to high-level descriptions and indicators for calls. Therefore, the state does not have a mechanism at this time that provides a reliable and direct source for recording and monitoring specific calls from beneficiaries, where access to a provider was limited or unavailable in the MA-FFS program. However, the level of detail in this tracking system is expected to improve in future years as the planned upgrades continue for the call center and its archival system.

When examining the top reasons a provider or enrollee called in CY2014, none of the categories identified clearly indicate that a FFS enrollee was unable to access a provider. In fact, the top five categories identified for provider calls to the DHS Help Desk in CY2014 include denials, billing, claim status, wrong transfers, and service agreements. The top five categories identified for beneficiary calls to the DHS Help Desk include MNsure, eligibility status, online or paper application, MinnesotaCare, and dental. Also, it should be noted that, among the benefits included in this report, the category for dental care received the largest number of calls in CY2014. However, it is unclear from this indicator how many, if any, of these calls were related to access issues.

Among the current categories for recording calls, there is a general category for "access" related questions from beneficiaries. The table below represents this available data for calls recorded as "access" calls and compares the rate of such calls received from MA-FFS enrollees to managed care enrollees.

Data Source:

- DHS Call Center Log Data

Table V1.B.1 Call Log Access Questions (CY2014)

	Baseline Recipients	Access Calls Received	Call Rate per 10,000 Recipients
MA-FFS	281,239	195	6.93
Managed Care	632,000	80	1.266

Despite the apparent disparity between the call rates in the table above for MA-FFS enrollees versus managed care populations, strong conclusions cannot be drawn. Managed care recipients have the option to call their health plan and DHS with questions and concerns about provider access, whereas MA-FFS enrollees call only have the option of calling DHS for such issues. Plus, many enrollees spend time in both FFS and managed care systems. Depending on the duration of enrollment in each system and the reason behind that variation, any subsequent comparison of these numbers is subject to a selection bias. Furthermore, the FFS rate represents annualized enrollees whereas the managed care rate represents enrollees whose enrollment duration was not annualized to compensate for enrollment variation.

In future updates to this report, DHS plans to improve its ability to monitor MA-FFS beneficiary feedback and compare their satisfaction in accessing providers and care to the state's managed care enrollees. This includes 1) enhancing our call-log tracking system for DHS Help Desk, and 2) adding MA-FFS recipients to DHS' annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Medicaid core survey that it currently uses to monitor consumer satisfaction for its managed care population. Therefore, in future reports, DHS plans to include responses from MA-FFS populations similar to those reported from the existing CAHPS® survey for the state's managed care enrollees. This includes questions and responses regarding enrollees' satisfaction with getting needed care and with getting such care on a timely basis.

C. Minnesota Health Access Survey

Another source for examining access is the Minnesota Health Access Survey. This statewide telephone survey is conducted every other year and collects information related to health insurance and coverage and access to health care services for all Minnesotans. The survey is conducted in partnership by the Minnesota Department of Health (MDH) and the University of Minnesota's School of Public Health. The last survey was conducted in 2015 with a 35% response rate. More information about this survey can be found **here.**

For purposes of this report, we assumes respondents who reported as having public health insurance coverage and income levels consistent with the eligibility limits of the MA program were MA enrollees. However, it should be noted that, given the nature of the data collected, no mechanism exists for ensuring the data is representative of only MA-covered respondents, or for identifying only FFS respondents. Still, the data below provides a general assessment of MA-beneficiary experience with accessing care and providers. The tables below represent the selected population surveyed in 2015 that is believed to consist of primarily MA enrollees and reflect their responses to questions about provider access.

Figure 28. Provider Access Questions by Issue and Location from MN Health Access Survey (2015)

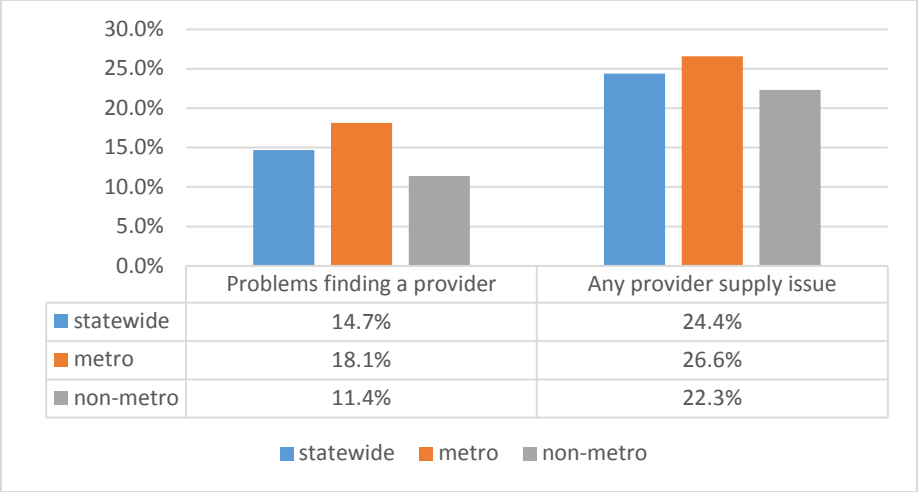
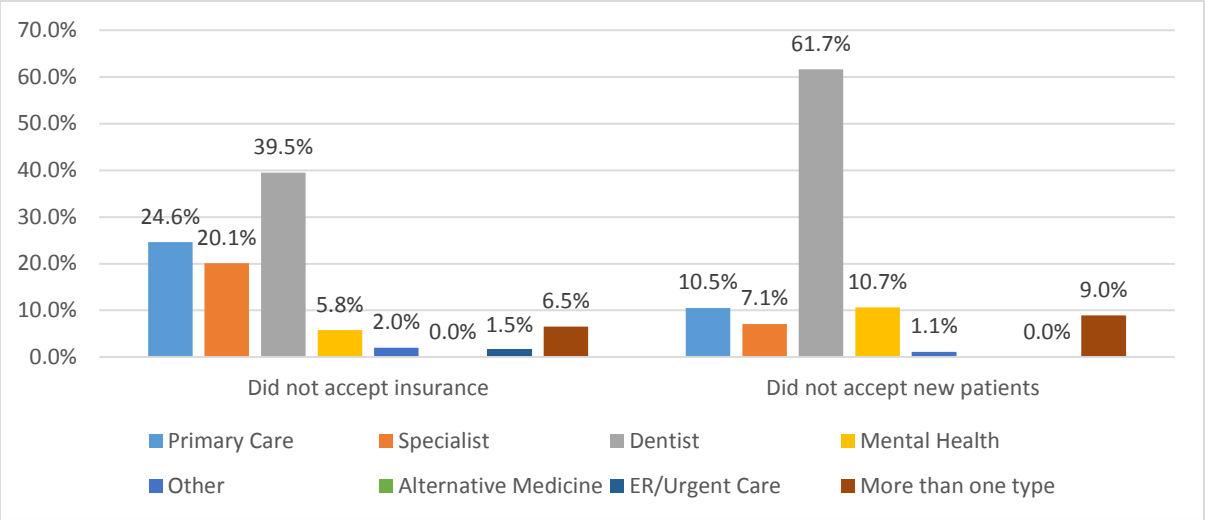


Figure 29 contains the percentage of MA enrollees who reported experiencing provider access issues. The category for "problems finding a provider" represents the percentage of those reporting as having been told that their insurance was not accepted or as having been told that a provider was not accepting new patients. The category for "any provider supply issue" includes those individuals reporting as having problems with finding a provider, or as being unable to get an appointment as soon as they thought one was needed.

Figure 29. Type of Provider with whom an access issue was identified by respondent to Health Access Survey



Of those who reported having an access issue as described above, Figure 30 shows the percentage of those who encountered a problem with specific types of providers.

VII. Sufficiency of Access

This report reflects the baselines DHS will use to meet the requirements of 42 C.F.R. § 447.203 for future monitoring and tracking of beneficiary access in the MA-FFS program. Without prior annual thresholds to compare to with respect to provider availability, beneficiary utilization, and HEDIS® or other

performance measures, it is difficult, at this time, for the state to make strong conclusions about the sufficiency of access to providers with respect to the services identified in this report. Therefore, based on the limited data available, there is no clear indication that the state does not meet the federal requirement of ensuring access that is comparable to that of the general population. DHS acknowledges, however, the apparent differences and gaps present throughout this plan and other reports with respect to enrollee access to dental care as compared to other services in the MA program. While there are some dental providers in FFS who benefit from significant add-on payments for their services to enrollees, the majority of dental providers in the state receive the base rate for the MA-FFS program. This creates a payment disparity among providers in FFS system, which could be a contributing factor to some of the access issues for enrollees with dental care.

It should also be noted that several efforts have been implemented to improve provider access in Minnesota since CY2014, including certain provider rate increases, health care workforce investments, implementation of accountable care delivery and payment models, and the expansion of telemedicine. Overall, Minnesota's goal is to promote access to appropriate, quality care for MA beneficiaries. This includes encouraging the development of payment and delivery models that support this type of access. The current measures for monitoring access in this plan do not capture these new emerging models that provide medical and non-medical services and supports for enrollees. In fact, these efforts are currently in the early stages of showing measurable improvement in health outcomes. We look forward to further discussions with stakeholders and CMS on how to best measure these models and their impact. Future updates to the baselines and measurements reflected in this plan will be helpful to the state in assessing the effectiveness of these and future efforts to improve access for MA beneficiaries.

Minnesota's Medicaid program has a history of strong provider participation in providing access to needed care for our enrollees. Going forward, DHS is committed to further refining its measures and conclusions regarding access to providers and plans to seek further public and stakeholder input on how best to accomplish those efforts in future updates to this report. This includes working with CMS and other stakeholders on remediation actions where access issues are identified.

Appendix A: Payment Rate Review

Supplement 1: Medicare and Medicaid Explanation for Home Health

Appendix B: Utilization Details

Appendix C: HEDIS® Measurements

Appendix D: Public Comments

Access Monitoring Review Plan

Summary of Payment Rate Comparison

Medicaid Rates and Average Payment Amounts as Compared to Medicare

Medicaid Service Area identified in the Access Monitoring Review Plan	Medicaid Base Rate as a Percentage of Medicare Base Rate	Average Medicaid Payment as a Percentage of Medicare Base Rate
Primary Care	78%	87%
Cardiology	72%	69%
Oncology	83%	91%
Orthopedic	82%	73%
Obstetric	77%	70%
Home Health	64%	61%
Mental Health (physician)	94%	112%
Mental Health (non-physician)	99%	101%
Durable Medical Equipment	100%	92%
Average:	**83%**	**84%**

Medicaid Rates and Average Payment as Compared to the State Employee Group Insurance Plan

Medicaid Service Area Identified in the Access Monitoring Review Plan	Medicaid Base Rate as a Percentage of Average SEGIP Payment	Average MA Payment as a Percentage of Average SEGIP Payment
Dental	47%	56%

Medicare base rates were effective January 1, 2014, and provided by NGS (National Government Services). Medicaid base rates were taken from Minnesota's CY 2014 Medical Assistance (MA) fee schedule. Medicaid and SEGIP average payment amounts were determined by aggregating total payments for CY 2014 and dividing by the number of units for each applicable service.

Primary Care Services

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
99213	50.06	38.80	78%	54.46	109%	71.90	55.84	78%	69.14	96%
99214	77.01	59.74	78%	84.36	110%	106.13	82.36	78%	102.21	96%
36415	3.00	3.00	100%	2.94	98%	3.00	3.00	100%	2.93	98%
99232	70.67	54.72	77%	63.12	89%	70.67	54.72	77%	(no data)	(n/a)
99233	101.95	79.01	77%	92.29	91%	101.95	79.01	77%	(no data)	(n/a)
71020	31.03	21.71	70%	19.63	63%	31.03	21.71	70%	19.48	63%
90471	25.12	19.54	78%	20.89	83%	25.12	19.54	78%	19.87	79%
99283	59.64	46.06	77%	48.11	81%	59.64	46.06	77%	(no data)	(n/a)
71010	23.77	16.66	70%	14.67	62%	23.77	16.66	70%	14.88	63%
99215	108.65	84.31	78%	122.19	112%	142.14	110.28	78%	129.43	91%
Average:	**$55.09**	**$42.36**	**78%**	**$52.27**	**90%**	**$63.53**	**$48.91**	**78%**	**$51.13**	**84%**

The average Medicaid rate is based on the allowed amount after ratable reductions and increases have been applied to the fee schedule rate. Please note that this average rate is compared to Medicare's fee schedule, not the paid amount under Medicare. Please see Minn. Stat. § 256B.76 for more information on which ratable reductions and increases applied in 2014 to physician services.

Cardiology Services

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
93010	8.38	5.80	69%	5.19	62%	8.38	5.80	69%	5.17	62%
93306	230.91	162.61	70%	146.68	64%	230.91	162.61	70%	144.61	63%
99232	70.67	54.72	77%	59.34	84%	70.67	54.72	77%	(no data)	(n/a)
99214	77.01	59.74	78%	73.46	95%	106.13	82.36	78%	97.11	92%
93325	26.02	18.18	70%	16.40	63%	26.02	18.18	70%	16.13	62%
93000	16.50	11.36	69%	10.47	63%	16.50	11.36	69%	10.19	62%
99233	101.95	79.01	77%	92.12	90%	101.95	79.01	77%	(no data)	(n/a)
93320	54.96	38.63	70%	34.00	62%	54.96	38.63	70%	34.34	62%
93018	14.49	10.10	70%	9.02	62%	14.49	10.10	70%	9.04	62%
93016	22.05	15.40	70%	13.76	62%	22.05	15.40	70%	13.80	63%
Average:	**$62.29**	**$45.55**	**72%**	**$46.04**	**71%**	**$62.21**	**$47.82**	**72%**	**$41.30**	**66%**

The average Medicaid rate is based on the allowed amount after ratable reductions and increases have been applied to the fee schedule rate. Please note that this average rate is compared to Medicare's fee schedule, not the paid amount under Medicare. Please see Minn. Stat. § 256B.76 for more information on which ratable reductions and increases applied in 2014 to physician services.

Oncology Services

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
99214	77.01	59.74	78%	78.55	102%	106.13	82.36	78%	97.21	91%
99215	108.65	84.31	78%	112.67	104%	142.14	110.28	78%	133.79	94%
36415	3.00	3.00	100%	2.92	97%	3.00	3.00	100%	2.93	98%
85025	10.61	10.61	100%	10.30	97%	10.61	10.61	100%	10.39	98%
99233	101.95	79.01	77%	98.61	97%	101.95	79.01	77%	(no data)	(n/a)
99213	50.06	38.80	78%	51.60	103%	71.90	55.84	78%	68.61	95%
80053	14.41	14.41	100%	13.98	97%	14.41	14.41	100%	13.99	97%
99232	70.67	54.72	77%	66.78	94%	70.67	54.72	77%	(no data)	(n/a)
96413	133.95	94.18	70%	85.53	64%	133.95	94.18	70%	84.34	63%
96375	22.44	15.65	70%	15.74	70%	22.44	15.65	70%	15.85	71%
Average:	**$59.28**	**$45.44**	**83%**	**$53.69**	**93%**	**$67.72**	**$52.01**	**83%**	**$53.39**	**88%**

The average Medicaid rate is based on the allowed amount after ratable reductions and increases have been applied to the fee schedule rate. Please note that this average rate is compared to Medicare's fee schedule, not the paid amount under Medicare. Please see Minn. Stat. § 256B.76 for more information on which ratable reductions and increases applied in 2014 to physician services

Orthopedic Services

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
99213	50.06	38.80	78%	34.68	69%	61.12	55.84	91%	50.44	85%
99203	74.11	57.51	78%	51.80	70%	89.90	82.08	91%	51.80	58%
99212	24.54	18.98	77%	16.95	69%	36.64	33.50	91%	29.99	82%
99214	77.01	59.74	78%	54.66	71%	90.21	82.36	91%	74.07	82%
20610	44.77	31.31	70%	27.09	61%	49.81	41.15	83%	36.15	73%
99202	48.99	37.97	78%	34.15	70%	62.37	59.95	96%	51.18	82%
73562	37.82	26.51	70%	(no rate)	(n/a)	32.15	26.51	82%	23.46	73%
99204	126.91	98.55	78%	89.29	70%	137.57	125.64	91%	113.87	83%
73030	31.26	21.96	71%	(no rate)	(n/a)	26.57	21.96	83%	19.64	74%
73610	34.33	23.98	70%	(no rate)	(n/a)	29.18	23.98	82%	21.25	73%
Average:	**$54.98**	**$41.53**	**75%**	**$44.09**	**69%**	**$61.55**	**$55.30**	**88%**	**$47.19**	**76%**

The average Medicaid rate is based on the allowed amount after ratable reductions and increases have been applied to the fee schedule rate. Please note that this average rate is compared to Medicare's fee schedule, not the paid amount under Medicare. Please see Minn. Stat. § 256B.76 for more information on which ratable reductions and increases applied in 2014 to physician services

Obstetric Services

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
76801	128.34	99.67	78%	89.51	70%	128.34	99.67	78%	89.51	70%
76805	148.72	115.58	78%	104.26	70%	148.72	115.58	78%	103.88	70%
76817	103.00	80.13	78%	72.69	70%	103.00	80.13	78%	71.71	70%
59025	46.12	35.73	75%	31.69	69%	46.12	35.73	77%	32.00	69%
76815	91.92	71.47	78%	63.35	69%	91.92	71.47	78%	63.92	70%
76816	118.23	91.85	78%	81.34	69%	118.23	91.85	78%	82.41	70%
76819	90.62	70.35	78%	62.47	69%	90.62	70.35	78%	63.20	70%
76811	187.73	146.02	78%	128.50	68%	187.73	146.02	78%	131.00	70%
76820	49.43	38.25	77%	33.66	68%	49.43	38.25	77%	35.53	72%
59400	1,980.76	1,387.89	70%	1241.98	63%	1,980.76	1,387.89	70%	(no data)	(n/a)
Average:	**$294.49**	**$213.69**	**77%**	**$190.95**	**69%**	**$294.49**	**$213.69**	**77%**	**$74.80**	**70%**

The average Medicaid rate is based on the allowed amount after ratable reductions and increases have been applied to the fee schedule rate. Please note that this average rate is compared to Medicare's fee schedule, not the paid amount under Medicare. Please see Minn. Stat. § 256B.76 for more information on which ratable reductions and increases applied in 2014 to physician services.

Mental Health Services – Physician

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
90791	127.22	114.68	90%	142.43	112%	131.58	118.91	90%	151.66	115%
90792	137.63	124.11	90%	155.30	113%	142.00	128.33	90%	161.73	114%
90785	14.11	12.67	90%	14.38	102%	14.11	14.11	100%	14.60	103%
90832	62.75	62.75	100%	69.80	111%	63.48	57.48	91%	72.57	114%
90834	83.79	75.70	90%	95.45	114%	84.15	84.15	100%	95.03	112%
90837	125.40	113.06	90%	142.08	113%	126.12	126.12	100%	141.35	112%
90853	25.10	22.41	89%	28.61	114%	25.83	25.83	100%	28.84	112%
Average:	**$82.29**	**$75.05**	**91%**	**$92.58**	**111%**	**$83.89**	**$79.28**	**96%**	**$95.11**	**112%**

Mental Health Services – Non-physician*

MA Procedure Code	Medicare Facility Base Rate	MA Facility Base Rate	MA Base Rate as a % of Medicare	Avg. MA Facility Payment	Average MA Pmt. as a % of Medicare	Medicare Non-facility Base Rate	MA Non-facility Base Rate	MA Base Rate as a % of Medicare	Average MA Non-Facility Payment	Average MA Pmt. as a % of Medicare
90791	120.86	114.68	95%	121.98	101%	125.00	118.91	95%	129.33	103%
90792	130.75	124.11	95%	(no rate)	(n/a)	134.90	128.33	95%	158.76	118%
90785	13.40	12.67	95%	10.73	80%	13.40	14.11	105%	12.55	94%
90832	59.61	62.75	105%	60.06	101%	60.31	57.48	95%	62.29	103%
90834	79.60	75.70	95%	85.25	107%	79.94	84.15	105%	83.12	104%
90837	119.13	113.06	95%	121.74	102%	119.81	126.12	105%	124.05	104%
90853	23.85	22.41	94%	22.89	96%	24.54	25.83	105%	24.63	101%
Average:	**$78.17**	**$75.05**	**96%**	**$70.44**	**98%**	**$79.70**	**$79.28**	**101%**	**$85.96**	**104%**

** Doctoral prepared (practitioners prepared at the masters level are paid at 80% of the doctoral rate).*

Home Health Services

MA Procedure Code	Medicare Base Rate*	MA Base Rate	MA Base Rate as % of Medicare	Average MA Payment*	Average MA Payment as a % of Medicare
T1021	54.91	57.00	104%	54.69	99%
S9129	133.46	71.11	53%	68.27	51%
S9131	132.56	69.69	53%	65.52	49%
S5181	(no rate)	49.25	(n/a)	48.03	(n/a)
T1030	121.23	74.28	61%	72.28	60%
S9128	144.03	70.75	49%	68.55	48%
Average:	**$117.24**	**$65.35**	**64%**	**$62.88**	**61%**

** Medicare base rate includes an administrative cost component that is not included in the MA base rate or average payment amount.*

See supplemental attachment 1 regarding Minnesota Medicaid payment policy versus Medicare payment policy for Home Health services.

Durable Medical Equipment (DME)

MA Procedure Code	Medicare Base Rate	MA Base Rate	MA Base Rate as % of Medicare	Average MA Payment*	Average MA Payment as a % of Medicare
B4035	11.77	11.77	100%	11.29	96%
E0601 NU	959.19	959.19	100%	787.52	82%
E0601 RR	91.35	91.35	100%	73.41	80%
E0570 NU	184.95	184.95	100%	160.76	86%
E0570 RR	17.61	17.61	100%	14.16	80%
K0739	14.55	14.55	100%	13.96	96%
A4217	3.43	3.43	100%	3.01	88%
A4357	10.61	10.61	100%	10.17	96%
A7005	33.71	33.71	100%	31.85	95%
A7003	2.62	2.62	100%	2.54	97%
A4351	1.99	1.99	100%	1.84	93%
A7038	4.33	4.33	100%	4.07	94%
E0143 NU	100.96	100.96	100%	106.89	105%
E0143 RR	20.35	20.35	100%	19.72	97%
E0100 NU	23.04	23.04	100%	23.13	100%
K0001 NU	579.70	579.70	100%	521.35	90%
K0001 RR	55.21	55.21	100%	47.35	86%
E0260 NU	1,390.10	1,390.10	100%	1330.61	96%
E0260 RR	132.39	132.39	100%	112.85	85%
Average	**$191.62**	**$191.62**	**100%**	**$172.44**	**92%**

* The average Medicaid rate is based on the allowed amount after ratable reductions and increases have been applied to the fee schedule rate. Please note that this average rate is compared to the Medicare fee schedule, and not the paid amount under Medicare. Please see Minn. Stat. § 256B.766 for more information about which ratable reductions applied in 2014 to DME services.

Dental Services

MA Procedure Code	SEGIP* Dental Payment Rate (Adult & Child)	MA Adult Dental Base Rate	Adult MA Base Rate as % of SEGIP	MA Child Dental Base Rate	Child MA Base Rate as a % of SEGIP	Average MA Dental Payment	Average MA Payment as a % of SEGIP
D0120	34.89	12.22	35%	18.70	54%	19.11	55%
D1110	70.87	26.52	37%	(n/a)	(n/a)	32.56	46%
D0220	19.75	6.10	31%	10.20	52%	9.26	47%
D1206	16.93	14.00	83%	14.00	83%	18.35	108%
D7140	115.75	44.70	39%	44.70	39%	58.30	50%
D0274	42.85	16.31	38%	23.80	56%	22.86	53%
D0140	42.44	15.93	38%	24.65	58%	22.57	53%
D0230	16.21	4.06	25%	8.50	52%	6.64	41%
D1120	48.98	(n/a)	(n/a)	18.34	37%	23.18	47%
D0150	47.39	15.93	34%	25.50	54%	27.81	59%
Average:	**$45.60**	**$17.31**	**40%**	**$20.93**	**54%**	**$24.64**	**56%**

** SEGIP is the State Employees Group Insurance Plan, which provides coverage to Minnesota state employees*

Supplemental Appendix 1 – Home Health Services

Medicare Payment Methodology and Medicaid Payment Methodology

Home Health Services

Under the prospective payment system, Medicare pays home health agencies (HHAs) a predetermined base payment. The payment is adjusted for the health condition and care needs of the beneficiary. The payment is also adjusted for the geographic differences in wages. The adjustment for the health condition, or clinical characteristics, and service needs of the beneficiary is referred to as the case-mix adjustment. The home health PPS will provide HHAs with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin; there are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. While payment for each episode is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. Adjusting payment to reflect the HHA's cost in caring for each beneficiary including the sickest, should ensure that all beneficiaries have access to home health services for which they are eligible.

The home health PPS is composed of six main features:

- The unit of payment under HHA PPS is for a 60-day episode of care.
- The payment is adjusted for case-mix based on a beneficiary's condition and needs
- Additional payments will be made to the 60-day case-mix adjusted episode payments for beneficiaries who incur unusually large costs.
- The proposed home health PPS has a low-utilization payment adjustment for beneficiaries whose episodes consist of four or fewer visits. These episodes will be paid the standardized, service-specific per-visit amount multiplied by the number of visits actually provided during the episode. A savings from reduced episode payments would be redistributed to all episodes paid under the PPS.
- The home health PPS will include a partial episode payment adjustment (PEP). A new episode clock will be triggered when a beneficiary elects to transfer to another HHA or when a beneficiary is discharged and readmitted to the same HHA during the 60-day episode.
- Under the PPS a HHA must bill for all home health services which includes nursing and therapy services, routine and non-routine medical supplies, home health aide and medical social services, except durable medical equipment (DME).

For low-utilization payments for Medicare home health care services that are paid using the service-specific per visit amount, there are additional adjustments to the visit rate. The per-visit payments occur if there are four visits or fewer in the 60-day episode of care, and there is a low utilization payment adjustment add-on. There is a rural add-on to the rate if applicable. The visit rate is also adjusted for the first visit for three home health disciplines: physical therapy, skilled nursing, and speech language pathology therapy. This is based on analysis that shows there are additional costs associated with the initial visit for an episode being performed by these disciplines. For example, if the first skilled visit is skilled nursing (SN), the payment for that visit would be 226.87 (1.8714 multiplied by the proposed SN per-visit amount of 121.23).

Eligibility for Medicare services has additional criteria for the person to be homebound, have a skilled need, and the person is required to making progress. Minnesota MA services are provided to a much greater range of recipients and for a longer duration for home care services (up to a year). While they still are required to be medically necessary, they don't have the criteria that the person is homebound and continue to make progress towards a goal.

Finally, there are administrative activities that Medicare-certified homecare agencies are required to perform because they are a Medicare-certified agency, whether providing Medicare home health care services or Medical Assistance home health care services.

APPENDIX B

Primary Care Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	962035	8640	5209	1.81
		Less than 12 Months	169896	1434669	8444	9851	0.94
		Total	281239	2396704	8522	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	520877	10332	5575	2.02
		Less than 12 Months	87557	786221	8979	10801	0.91
		Total	137970	1307098	9474	9601	1.08
	Non-Metro	12 Months	60930	441158	7240	4835	1.63
		Less than 12 Months	82339	648448	7875	8863	0.97
		Total	143269	1089606	7605	7493	1.11
Age							
	0-20	12 Months	50297	334812	6657	8632	0.84
		Less than 12 Months	78164	604832	7738	19446	0.43
		Total	128461	939644	7315	15824	0.50
	21-64	12 Months	55438	571601	10311	4458	2.52
		Less than 12 Months	86194	777506	9020	7688	1.28
		Total	141632	1349107	9525	6933	1.50
	65+	12 Months	5608	55622	9918	3149	3.44
		Less than 12 Months	5538	52331	9450	3031	3.40
		Total	11146	107953	9685	3097	3.41
Disabled							
	Not Disabled	12 Months	50806	319560	6290	7406	0.93
		Less than 12 Months	155194	1227950	7912	10353	0.83
		Total	206000	1547510	7512	9728	0.84
	Disabled	12 Months	60537	642475	10613	4572	2.53
		Less than 12 Months	14703	206719	14060	5419	2.83
		Total	75240	849194	11287	4697	2.62

OB Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibi ity Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score	
Total FFS Population		12 Months	52393	6694	128	77	1.81	Population includes females only < age 65
		Less than 12 Months	86401	46348	536	626	0.94	
		Total	138794	53042	382	N/A	1.09	
Geographic Location								
	Metro	12 Months	22722	2875	127	68	2.02	
		Less than 12 Months	44076	26083	592	712	0.91	
		Total	66798	28958	434	439	1.08	
	Non-Metro	12 Months	29671	3819	129	86	1.63	
		Less than 12 Months	42325	20265	479	539	0.97	
		Total	71996	24084	335	330	1.11	
Age								
	0-20	12 Months	22011	1036	47	61	0.84	
		Less than 12 Months	38813	6033	155	391	0.43	
		Total	60824	7069	116	251	0.50	
	21-64	12 Months	30382	5657	186	81	2.52	
		Less than 12 Months	47588	40315	847	722	1.28	
		Total	77970	45972	590	429	1.50	
	65	12 Months	N/A	N/A	N/A	N/A	3.44	
		Less than 12 Months	N/A	N/A	N/A	N/A	3.40	
		Total	N/A	N/A	N/A	N/A	3.41	
Disabled								
	Not Disabled	12 Months	25093	5965	238	280	0.93	
		Less than 12 Months	79981	45714	572	748	0.83	
		Total	105074	51679	492	637	0.84	
	Disabled	12 Months	27300	729	27	12	2.53	
		Less than 12 Months	6420	634	99	38	2.83	
		Total	33720	1363	40	17	2.62	

Dental Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	282266	2535	1528	1.81
		Less than 12 Months	169896	234547	1381	1610	0.94
		Total	281239	516813	1838	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	124158	2463	1329	2.02
		Less than 12 Months	87557	117620	1343	1616	0.91
		Total	137970	241778	1752	1776	1.08
	Non-Metro	12 Months	60930	158108	2595	1733	1.63
		Less than 12 Months	82339	116927	1420	1598	0.97
		Total	143269	275035	1920	1891	1.11
Age							
	0-20	12 Months	50297	120027	2386	3094	0.84
		Less than 12 Months	78164	109586	1402	3523	0.43
		Total	128461	229613	1787	3867	0.50
	21-64	12 Months	55438	151185	2727	1179	2.52
		Less than 12 Months	86194	118366	1373	1170	1.28
		Total	141632	269551	1903	1385	1.50
	65+	12 Months	5608	11054	1971	626	3.44
		Less than 12 Months	5538	6595	1191	382	3.40
		Total	11146	17649	1583	506	3.41
Disabled							
	Not Disabled	12 Months	50806	98714	1943	2288	0.93
		Less than 12 Months	155194	200083	1289	1687	0.83
		Total	206000	298797	1450	1878	0.84
	Disabled	12 Months	60537	183552	3032	1306	2.53
		Less than 12 Months	14703	34464	2344	903	2.83
		Total	75240	218016	2898	1206	2.62

Cardiology Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	31861	286	173	1.81
		Less than 12 Months	169896	39780	234	273	0.94
		Total	281239	71641	255	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	18060	358	193	2.02
		Less than 12 Months	87557	21847	250	300	0.91
		Total	137970	39907	289	293	1.08
	Non-Metro	12 Months	60930	13801	227	151	1.63
		Less than 12 Months	82339	17933	218	245	0.97
		Total	143269	31734	221	218	1.11
Age							
	0-20	12 Months	50297	5312	106	137	0.84
		Less than 12 Months	78164	6348	81	204	0.43
		Total	128461	11660	91	196	0.50
	21-64	12 Months	55438	22578	407	176	2.52
		Less than 12 Months	86194	29261	339	289	1.28
		Total	141632	51839	366	266	1.50
	65+	12 Months	5608	3971	708	225	3.44
		Less than 12 Months	5538	4171	753	242	3.40
		Total	11146	8142	730	234	3.41
Disabled							
	Not Disabled	12 Months	50806	6819	134	158	0.93
		Less than 12 Months	155194	28679	185	242	0.83
		Total	206000	35498	172	223	0.84
	Disabled	12 Months	60537	25042	414	178	2.53
		Less than 12 Months	14703	11101	755	291	2.83
		Total	75240	36143	480	200	2.62

Orthopedics Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	24296	218	132	1.81
		Less than 12 Months	169896	27343	161	188	0.94
		Total	281239	51639	184	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	12396	246	133	2.02
		Less than 12 Months	87557	12717	145	175	0.91
		Total	137970	25113	182	184	1.08
	Non-Metro	12 Months	60930	11900	195	130	1.63
		Less than 12 Months	82339	14626	178	200	0.97
		Total	143269	26526	185	182	1.11
Age							
	0-20	12 Months	50297	6173	123	159	0.84
		Less than 12 Months	78164	5552	71	179	0.43
		Total	128461	11725	91	197	0.50
	21-64	12 Months	55438	16445	297	128	2.52
		Less than 12 Months	86194	20516	238	203	1.28
		Total	141632	36961	261	190	1.50
	65+	12 Months	5608	1678	299	95	3.44
		Less than 12 Months	5538	1275	230	74	3.40
		Total	11146	2953	265	85	3.41
Disabled							
	Not Disabled	12 Months	50806	6968	137	161	0.93
		Less than 12 Months	155194	21989	142	185	0.83
		Total	206000	28957	141	182	0.84
	Disabled	12 Months	60537	17328	286	123	2.53
		Less than 12 Months	14703	5354	364	140	2.83
		Total	75240	22682	301	125	2.62

Oncology Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	21259	191	115	1.81
		Less than 12 Months	169896	22875	135	157	0.94
		Total	281239	44134	157	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	14899	296	159	2.02
		Less than 12 Months	87557	14903	170	205	0.91
		Total	137970	29802	216	219	1.08
	Non-Metro	12 Months	60930	6360	104	70	1.63
		Less than 12 Months	82339	7972	97	109	0.97
		Total	143269	14332	100	99	1.11
Age							
	0-20	12 Months	50297	1605	32	41	0.84
		Less than 12 Months	78164	1260	16	41	0.43
		Total	128461	2865	22	48	0.50
	21-64	12 Months	55438	16779	303	131	2.52
		Less than 12 Months	86194	18880	219	187	1.28
		Total	141632	35659	252	183	1.50
	65+	12 Months	5608	2875	513	163	3.44
		Less than 12 Months	5538	2735	494	158	3.40
		Total	11146	5610	503	161	3.41
Disabled							
	Not Disabled	12 Months	50806	7714	152	179	0.93
		Less than 12 Months	155194	12861	83	108	0.83
		Total	206000	20575	100	129	0.84
	Disabled	12 Months	60537	13545	224	96	2.53
		Less than 12 Months	14703	10014	681	263	2.83
		Total	75240	23559	313	130	2.62

Chemical Dependency Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	29216	262	158	1.81
		Less than 12 Months	169896	62370	367	428	0.94
		Total	281239	91586	326	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	18541	368	198	2.02
		Less than 12 Months	87557	34330	392	472	0.91
		Total	137970	52871	383	388	1.08
	Non-Metro	12 Months	60930	10675	175	117	1.63
		Less than 12 Months	82339	28040	341	383	0.97
		Total	143269	38715	270	266	1.11
Age							
	0-20	12 Months	50297	2644	53	68	0.84
		Less than 12 Months	78164	3198	41	103	0.43
		Total	128461	5842	45	98	0.50
	21-64	12 Months	55438	25134	453	196	2.52
		Less than 12 Months	86194	58894	683	582	1.28
		Total	141632	84028	593	432	1.50
	65+	12 Months	5608	1438	256	81	3.44
		Less than 12 Months	5538	278	50	16	3.40
		Total	11146	1716	154	49	3.41
Disabled							
	Not Disabled	12 Months	50806	9362	184	217	0.93
		Less than 12 Months	155194	51603	333	435	0.83
		Total	206000	60965	296	383	0.84
	Disabled	12 Months	60537	19854	328	141	2.53
		Less than 12 Months	14703	10767	732	282	2.83
		Total	75240	30621	407	169	2.62

Mental Health Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	697008	6260	3774	1.81
		Less than 12 Months	169896	286558	1687	1968	0.94
		Total	281239	983566	3497	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	339616	6737	3635	2.02
		Less than 12 Months	87557	134832	1540	1852	0.91
		Total	137970	474448	3439	3485	1.08
	Non-Metro	12 Months	60930	357392	5866	3917	1.63
		Less than 12 Months	82339	151726	1843	2074	0.97
		Total	143269	509118	3554	3501	1.11
Age							
	0-20	12 Months	50297	361709	7191	9325	0.84
		Less than 12 Months	78164	109123	1396	3508	0.43
		Total	128461	470832	3665	7929	0.50
	21-64	12 Months	55438	323460	5835	2523	2.52
		Less than 12 Months	86194	173048	2008	1711	1.28
		Total	141632	496508	3506	2552	1.50
	65+	12 Months	5608	11839	2111	670	3.44
		Less than 12 Months	5538	4387	792	254	3.40
		Total	11146	16226	1456	465	3.41
Disabled							
	Not Disabled	12 Months	50806	167798	3303	3889	0.93
		Less than 12 Months	155193.5	185414	1195	1563	0.83
		Total	205999.5	353212	1715	2220	0.84
	Disabled	12 Months	60537	529210	8742	3766	2.53
		Less than 12 Months	14703	101144	6879	2651	2.83
		Total	75240	630354	8378	3486	2.62

Telemedicine Mental Health Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	1473	13	8	1.81
		Less than 12 Months	169896	684	4	5	0.94
		Total	281239	2157	8	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	203	4	2	2.02
		Less than 12 Months	87557	90	1	1	0.91
		Total	137970	293	2	2	1.08
	Non-Metro	12 Months	60930	1270	21	14	1.63
		Less than 12 Months	82339	594	7	8	0.97
		Total	143269	1864	13	13	1.11
Age							
	0-20	12 Months	50297	428	9	11	0.84
		Less than 12 Months	78164	160	2	5	0.43
		Total	128461	588	5	10	0.50
	21-64	12 Months	55438	1008	18	8	2.52
		Less than 12 Months	86194	507	6	5	1.28
		Total	141632	1515	11	8	1.50
	65+	12 Months	5608	37	7	2	3.44
		Less than 12 Months	5537.92	17	3	1	3.40
		Total	11145.92	54	5	2	3.41
Disabled							
	Not Disabled	12 Months	50806	333	7	8	0.93
		Less than 12 Months	155194	447	3	4	0.83
		Total	206000	780	4	5	0.84
	Disabled	12 Months	60537	1140	19	8	2.53
		Less than 12 Months	14703	237	16	6	2.83
		Total	75240	1377	18	8	2.62

Mental Health Medication Management Utilization by Population Criteria in 2014

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score	
Total FFS Population		12 Months		111343	59654	536	323	1.81
		Less than 12 Months		169896	27746	163	191	0.94
		Total		281239	87400	311	N/A	1.09
Geographic Location								
	Metro	12 Months		50413	29702	589	318	2.02
		Less than 12 Months		87557	13425	153	184	0.91
		Total		137970	43127	313	317	1.08
	Non-Metro	12 Months		60930	29952	492	328	1.63
		Less than 12 Months		82339	14321	174	196	0.97
		Total		143269	44273	309	304	1.11
Age								
	0-20	12 Months		50297	20384	405	526	0.84
		Less than 12 Months		78164	6563	84	211	0.43
		Total		128461	26947	210	454	0.50
	21-64	12 Months		55438	37631	679	294	2.52
		Less than 12 Months		86194	20761	241	205	1.28
		Total		141632	58392	412	300	1.50
	65	12 Months		5608	1639	292	93	3.44
		Less than 12 Months		5538	422	76	24	3.40
		Total		11146	2061	185	59	3.41
Disabled								
	Not Disabled	12 Months		50806	13063	257	303	0.93
		Less than 12 Months		155194	17929	116	151	0.83
		Total		206000	30992	150	195	0.84
	Disabled	12 Months		60537	46591	770	332	2.53
		Less than 12 Months		14703	9817	668	257	2.83
		Total		75240	56408	750	312	2.62

Home Health Utilization by Population Criteria in 2014 (Health Home Health Services Home Health Aide)

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	12050	108	65	1.81
		Less than 12 Months	169896	2422	14	17	0.94
		Total	281239	14472	51	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	4020	80	43	2.02
		Less than 12 Months	87557	862	10	12	0.91
		Total	137970	4882	35	35	1.08
	Non-Metro	12 Months	60930	8030	132	88	1.63
		Less than 12 Months	82339	1560	19	21	0.97
		Total	143269	9590	67	66	1.11
Age							
	0-20	12 Months	50297	200	4	5	0.84
		Less than 12 Months	78164	0	0	0	0.43
		Total	128461	200	2	3	0.50
	21-64	12 Months	55438	9510	172	74	2.52
		Less than 12 Months	86194	1286	15	13	1.28
		Total	141632	10796	76	55	1.50
	65+	12 Months	5608	2340	417	132	3.44
		Less than 12 Months	5538	1136	205	66	3.40
		Total	11146	3476	312	100	3.41
Disabled							
	Not Disabled	12 Months	50806	2076	41	48	0.93
		Less than 12 Months	155194	1148	7	10	0.83
		Total	206000	3224	16	20	0.84
	Disabled	12 Months	60537	9974	165	71	2.53
		Less than 12 Months	14703	1274	87	33	2.83
		Total	75240	11248	149	62	2.62

Home Health Utilization by Population Criteria in 2014 (Health Home Health Services Nursing Care)

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	64758	582	351	1.81
		Less than 12 Months	169896	15605	92	107	0.94
		Total	281239	80363	286	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	35593	706	381	2.02
		Less than 12 Months	87557	8564	98	118	0.91
		Total	137970	44157	320	324	1.08
	Non-Metro	12 Months	60930	29165	479	320	1.63
		Less than 12 Months	82339	7041	86	96	0.97
		Total	143269	36206	253	249	1.11
Age							
	0-20	12 Months	50297	2749	55	71	0.84
		Less than 12 Months	78164	2675	34	86	0.43
		Total	128461	5424	42	91	0.50
	21-64	12 Months	55438	54555	984	426	2.52
		Less than 12 Months	86194	10191	118	101	1.28
		Total	141632	64746	457	333	1.50
	65+	12 Months	5608	7454	1329	422	3.44
		Less than 12 Months	5538	2739	495	159	3.40
		Total	11146	10193	915	292	3.41
Disabled							
	Not Disabled	12 Months	50806	6922	136	160	0.93
		Less than 12 Months	155194	6790	44	57	0.83
		Total	206000	13712	67	86	0.84
	Disabled	12 Months	60537	57836	955	412	2.53
		Less than 12 Months	14703	8815	600	231	2.83
		Total	75240	66651	886	369	2.62

Home Health Utilization by Population Criteria in 2014 (Health Home Health Services Total)

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	165274	1484	895	1.81
		Less than 12 Months	169896	26239	154	180	0.94
		Total	281239	191513	681	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	88277	1751	945	2.02
		Less than 12 Months	87557	13605	155	187	0.91
		Total	137970	101882	738	748	1.08
	Non-Metro	12 Months	60930	76997	1264	844	1.63
		Less than 12 Months	82339	12634	153	173	0.97
		Total	143269	89631	626	616	1.11
Age							
	0-20	12 Months	50297	37400	744	964	0.84
		Less than 12 Months	78164	4556	58	146	0.43
		Total	128461	41956	327	707	0.50
	21-64	12 Months	55438	106962	1929	834	2.52
		Less than 12 Months	86194	14306	166	141	1.28
		Total	141632	121268	856	623	1.50

	65+	12 Months	5608	20912	3729	1184	3.44
		Less than 12 Months	5538	7377	1332	427	3.40
		Total	11146	28289	2538	811	3.41
Disabled							
	Not Disabled	12 Months	50806	23343	459	541	0.93
		Less than 12 Months	155194	12015	77	101	0.83
		Total	206000	35358	172	222	0.84
	Disabled	12 Months	60537	141931	2345	1010	2.53
		Less than 12 Months	14703	14224	967	373	2.83
		Total	75240	156155	2075	864	2.62

Home Health Utilization by Population Criteria in 2014 (Occupational Therapies)

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	4970	45	27	1.81
		Less than 12 Months	169896	2043	12	14	0.94
		Total	281239	7013	25	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	3651	72	39	2.02
		Less than 12 Months	87557	1368	16	19	0.91
		Total	137970	5019	36	37	1.08
	Non-Metro	12 Months	60930	1319	22	14	1.63
		Less than 12 Months	82339	675	8	9	0.97
		Total	143269	1994	14	14	1.11
Age							
	0-20	12 Months	50297	922	18	24	0.84
		Less than 12 Months	78164	148	2	5	0.43
		Total	128461	1070	8	18	0.50
	21-64	12 Months	55438	3447	62	27	2.52
		Less than 12 Months	86194	1286	15	13	1.28
		Total	141632	4733	33	24	1.50
	65+	12 Months	5608	601	107	34	3.44
		Less than 12 Months	5538	609	110	35	3.40
		Total	11146	1210	109	35	3.41
Disabled							
	Not Disabled	12 Months	50806	653	13	15	0.93
		Less than 12 Months	155194	994	6	8	0.83
		Total	206000	1647	8	10	0.84
	Disabled	12 Months	60537	4317	71	31	2.53
		Less than 12 Months	14703	1049	71	27	2.83
		Total	75240	5366	71	30	2.62

Home Health Utilization by Population Criteria in 2014 (DME/Medical Supplies)

Population Criteria	Category	Eligibility Duration	Population	Number of Claims	Raw Utilization Rate (per 1000 Person-Years)	Adjusted Utilization Rate	Average ACG Score
Total FFS Population		12 Months	111343	504746	4533	2733	1.81
		Less than 12 Months	169896	169896	1000	1167	0.94
		Total	281239	674642	2399	N/A	1.09
Geographic Location							
	Metro	12 Months	50413	263885	5234	2824	2.02
		Less than 12 Months	87557	86989	994	1195	0.91
		Total	137970	350874	2543	2577	1.08
	Non-Metro	12 Months	60930	240861	3953	2640	1.63
		Less than 12 Months	82339	82907	1007	1133	0.97
		Total	143269	323768	2260	2226	1.11
Age							
	0-20	12 Months	50297	125016	2486	3223	0.84
		Less than 12 Months	78164	30616	392	984	0.43
		Total	128461	155632	1212	2621	0.50
	21-64	12 Months	55438	324387	5851	2530	2.52
		Less than 12 Months	86194	110214	1279	1090	1.28
		Total	141632	434601	3069	2233	1.50
	65+	12 Months	5608	55343	9869	3133	3.44
		Less than 12 Months	5538	29066	5249	1683	3.40
		Total	11146	84409	7573	2421	3.41
Disabled							
	Not Disabled	12 Months	50806	82931	1632	1922	0.93
		Less than 12 Months	155194	108428	699	914	0.83
		Total	206000	191359	929	1203	0.84
	Disabled	12 Months	60537	421815	6968	3001	2.53
		Less than 12 Months	14703	61468	4181	1611	2.83
		Total	75240	483283	6423	2673	2.62

APPENDIX C

	Report Year 2015 HEDIS Measures, Measurement Year 2014	Minnesota DHS State Average Rates						National Committee for Quality Assurance (NCQA)
		FFS MA			Medicaid (Without FFS MA)			Medicaid (National HMO Avg.)
HEDIS Measures	HEDIS Measure Name / Age Group	Numerator	Denominator	MN FFS MA Rate (Reporting Year 2015; Measurement Year 2014)	Numerator	Denominator	MN Medicaid Avg. Rate (Reporting Year 2015; Measurement Year 2014)	Medicaid (HMO) National Avg. Rate (reported by Quality Compass)
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44)	25,647	30,638	83.71%	121,316	139,331	87.07%	79.36%
	Adults' Access to Preventive/Ambulatory Health Services (45-64)	28,036	29,930	93.67%	83,761	92,477	90.57%	86.60%
	Adults' Access to Preventive/Ambulatory Health Services (65+)	4,349	5,841	74.46%	42,465	43,839	96.87%	85.80%
	Adults' Access to Preventive/Ambulatory Health Services (Total)	**58,032**	**66,409**	**87.39%**	247,542	275,647	89.80%	82.03%
ADV	Annual Dental Visit (ADV) 2-3 YEARS	992	5,069	19.57%	8,444	25,413	33.23%	35.58%
	Annual Dental Visit (ADV) 4-6 YEARS	3,287	8,180	40.18%	23,651	38,970	60.69%	56.95%
	Annual Dental Visit (ADV) 7-10 YEARS	5,533	12,609	43.88%	33,237	51,264	64.83%	59.72%
	Annual Dental Visit (ADV) 11-14 YEARS	5,278	12,611	41.85%	27,179	44,452	61.14%	54.80%
	Annual Dental Visit (ADV) 15-18 YEARS	4,070	10,758	37.83%	19,515	37,331	52.28%	46.84%
	Annual Dental Visit (ADV) 19-21 YEARS	1,359	4,168	32.61%	6,826	17,469	39.07%	31.95%
	Annual Dental Visit (ADV) (Total)	**20,519**	**53,395**	**38.43%**	**118,852**	**214,899**	**55.31%**	48.74%
AMM	Antidepressant Medication Management - Effective Acute Phase Treatment	938	1,917	48.93%	5,347	10,583	50.52%	52.25%
	Antidepressant Medication Management - Effective Continuation Phase Treatment	652	1,917	34.01%	3,873	10,583	36.60%	36.99%
BCS	Breast Cancer Screening - Total	6,592	10,598	62.20%	14,176	23,832	59.48%	58.76%
CAP	Children and Adolescents' Access To PCP (12-24 Months)	2,024	2,465	82.11%	17,972	18,442	97.45%	95.50%
	Children and Adolescents' Access To PCP (25 Months - 6 years)	9,977	13,011	76.68%	57,521	63,210	91.00%	87.78%
	Children and Adolescents' Access To PCP (7-11 Yrs)	9,218	10,599	86.97%	31,722	34,142	92.91%	90.95%
	Children and Adolescents' Access To PCP (12-19 Years)	14,188	16,106	88.09%	39,781	42,970	92.58%	89.32%
	Children and Adolescents' Access To PCP (Total)	**35,407**	**42,181**	**83.94%**	**146,996**	**158,764**	**92.59%**	NR
FUH	Follow Up After Hospitalization For Mental Illness - 7 days (Total)	1,277	5,777	22.10%	1,787	7,209	24.79%	43.95%
	Follow Up After Hospitalization For Mental Illness - 30 days (Total)	2,585	5,777	44.75%	3,315	7,209	45.98%	63.09%
IET	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs)	117	491	23.83%	195	1,149	16.97%	15.74%
	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (18+ Yrs)	1,145	8,772	13.05%	2,588	23,517	11.00%	10.75%
	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (Total)	**1,262**	**9,263**	**13.62%**	**2,783**	**24,666**	**11.28%**	11.24%
IET	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation (13-17 Yrs)	274	491	55.80%	488	1,149	42.47%	41.35%
	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation (18+ Yrs)	3,966	8,772	45.21%	8,442	23,517	35.90%	38.01%
	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation (Total)	**4,240**	**9,263**	**45.77%**	**8,930**	**24,666**	**36.20%**	38.25%

Data Source: *(**Data sources**: HEDIS RY 2015 MN-DHS Administrative data from MMIS data warehouse database, NCQA's Quality Compass HEDIS RY 2015 National and State Benchmarks)*

APPENDIX D

Access Monitoring Review Plan

Public Comments and Department Responses

Public Comment: In the future will there be the ability to add more detail and more services or are we locked into specific services or codes? When rates change for services other than those included in the plan does that trigger their inclusion in the plan?

Department Response: The final rule requires the Department to evaluate any instance where a proposed rate change may affect access to services. If the Legislature reduces or restructures rates in such a way, for a service that was not included in the initial data, the Access Monitoring Review Plan will be expanded to address the affected service.

Public Comment: We are disappointed that PMAPs are not included since so many people with mental illnesses are on PMAP plans. We are also hearing from many providers that they are being paid below the Medicaid rate through PMAPs which is significantly negatively effecting them and making it difficult to hire more professionals to increase access. Knowing the long waiting times for virtually any mental health service we find it disturbing that 24% of providers had not seen anyone in a year.

Department Response: The federal regulation, at 42 C.F.R. §447.203 governing the Access Monitoring Review Plan, limits the review to those services provided through fee-for-service. A different set of federal regulations, at 42 C.F.R. Part 438, require a separate quality reporting mechanism for Medicaid managed care plans.

We understand the commenter's concern regarding the number of providers who did not see patients during the year, but also note that the reasons for this figure extend beyond the willingness of providers to treat Medicaid patients. For example, some providers have retired and others took a leave of absence during the year upon which the data was derived. We continue to review the data to determine the reasons and whether there are additional steps the Department can take to ensure fee-for-service enrollees have access to mental health services.

Public Comment: A commenter noted she is unable to find a psychiatrist to treat her son because he receives medical cannabis.

Department Response: We share your concern regarding your inability to find psychiatric care for your son. However, this issue is better addressed by contacting the recipient helpdesk who can assist in locating a psychiatric provider for your son.

Public Comment: For all of the five areas addressed in the plan, data for people with disabilities should be disaggregated as we believe individuals with disabilities have a much more difficult time finding, accessing and utilizing services. Additionally, many providers may not be familiar with and knowledgeable about the unique needs of people with disabilities.

Department Response: We appreciate the feedback and agree that there is value to separately examining this population. Due to the time constraints under which the report was prepared, we did not have the ability to examine recipient populations in such detail, but intend to do so in future versions of this report.

Public Comment: Are the providers who are available accessible for people with disabilities, mobility issues, etc.? This could also be an important component of seeing how services are provided.

Department Response: We appreciate the feedback. Prior to submitting a future version of this report, we will determine the significance of this issue, and how it could be included in the report.

Public Comment: What is the basis for the Department's definition of home health services?

Department Response: The CMS explanation of the final rule indicates that states should use the definition of home health found in 42 C.F.R. § 440.70 for purposes of the access review.

Public Comment: We received multiple comments regarding the provider enrollment process, provider qualifications, and service limitations.

Department Response: We appreciate the feedback, but these issues are outside the scope of the Access Monitoring Review Plan. We have forwarded the comments to the appropriate Department staff for consideration.

Public Comment: We received multiple comments expressing concern over the Department's decision to divide Minnesota's counties into the two categories of Metro and Non-Metro. Commenters expressed concern that such a division may skew the data related to provider availability because of the large numbers of providers in areas such as Duluth and Rochester. Commenters specifically questioned how this would affect reporting of access to dental services.

Department Response: We agree that the geographic divisions do not fully describe all of the unique access issues Medicaid recipients experience. We do, however, believe this report creates a sufficient baseline to begin analyzing the ability of Medicaid recipients to access services. Due to the time constraints under which the report was prepared, we did not have the ability to further delineate geographic regions for this report. Prior to submitting a future version of this report, we will determine whether and how to further divide the Medicaid population and available dental providers into additional geographic categories beyond metro and non-metro.

Public Comment: I have a Traumatic Brain Injury as a result of a motor vehicle collision. I receive home care through a Home and Community Based Services waiver. I am aware that CMS has established a new HCBS rule focused on person-centered planning. This has not been my experience.

I recently discontinued my home health aide services because of the inconsistent quality and delivery of services. Despite repeated requests, by me and by my county case manager, the schedule for visits was changed frequently. Even when the printed schedule did not change, the caregiver often showed up at random times. This confused and frustrated me. In addition, I was frequently confused by the way services were reported. The aide was required to use my personal phone to clock in, clock out, and record specific services delivered. I repeatedly heard her report performing services which she had not, in fact, performed.

Access to services is very important for people with disabilities. Unfortunately, just because services are available, or even provided, does not mean they are effective at meeting my needs.

Department Response: We share the commenter's concern about quality of care. The Department is committed to ensuring that people receive the highest quality care that meets their needs. We agree that the Access Monitoring Review Plan is only one component of a larger strategy to ensure access to services of appropriate quality. That strategy must include: methods to prevent fraud and abuse and to detect it when it does occur; appropriate performance and quality metrics to identify problems; provider participation standards that ensure that providers are qualified; as well as an active community of consumers and advocates who can help identify issues as they develop.

Public Comment: Please clarify how dental is included in this report.

Department Response: Dental services are included as a component of primary care. The Department chose to analyze this component separately in order to better identify and understand the unique issues related to accessing dental services.

Public Comment: Based on the data and findings in the report, we are concerned about the following statement in the summary of the report: "*...it is difficult, at this time, for the state to make strong conclusions about the sufficiency of access to providers with respect to the services identified in this report. Therefore, based on the limited data available, there is no clear indication that the state does not meet the federal requirement of ensuring access that is comparable to that of the general population.*"

However, DHS does recognize "*the apparent differences and gaps present throughout this plan and other reports with respect to enrollee access to dental care as compared to other services in the MA program.*" We recommend that given the abundant empirical and qualitative evidence in Minnesota (some contained in your report), that DHS amend the statements in the report to elevate the lack of access to dental care for the state's MA population.

Again, according to the data in the report, fee-for-service MA enrollees are less likely to have a dental encounter when compared to MA enrollees in managed care. It should be noted that the dental access rate of the fee-for service MA population is not compared to the "general population," as required under section 1902(a)(30)(A) of the Social Security Act.

As this report represents a "baseline," FQHCs and other safety net dental providers are interested in partnering with DHS to improve these unacceptable dental access issues. While you correctly highlight the rates as part of the problem, other solutions regarding workforce and innovation will ensure that Minnesota's low-income population can access all needed services, including dental care.

Department Response: We appreciate the comment. The report specifically acknowledges that indicators of access to dental care are not as good as they are for other services. As noted in the previous dental reports produced by the Department, there are several factors, including rates, complex payment structures, administrative complexity, and workforce development barriers that contribute to the challenges of dental access. We look forward to working with our community partners to help us develop new policies and approaches that are designed to increase access to dental services for Medicaid enrollees.

Public Comment: For dental services, the Department compared payment rates to the State Employee Group Insurance Plan (SEGIP). Can the Department compare payment rates for the other service categories (i.e. primary care, specialist, pre- and post-natal obstetrics, behavioral health, and home health) to SEGIP as opposed to Medicare? This would provide a more consistent comparison across the service categories.

Department Response: In future versions of the Access Monitoring Review Plan, we plan to compare Medicaid payment rates to a wider variety of commercial and public payers.

Public Comment: I must take issue with the Department of Human Service's contention that there is no dental access problem in Minnesota. Over the past 50 years of pediatric practice, I have seen: 1) an increasing problem with lack of access to dental care for those children covered by Medicaid and MinnesotaCare; 2) an increase in use of the emergency department by those children for non-traumatic dental pathology (abscessed tooth), often with monthly visits for an "abscessed tooth"; and 3) an increase in ambulatory surgery for restorative care teeth. The cost to the Medicaid budget for those two types of visits is significant. It is essential that DHS openly recognize that the lack of access for comprehensive dental care is acute for children covered by Medicaid and MinnesotaCare.

Department Response: The report notes the gaps in dental access compared to other Medicaid services. This report uses data from calendar year 2014 to establish the baseline measures and does not take into account the efforts taken since 2014 to improve access. We also understand that additional efforts to address a series of issues are necessary to improve access.

Public Comment: We know the individuals with disabilities have a difficult time obtaining dental services in general. This is additionally compounded when they need specialized dental services including orthodontists. We know that people who require sedation for dental procedures have a difficult time finding a provider. Should that type of data be collected?

Department Response: We appreciate the feedback. Prior to submitting a future version of this report, we will determine the significance of this issue, and how it could be included in the report.

Public Comment: Lack of or inadequate transportation is often cited as a problem in obtaining services. Should the monitoring plan address this?

Department Response: We agree that transportation can play a role in a person’s ability to access services. We intend to look at this factor more closely in the next version of the report.

Public Comment: When the patient needs a dental crown my insurance pays some and we have to pay the rest.

Department Response: This comment is outside the scope of the Access Monitoring Review Plan. We do note that Medicaid payment is considered final payment, but some cost-sharing may be required.

Public Comment: Language: How do providers provide services to individuals whose primary language is not English? Lack of culturally competent providers may be an issue – especially when an individual has a disability.

Department Response: We agree that communication barriers can play a role in accessing needed medical services. Prior to submitting a future version of this report, we will determine the significance of this issue, and how it could be included in the report.