Minnesota Department of **Human Services**

February 13, 2012

Kathleen Sebelius, Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Long Term Care Realignment Section 1115 Waiver Request

Dear Secretary Sebelius:

I am pleased to present you with the first phase of a bipartisan Medicaid reform package that the 2011 Minnesota Legislature enacted and Governor Dayton signed. The reform package will include numerous projects to support the goals of achieving better health outcomes, increasing independence and community integration, reduced reliance on institutional care, and overall simplification and sustainability of the program.

This first request asks for federal authority to test reforms that promote more appropriate use of long-term care resources in the face of the challenges posed by an aging population and rising health care costs. Minnesota is a national leader in providing care to low-income people with long-term care needs. Minnesota has led many successful efforts to create viable community alternatives to institutional care, integrate coordination of care for dual eligible, and promote quality care.

Minnesota seeks to move its Medicaid program closer to a new equilibrium in which people with lower needs have their needs met with lower cost, lower intensity services. First, Minnesota proposes to modify its nursing facility level of care criteria to target services to those in greater need and manage utilization of high-cost services more effectively. In addition, Minnesota proposes to provide home and community-based services to people who do not otherwise qualify for home and community-based waiver programs but have some need for community support. The Alternative Care program provides an expansive home and community services benefit to people age 65 or older who need a nursing facility level of care but do not yet meet Medicaid financial eligibility requirements. Essential Community Services will provide a more modest package of home and community services to people who do not meet a nursing facility level of care but have been assessed to have some need for community support. Both programs provide valuable support to at-risk people to avert or delay the need for institutional care.

I invite you to review the enclosed proposal for thoughtful, incremental reform to Minnesota's Medicaid program. The second phase of this reform effort will include a larger request for waivers to be submitted in late April of this year. If you have any questions regarding this request, please contact my

Medicaid Director, David Godfrey, at (651) 431-2192. I look forward to working with you and your staff to continue to develop important health care reforms.

Sincerely,

Lucinda Jesson
Commissioner

cc: Cindy Mann, Deputy Administrator and Director, Center for Medicare & Medicaid Services
Verlon Johnson, Associate Regional Administrator, Center for Medicare & Medicaid Services

State of Minnesota

Long-Term Care Realignment Section 1115 Waiver Proposal

Submitted February 13, 2012

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Section One – Executive Summary

1.1. Introduction

Minnesota seeks federal authority to test reforms that promote appropriate use of long-term care resources in the face of challenges posed by an aging population and rising health care costs. Minnesota is a national leader in providing care to low-income people with long-term care needs. Minnesota has led many successful efforts to create viable community alternatives to institutional care, integrate coordination of care for dual eligibles, and promote quality care. Despite Minnesota's past successes, however Minnesota must continue to innovate to meet demographic and health care cost challenges. In an era of rising cost and caseload pressures, it is imperative that Minnesota distribute its long-term care program resources efficiently and fairly. To improve the efficiency, equitability, and accuracy of this process, Minnesota urgently needs to reform its nursing facility level of care standards. To help prevent institutionalization of vulnerable seniors, Minnesota also needs to continue to provide home and community-based supports to seniors with demonstrated long-term care needs who are just above Medicaid income and asset limits. By allowing Minnesota the latitude to make the key program modifications requested here and test whether such alterations would contribute to the sustainability of Medicaid long-term care services, CMS is investing in a demonstration that will promote key objectives of Title XIX by strategically targeting long-term care resources where they will have the most positive impact.

The maintenance of effort requirement treats all states as if they are starting from the same eligibility "baseline." It also elevates preserving eligibility for every individual who would have been eligible under 2010 standards above preserving payment rates or benefit levels. When states are confronted with the need to improve sustainability in the long term, the maintenance of effort requirement prevents those states with higher baseline eligibility standards, more generous methodologies, or a level of care assessment process that is more generous, from using all the tools available to them to target resources to those most in need.

The maintenance of effort requirement should be waived where necessary to ensure that states can continue to test innovations and improvements in long-term care. Nationwide, although people over age 65 and people with disabilities make up about one-quarter of Medicaid enrollees, they account for two-thirds of program spending. States that come forward with innovative proposals should not be limited to benefit and rate-cutting strategies and prevented from testing ideas that may benefit the program as a whole.[1]

[1] The choice between thoughtful reform and provider rate cuts is set out starkly here. If Minnesota fails to secure federal waiver authority to adopt a modified nursing facility level of

Not only does long-term care represent an overwhelming majority of the Medicaid expenses states must manage, but the effect of the longer maintenance of effort period for children may prevent states from testing thoughtful reforms until 2019. The maintenance of effort period is five years longer for children even though the institutional level of care standard must be the same for the entire population, and the type of budgeting methodology and the choice of the special income standard must be uniform throughout the waiver program. Many states, including Minnesota, have waiver programs that combine children and adults.

Minnesota's proposed demonstration project is not an attempt to step back from our commitment to providing needed supports and services that are needed to live safely in the community, and to provide nursing facility care to those who are most vulnerable. The proposed demonstration does, however, allow Minnesota to continue to evolve its long-term care system in a manner that creates the right incentives so that the program can be sustained over time.

Minnesota needs to move toward a program in which people with lower needs have their needs met with lower cost, lower intensity services. It is critical that we address the challenges posed by Minnesota's aging population by managing growth in public spending for long-term care. The proposed modifications to the nursing facility level of care criteria will help target services to those in greater need. Controlling entry to full long-term care services eligibility will assist Minnesota in ensuring that access to the more intensive, higher-cost services is reserved for those with higher needs.

Minnesota has been engaged in planning for this transition with community stakeholders since 2009 and has developed a number of strategies for managing the proposed changes with the least disruption to beneficiaries and applicants, including referral protocols for people seeking long-term care services who do not meet the revised nursing facility level of care criteria. For those whose Medical Assistance eligibility is affected by changes in level of care, there are other available routes to Medical Assistance coverage, including spending down to the medically needy standard. Minnesota also proposes to create a new program called Essential Community Supports to provide a modest package of home and community-based services to people who were receiving long term care services and lost eligibility for Medicaid payment of those services due to the implementation of the revised nursing facility level of care standard. Case managers will work with those who lose long term care services and assist with transition planning to state plan benefits, including personal care assistant and home health services, where appropriate.[2] The results of this program will inform Minnesota's efforts to determine what benefits might be

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care standard, the legislature has directed the state Medicaid agency to implement a 1.67 percent rate reduction for long-term care providers, excluding nursing facilities, from July 1, 2012 to December 31, 2013.

[2] Not all people who will lose access to Medicaid-funded long term care services will qualify for personal care assistant or home care services.

most effective under a Community First Choice approach under the authority of Section 1915(i) in the future.

1.2 Overview of Demonstration Proposal

Minnesota's current nursing facility level of care standards are generous and allow for Medicaid nursing facility payment or home and community-based waiver services for a person who needs ongoing or periodic assistance in just one activity of daily living, such as bathing.

Minnesota has also taken up the option to apply the special income standard to people aged 65 and older who seek home and community-based waiver services and would otherwise require the level of care furnished in a nursing facility. The practical effect of these generous policies is that the Elderly Waiver in particular includes a number of participants with relatively low needs and comparatively high incomes. To a lesser extent, there are also some people under age 65 with relatively low needs and comparatively high household incomes on other home and community-based waivers (such as Community Alternatives for Disabled Individuals) because qualifying for a nursing facility level of care allows a Medical Assistance applicant to qualify without regard for their spouse's income and assets. These enrollees have access to all waivered services, including high-intensity, high-cost services, despite the fact that their needs are relatively low and Minnesota's state plan services are generous.

Extending full acute and long-term care benefits to higher income, lower needs individuals has undoubtedly contributed to Minnesota's success in diverting premature entry into nursing facilities and balancing the system so that a significant proportion of Medicaid eligibles with long-term care needs are cared for in the community. Over time, however, it has become apparent that a more tailored approach is necessary. The proportion of seniors in the population is rising, and many seniors are living longer than ever before. The Medicaid safety net is also increasingly used by middle income families who were initially able to pay for their own long-term care services but have exhausted their resources over time.

In addition to these demographic shifts, a wide range of assisted living facilities and other supportive residential settings have become more popular and widely available in the marketplace in the decades since the implementation of Minnesota's Elderly Waiver. Housing costs and service charges in these settings are high. People with minimal care needs who choose to reside in supportive residential settings using their private resources are spending down their assets to Medicaid eligibility limits more quickly than in the past. As a result, forty-five percent of Elderly Waiver beneficiaries receiving Medicaid payment for this type of supportive living in Minnesota are at the two lowest levels of functional need for assistance with activities of daily living.

Medicaid payment for supportive services in residential settings such as assisted living should be reserved primarily for those individuals at higher levels of need. Minnesota needs to align incentives for consumers and providers to discourage Medicaid payment of the most intensive services for the lowest need individuals. Minnesota seeks federal authority to undertake targeted efforts aimed at encouraging more appropriate use of long-term care services by individuals with low long-term care needs before they transition into full Medicaid coverage.

The proposed adjustment to Minnesota's nursing facility level of care standards will likely result in a loss of Medicaid payment of long term care services for people with the lowest needs who are currently receiving long-term care services. Loss of eligibility for Medicaid payment of long term care services may also result in out of pocket costs in the form of a spend down or ineligibility for Medicaid due to the financial eligibility rules. Minnesota proposes to provide a limited benefit package of low-cost, high-impact home and community-based services called Essential Community Supports to this group to ease the transition away from Medicaid payment of all long term care services and to promote continued community living.

The proposed adjustment to Minnesota's nursing facility level of care standards will also likely result in delayed Medicaid eligibility for higher income, lower needs individuals aged 65 and older who have not yet applied for Medicaid coverage. Minnesota is committed, however, to supporting these individuals. Minnesota will provide a package of low-cost, high-impact home and community-based services called Essential Community Supports, to this group to promote continued community living. In addition, Minnesota will also offer a more robust package of services through the Alternative Care program to individuals who meet the nursing facility level of care standards and who reside at home but whose income and resources are above Medicaid categorical eligibility levels. These strategies, along with statewide implementation of long-term care options counseling for private pay individuals considering a move into supportive living and a concerted effort currently underway to identify and assist any individual residing in a nursing facility who wishes to return to the community, will help Minnesota distribute public long-term care resources in a manner designed to make best use of those resources and support living in the community.

In sum, Minnesota seeks federal authority for the following activities:

1) Minnesota proposes to modify its nursing facility level of care standard as described in Appendix I to allow entry to nursing facilities and the home and community-based waivers for individuals demonstrating one or more of the following characteristics: a high need for assistance in four or more activities of daily living (ADL); a high need for assistance in one ADL that requires 24-hour staff availability; a need for daily clinical monitoring; significant difficulty with cognition or behavior; qualifying nursing facility stay of 90 days; or living alone and risk factors are present. This replaces a standard that,

for example, allowed a determination of nursing facility level of care if an individual needs ongoing periodic assistance with any one activity of daily living.

2) Minnesota seeks authority for federal matching funds for the Alternative Care program. This program provides a range of home and community-based long-term care services for seniors who meet the nursing facility level of care criteria, and who have modest income and assets that are above Medicaid eligibility thresholds, and/or have insufficient medical expenses to "spend down" to Medicaid eligibility levels.[3] This program serves individuals whose combined income and assets would be insufficient to support 135 days of nursing facility care before they would spend down to Medicaid financial eligibility.

3) Minnesota seeks authority for federal matching funds for the Essential Community Supports program, a benefit of up to $400 per person per month, dependent upon assessed need.[4] This program will provide limited community-based long-term care services for two groups: a) seniors who do not meet the nursing facility level of care standard, who have modest income or assets above Medicaid eligibility thresholds, and/or who have insufficient medical expenses to "spend down" to Medicaid eligibility levels. Combined income and assets would be insufficient to support 135 days of nursing facility care before they would spend down to Medicaid. This program will also serve: b) people who were receiving long term care services prior to implementation of the revised nursing facility level of care standards and have lost eligibility for Medical Assistance payment of long term care services due to the implementation of the revised nursing facility level of care standard. Most members of this group will continue to be eligible for state plan benefits under Medical Assistance. Members of this group who have lost Medicaid eligibility must have combined income and assets that would be insufficient to support 135 days of nursing facility care before they would spend down to Medicaid financial eligibility. The evaluation of this component of the Essential Community Supports program will inform Minnesota's efforts to determine what benefits might best be made available through Section 1915(i) authority in the future to assist all Medicaid enrollees who do not meet the nursing facility level of care criteria but have an assessed need for supportive services.

[3] Alternative Care enrollment is limited by state appropriation. The program is expected to be fully funded.

[4] Essential Community Supports enrollment is limited by state appropriation. The program is expected to be fully funded.

Section Two – Background and History

2.1 Introduction

Minnesota ranked first nationally in delivering long-term care services for older adults and people with disabilities in a recent national report. AARP, The Commonwealth Fund and the SCAN Foundation concluded that Minnesota outperforms other states in long-term services and supports because of the state's work in providing viable community alternatives to institutional care, enhancing access, ensuring quality in the long-term care marketplace in the state, and in supporting family caregivers. See *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, released September 8, 2011 on the AARP website at http://www.longtermscorecard.org/?omnicid=20

Despite past successes, continuing reform is needed to ensure the viability of the state's public programs for our most vulnerable citizens. One of the greatest pressures on the growth of public long-term care spending in both nursing facilities and home and community-based services is the increase in the proportion of the population that is over 65 years of age. Beginning in 2011, the first wave of the generation, born between 1946 and 1964, begins to turn 65. For the next 30 years this cohort will dominate Minnesota's population growth. Between 2010 and 2020, the proportion of the population aged 65 and above will increase by 40%, while the under-65 population is forecast to increase by about 4%. A 2006 Harvard University study found that Minnesota ranks second among the states in terms of life expectancy at birth: 78.82 years (only behind Hawaii at 80.0). See page two of the *2010 Report to the Minnesota State Legislature on the Status of Long-Term Care in Minnesota* at http://www.dhs.state.mn.us/id_005728

Longer life expectancy in Minnesota, coupled with a small net in-migration of people aged 85+ returning to Minnesota after living their younger retirement years in another state, contribute to gradually increasing numbers and proportion of the "oldest old." An older society will be a permanent fixture of the state's demographic profile into the foreseeable future. See page two of the *2010 Report to the Minnesota State Legislature on the Status of Long-Term Care in Minnesota* at http://www.dhs.state.mn.us/id_005728

In addition to demographic challenges, Minnesota has experienced significant growth in enrollment and spending in home and community-based services in recent years. In the period 2001 to 2009, the overall number of people aged 65 and older served through the Elderly Waiver, Medical Assistance and the Alternative Care program has grown from 23,000 to more than 34,000, a 46% increase. During the same time period, the expenditures for home and community-based services have grown from $130 million to $346 million, a 166% increase.

During the same period, the Elderly Waiver program has expanded to 26,000 in 2009, more than double the 11,000 people served in 2001; and costs have increased more than 300%.[5] See pages 18-19 of the *2010 Report to the Minnesota State Legislature on the Status of Long-Term Care in Minnesota* at http://www.dhs.state.mn.us/id_005728.

In light of these demographic and health care cost challenges, it is imperative that Minnesota distribute its long-term care program resources efficiently and fairly.

2.2 Minnesota Eligibility Standards and Medicaid Benefit Package

Minnesota has five 1915(c) waivers for home and community-based services, three of which utilize the nursing facility level of care assessment. These are:

- The **Community Alternatives for Disabled Individuals (CADI) Waiver** serves people with disabilities who need the level of care provided in a nursing facility but choose to live in the community. 16,960 people were receiving CADI waiver services in September, 2011.
- The **Brain Injury (BI) Waiver** provides services to people with a brain injury who need neurobehavioral hospital or nursing facility level of care but choose to live in the community. 987 people were receiving BI waiver services due to a need for nursing facility level of care in September, 2011.
- **The Elderly Waiver** (EW) program provides services to people who are age 65 or older who need the level of care provided in a nursing facility but choose to live in the community. 22,831 people were receiving EW services in September, 2011.

Seniors with incomes at or below 100% of the federal poverty limit and assets of below $3,000 per person are categorically eligible for Medicaid in Minnesota. Minnesota also has a "medically needy" category, under which prospective enrollees may become eligible by incurring sufficient medical expenses to reduce their income to 75% of the federal poverty limit. The personal care assistant (PCA) benefit is a state plan benefit. This means that some MA enrollees who do not meet the nursing facility level of care standard can receive personal care services. The same is true for home health agency services, which is a mandatory Medicaid benefit.

Minnesota has opted to extend categorical eligibility to individuals age 65 or older who are institutionalized or seeking Elderly Waiver with incomes up to 300% of the Supplemental Security Income (SSI) benefit rate who meet the Minnesota Medicaid nursing facility level of

[5] While these figures have increased for the Elderly Waiver, Alternative Care and Medical Assistance home care programs, the number of older persons served and dollars expended for nursing facility care for the same target population have declined.

care criteria. In addition, people of all ages who meet the nursing facility level of care criteria may be evaluated for Medicaid financial eligibility as an individual and are exempt from evaluation of the income of other household members.[6]

2.3 Minnesota's Health Care Delivery System for Seniors and People with Disabilities

Minnesota's home and community-based waiver programs and income standards operate within a health care delivery system that has a history of innovation for dual eligibles and people with disabilities.

Minnesota's Medicaid-eligible seniors are required to enroll in managed care plans that coordinate both acute care and long-term care services. Minnesota created the first fully integrated Medicare-Medicaid dual eligible demonstration in1995. Medicaid seniors, including dual eligibles, are required to enroll in Minnesota Senior Health Options (MSHO) or Minnesota SeniorCare Plus (MSC+). MSHO serves 37,000 senior dual eligibles statewide through contracts with eight Medicare Advantage Special Needs Plans (SNPs) that have a history of commitment and experience in providing Medicaid services in Minnesota. Both MSHO and MSC+ include Medicaid coverage for primary, acute, mental health and long-term care, including all Elderly Waiver services. MSC+ is a Medicaid managed care program providing primary, acute and long-term care services. MSC+ is not integrated with Medicare. MSC+ serves about 11,500 seniors statewide.

People with disabilities from age 18 to age 64 may enroll in managed care under Special Needs BasicCare (SNBC). SNBC provides integrated primary, acute and behavioral health services including health care home benefits, to people with disabilities through six managed care organizations, five of which are also integrated Medicare/Medicaid SNPs. SNBC was designed especially for people with disabilities by a large stakeholders group which continues to meet quarterly to advise the State on managed care purchasing and delivery models for people with disabilities. In addition to most state plan services, SNBC includes all Medicaid mental health services including Mental Health Targeted Case Management MH-TCM). Thirty-eight percent of SNBC enrollees meet state criteria for serious mental illness; therefore SNBC has been a platform for a number of physical and behavioral service integration initiatives. SNBC is now available in 78 of Minnesota's 87 counties and will be expanding statewide.

Minnesota also has a state-funded program that provides home and community-based services to people age 65 and older of marginal financial means. Through this waiver proposal, the state

[6] Additional information about the interaction between nursing facility level of care and financial eligibility, including TEFRA, is included at Appendix X.

seeks federal funding support for the program. The Alternative Care program is designed to support elderly people in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for elderly people.

The Alternative Care program provides an array of home and community-based services (such as chore services, home delivered meals, respite care, companion services, and adult day care) to elderly Minnesotans who are not yet financially eligible for Medicaid, but who need nursing facility level of care and who would "spend down" to Medicaid within 135 days of admission to a nursing facility. The program currently serves about 3,200 people on average per month. Enrollees pay a monthly premium. Most are Medicare-eligible and receive prescription drug coverage pursuant to Medicare Part D. Many of the participants are also eligible for Medicaid payment of a portion of their Medicare premiums under Medicare Savings programs such as QMB, SLMB and QI1.

2.4 Minnesota's Current Health Care Reform Initiatives

Against this backdrop, Minnesota is in the midst of implementing a complex mix of health care delivery, payment and purchasing innovations as part of its overall health reform strategy. These innovations align directly with new goals and opportunities provided through the Affordable Care Act (ACA).

2.4. 1 Health Care Homes and Payment Reform

Minnesota is in the midst of implementation of an all payer Health Care Home program designed to encourage provider accountability for a broad range of performance outcomes. CMS approved the addition of care coordination under Health Care Home to Minnesota's state plan in July of 2010. The benefit is available under both managed care and fee-for-service delivery systems. We expect that one in six primary care clinics will be certified by the end of 2011. Efforts are also underway to link Health Care Home with local public health and social services resources to maximize efficiency.

Building on the State's Health Care Home program, Minnesota was approved to participate in the Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), which will provide Medicare payment for Medicare beneficiaries including some dual eligibles served under fee for service. In addition, Minnesota is currently evaluating proposals for the Health Care Delivery System Demonstration, which will test payment methodologies for accountable care organizations, thereby providing additional incentives to utilize the health care home models efficiently.

2.4.2 Duals Demonstration

Minnesota is actively engaged in working with the Center for Medicare and Medicaid Innovation and the Coordinated Health Care Office to improve care for dual eligibles. Minnesota is participating in the State Demonstration to Integrate Care for Dually Eligible Individuals. Minnesota's proposal seeks to take existing primary care and care coordination models to a new level of consistency and performance, advance provider level payment reforms, stabilize the Special Needs Plan platform, develop linked Medicare and Medicaid data bases, and develop sophisticated cross system sub-population performance metrics and risk sharing models for use across all service delivery systems.

2.4.3 MnCHOICES

The Minnesota Department of Human Services (DHS), in collaboration with stakeholders, is developing a new web-based application referred to as MnCHOICES. This new assessment process and data collection application was developed to improve tribal and county agencies' and managed care organizations' ability to consistently assess individuals, and develop appropriate care plans, including community support plans. Improved data collection will help managed care, county and tribal agencies and DHS to monitor programs, evaluate service outcomes, and better evaluate the impact of policy and program changes on public spending and service outcomes. This initiative includes:

- Adoption of a developed software application for intake, assessment, care planning, and program monitoring and evaluation
- Statewide assessor training and certification
- Protocols and standards for ensuring reliable and consistent application of level of care criteria, program and service eligibility, and care planning and service authorization requests.

The MnCHOICES comprehensive assessment work process and software will allow Minnesota to move from paper documentation of assessments, care planning, and the determination of level of care to a single electronic format, which will help to ensure that assessments are complete, that care plans reflect appropriate services, and that professional determinations are supported by assessment information. This change will also allow Minnesota to more fully incorporate assessment, care planning, and level of care information into our Medicaid Management Information System (MMIS).

The expectation that the assessment is documented and that the determination of level of care is supported by the information contained in assessment is not new. It is reflected in Minnesota's practice of auditing the paper forms used to document level of care

determinations during case file reviews. These audits are completed as part of the quality review process in the home and community–based waiver programs. For example, DHS reviews a random sample of case files for audit during the state reviews of county and tribal administration of waiver programs. Similarly, the case files of managed care enrollees are randomly selected and audited as part of the waiver quality review process. The change to the electronic format in the assessment, care planning, and level of care determination process will allow this audit function to be standardized and automated, and will allow the review of all cases rather than a sample of cases under both fee-for-service and managed care. Assessments and development of care plans will continue to be conducted face-to-face with applicants and enrollees.

2.4.4 Return to Community

A new initiative known as Return to Community (RTC) was implemented in Minnesota in April of 2010. Supported by the Centers for Medicare & Medicaid Services and the Administration on Aging, the Return to Community Initiative targets private pay individuals who have been in a nursing facility for less than 90 days, expressed a desire to return home and/or have support in the community to assist with returning home. The program provides in-person long-term care options counseling for consumers who are not covered by Medicaid. Consumers who are directly assisted by Senior LinkAgeLine® Community Living Specialists receive an in-person visit within 72 hours of discharge from the nursing facility. Additional follow-up occurs over the phone at 14, 30 and 60 days and then quarterly for up to five years. Those who return to the community without direct assistance from a Community Living Specialist have the option to receive a check-in call every 90 days for five years to ensure successful living in the community. The program has two general approaches: 1) providing intervention through a formal transition program targeted to nursing facility residents who have expressed a desire to return to the community. The intervention involves assessment, care planning, service coordination, placement and ongoing monitoring of care in the community; and 2) providing interventions that motivate and support nursing facility providers to facilitate discharge to the community through their own efforts or in cooperation with formal transition programs. The support provided will assist nursing facility providers in meeting the CMS requirements for MDS 3.0 to plan and make referrals to a designated local contact agency to assist residents indicating a desire to return to the community.

All Minnesota nursing facilities have received joint letters from DHS and the Minnesota Board on Aging about the Return to Community initiative, instructions about how to inform their patients of the initiative, and a supply of brochures. Since the inception of the program, over 410 individuals have received in person long-term care options counseling from a Community Living Specialist. Of these, 251 have been discharged to the community after direct assistance from a Community Living Specialist. The program

is providing telephone follow-up calls for 900 individuals, who may have returned with help from a Community Living Specialist, families, nursing facility social worker, case worker or managed care coordinator.

2.4.5 Money Follows the Person

On February 22, 2011, the U.S. Department of Health and Human Services announced awards to thirteen states to receive Money Follows the Person Demonstration Program Grants. Additional funding is available from 2011 to 2016 under the Affordable Care Act. Minnesota is one of the states awarded grants in 2011 and joins 29 other states and the District of Columbia already operating MFP programs. Minnesota will receive an award of up to $187.4 million in federal funds over five years to improve community services and support people in their homes rather than institutions. First-year funding for Minnesota is $13.4 million. Participation in this program will help DHS to provide more individualized care for some of Minnesota's most vulnerable residents and continue to rebalance its long-term care system away from dependence on institutional care.

The goals of the MFP demonstration include:

- Simplify and improve the effectiveness of transition services that help people return to their homes after hospitalization or nursing facility stays.
- Advance promising practices to better serve individuals with complex needs in the community
- Increase stability of individuals in the community by strengthening connections among health care, community support, employment and housing systems

2.4.6 Future Reform Initiatives

The 2011 Minnesota Legislature directed DHS to reform components of the Medical Assistance program for seniors and people with disabilities or other complex needs, and Medical Assistance enrollees in general, in order to achieve better outcomes, such as:

- community integration and independence;
- improved health;
- reduced reliance on institutional care;
- maintaining or obtaining employment and housing; and
- long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs.

DHS is exploring a number of options to achieve these outcomes, including:

- health care delivery demonstration projects to utilize accountable care organization payment principles;
- promotion of personal responsibility for healthy behaviors and selection of high quality, low-cost providers;
- methods to empower and encourage work, housing and independence for adults with disabling conditions who are not yet certified as disabled;
- realignment of existing funding, services and supports for people with disabilities and older people to ensure community integration and a more sustainable service system;
- expansion of long-term supports to allow seniors to remain in their homes and communities
- examination of care transitions from acute care to community care to prevent hospitalizations and nursing facility placement;
- improved integration of Medicare and Medicaid; and
- provision of enhanced services for individuals with serious mental illness and other complex needs.

These future reform efforts are more fully described in a recent DHS report to the legislature, a copy of which is on the DHS public website at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6484-ENG

Reliable and consistent application of the nursing facility level of care eligibility threshold is critical to the success of the reform efforts described herein and to the long-term sustainability of Minnesota's Medicaid program. By supporting Minnesota's proposed modifications to the nursing facility level of care criteria, CMS will support successful implementation of Minnesota's myriad efforts to reform and improve the delivery of care.

Section Three – Demonstration Design and Overview

3. 1 Demonstration Components and Populations

Minnesota seeks federal authority for the following activities:

1) Minnesota proposes to modify its nursing facility level of care (NF LOC) as set out at Appendix I and to require that a person must demonstrate one or more of the following:
   - a high need for assistance in four or more activities of daily living (ADL); or
   - a high need for assistance in one ADL that requires 24-hour staff availability; or
   - a need for daily clinical monitoring; or
   - significant difficulty with cognition or behavior; or
   - the person lives alone and risk factors are present.

This replaces a standard that allowed a determination of nursing facility level of care if an individual needs ongoing periodic assistance with any one activity of daily living. The determination will be linked to standard items contained within the state Long-Term Care Consultation assessment and the Minimum Data Set (MDS). The new criteria greatly simplify the level of care decision and more precisely define the needs that must be present to meet the nursing facility level of care criteria. The goal of this reform is to increase program stability by ensuring that higher intensity, higher cost services are used when necessary, and relying on high impact, lower cost services for people with lower needs and fewer dependencies.

2) Minnesota seeks authority for federal matching funds for costs not otherwise matchable for expenditures of the Alternative Care program. This program provides a range of long-term care services for seniors who meet the nursing facility level of care standard, who live in their own home, have combined income and assets that are above Medicaid eligibility thresholds, and do not utilize medical expenses to "spend down" to Medicaid eligibility levels. This program includes most services available under the Elderly Waiver except for residential-based services like customized living or foster care. Beneficiaries covered under this program are not eligible for full Medicaid state plan benefits. Most are Medicare-eligible and receive prescription drug coverage pursuant to Medicare Part D. Many of the enrollees are also eligible for Medicaid payment of a portion of their Medicare premiums under Medicare Savings programs such as QMB, SLMB and QI1. Enrollees must pay a monthly fee based on income and assets to participate. To be eligible, a person's income and assets must be inadequate to fund a nursing facility stay for more than 135 days. The goal of this reform is to support seniors who require nursing facility level of care and who have incomes just above Medicaid eligibility levels with a comprehensive set of home and community-based services in order to promote living at home longer. Connecting higher income, high needs seniors with community services earlier will divert seniors from nursing facilities and encourage more efficient use of services once full Medicaid eligibility is established.

3) Minnesota seeks authority for federal matching funds for costs not otherwise matchable for expenditures of the Essential Community Supports program. This program will provide limited community long-term care services for seniors who do not meet the nursing facility level of care standard but have been assessed as in need of services provided under the program, have income or assets above Medicaid eligibility thresholds, and have insufficient medical expenses to "spend down" to Medicaid eligibility levels. Beneficiaries covered under this program are not eligible for full Medicaid state plan benefits. The four covered services are low-cost, high-impact services that are currently most often included in waiver planning for individuals with lower needs. To be eligible, a person's income and assets must be inadequate to fund a nursing facility stay for more than 135 days. Most are Medicare-eligible and receive prescription drug coverage

pursuant to Medicare Part D. Many are also eligible for Medicaid payment of a portion of their Medicare premiums under Medicare Savings programs such as QMB, SLMB and QI1. Enrollees pay no monthly fee to participate. The goal of this reform is to support seniors who do not yet meet nursing facility level of care criteria and who have incomes and/or resources just above Medicaid eligibility levels with a low cost, high-impact set of home and community-based services to promote living at home longer. Providing accurate information about level of care needs and supportive services now will encourage more efficient use of services once full Medicaid eligibility is established. This program will also serve people of any age who were receiving long-term care services and lost eligibility for Medical Assistance payment of long-term care services due to the implementation of the revised nursing facility level of care standard. This component of the Essential Community Supports program will inform Minnesota's efforts to determine what benefits might best be made available through Community First Choice under the authority of Section 1915(i) authority in the future.

The Demonstration includes the following population groups:

Eligibility Group	Description	Authority Requested	Note
MA Ineligible Seniors who do not meet revised nursing facility level of care (NF LOC) and do not meet income and asset test for categorical eligibility for Medical Assistance without eligibility rules applicable to those who meet NF LOC	Adults age 65 or over with incomes above 100% FPL and at or below SIS[7] and/or seniors who required application of anti-impoverishment rules to meet Medicaid financial eligibility standards and who would have met pre-waiver NF LOC but do not meet revised NF LOC	Waiver of MOE and authority to match ECS expenditures	Community seniors who do not meet NF LOC may not utilize SIS income standard. May be eligible for MA with a spend down. If not eligible for MA, may receive Essential Community Supports.
MA Ineligible disabled adults under age 65 who do not meet revised nursing facility level of care (NF LOC) and do not meet income and asset test for categorical eligibility for Medical	MOE waiver is needed for adults under age 65 residing in the community with incomes above 100% FPL and who would have met pre - waiver NF LOC standards but do not meet revised NF LOC, reside with spouse who does not	Waiver of MOE and authority to match ECS expenditures	Disabled adults who do not meet NF LOC may not use spousal deeming exception. May be eligible for MA with a spend down, MA for Employed Persons with Disabilities, or

[7] SIS refers to the special income standard, or up to 300% of the Supplemental Security Income (SSI) benefit rate.

Eligibility Group	Description	Authority Requested	Note
Assistance without ability to use exception from deeming of spousal income	receive LTC services, and would have met Medicaid financial eligibility requirements if spousal income was not deemed.		MinnesotaCare.
MA Ineligible children who do not meet revised nursing facility level of care (NF LOC) and do not meet income and asset test for categorical eligibility for Medical Assistance without ability to use exception from deeming of parental income	No children are expected to lose Medical Assistance eligibility due to the revised nursing facility level of care. Parents' income is not deemed to disabled children ages 18 to 21. Hypothetically, there could be children under age 18 who are certified disabled and would have met pre-waiver NF LOC but do not meet revised NF LOC and would have met Medicaid financial eligibility requirements under a disabled basis or under TEFRA but do not meet once parental income and assets are deemed.	Waiver of MOE and authority to match ECS expenditures	Disabled children under 18 who do not meet NF LOC may not use parental deeming exception. May be eligible for MA with a spend down, MA under child basis of eligibility (150% FPG), MinnesotaCare (275% FPG)
MA Eligible Transition Group	People of any age residing in the community who are eligible for MA, received Medicaid long term care benefits prior to implementation of the demonstration and no longer meet revised NF LOC criteria e	Authority to match ECS expenditures	May receive Essential Community Supports. May also qualify for Medicare Savings Program i.e. QMB, SLMB, QI1.
Alternative Care seniors	Adults age 65 or over residing in the community who are not eligible for MA, do meet revised NF LOC, and have inadequate income and resources for 135 days NF care	Authority to match Alternative Care expenditures	May receive Alternative Care services. May also qualify for Medicare Savings Program i.e. QMB, SLMB, QI1.

3. 2 Nursing Facility Level of Care Criteria

Nursing facility level of care criteria are used to determine whether a person is at risk of institutionalization. Nursing facility level of care status affects eligibility for Medical Assistance payment for nursing facility services and home and community-based service (HCBS) waivers that provide alternatives to nursing facility services.[8] Minnesota's home and community-based service programs that provide alternatives to nursing facility services are the Elderly Waiver (EW), the Community Alternatives for Disabled Individuals (CADI) waiver and the Brain Injury-Nursing Facility (BI-NF) waiver programs. Waiver enrollees must meet nursing facility level of care criteria at application to be eligible for waiver services, and must continue to meet nursing facility level of criteria at annual reassessment.

For purposes of Medical Assistance payment of long-term care services under the modified nursing facility level of care criteria, a recipient must meet *one* of the following proposed nursing facility level of care criteria. This determination may be made using either the Minimum Data Set assessment or a face-to-face Long-Term Care Consultation assessment:[9]

- The person requires clinical monitoring[10] at least once per day. Monitoring can be delegated as appropriate; OR
- The person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of daily living: bathing, dressing, eating, grooming, and walking (4 ADLs); OR
- The person needs the assistance of another person or constant supervision to begin and complete toileting *or* transferring *or* positioning, and the assistance cannot be scheduled (1 "critical" ADL); OR

[8] Additional eligibility requirements for Medical Assistance payments of nursing facility and HCBS waiver services include meeting income and asset requirements, meeting asset transfer requirements; meeting the home equity limit; and naming the state the beneficiary of certain annuities.

[9] For those with the lowest needs, an LTCC face-to-face assessment may be more appropriate.

[10] The term "clinical monitoring" is described on DHS Form 3428B which has not changed for more than ten years, and the revised nursing facility level of care criteria use the same definition. There is no defined list of conditions or treatments related to clinical monitoring for purposes of nursing facility level of care, and DHS believes that attempting to create such a list at this time would unnecessarily restrict the ability of long term care assessors to exercise professional judgment. In order to meet this criteria, clinical monitoring must be based on a plan that meets the requirements for clinical monitoring outlined on DHS Form 3428 (a form that has been published since 1996). What has changed is the new standard is that clinical monitoring must be needed at least once every 24 hours if a person wants to qualify for nursing facility level of care and does not have qualifying functional, cognitive/behavioral, or frailty/vulnerability needs.

- The person has significant difficulty with memory[11], using information, daily decision making, or behavioral needs that require at least occasional staff intervention[12]: OR
- The person is determined to be at risk for nursing facility admission or readmission because the person currently lives alone or will live alone upon discharge and also meets one of the following criteria:
    - the person has experienced a fall resulting in a fracture;
    - the person has been determined to be at risk of maltreatment, exploitation, or neglect, *including self-neglect*; or
    - the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

These criteria provide access to long-term care services for individuals who may be able to complete most of their own personal cares, and have no

[11] Commenters requested additional clarification of what was meant by "Significant difficulty with memory." Cognitive needs are captured in any one of three ways in the current assessment tool, DHS Form 3428. The Mental Status Exam (MSE) on page 20 of DHS Form 3428 is a validated dementia screen that has been part of the assessment tool for many years. A score of 10 or greater on this exam (indicating the possible presence of dementia) meets level of care criteria. "Self-preservation" on page 21 of DHS Form 3428 is an item that considers how well the individual can avoid harm (doesn't leave the stove on, e.g.), recognize and appropriately respond to risks in the environment (understands fire is an immediate risk, can get help in an emergency, e.g.). An individual who is assessed as either mentally and/or physically unable to recognize, make appropriate decisions, and take action in a changing environment and/or potentially harmful situation meets level of care. "Orientation" on pages 17 and 20 of the current DHS Form 3428 is also assessed, defined as the awareness of an individual to his or present environment in relation to time, place and person. A person that has partial or intermittent periods of disorientation will meet the revised level of care criteria due to significant difficulty with memory.

[12] Commenters requested additional clarification of what behavioral needs would allow a person to meet the revised level of care. The threshold for the revised level of care criteria related to behavioral needs is the need for "occasional staff intervention." This can include intervention to maintain reductions in behaviors as well as interventions needed in response to behavioral events. "Occasional" is defined as occurring less than four times per week. Like clinical monitoring, however, this intervention needs to be based on appropriate assessment of the behavior(s), a plan for intervention developed by appropriate professionals, staff training in delivering and monitoring of the effectiveness of the intervention, and so on. For example, several commenters expressed concern about the potential impact on individuals with mental illness, in particular those individuals who have less need for behavioral interventions because their current services have contributed to a reduction in those behaviors. The revised criteria account for risk based on the potential for self-neglect and risk based on the need for occasional intervention to address behavioral needs, which can include supports delivered to maintain reductions in behaviors.

cognitive, behavioral or clinical monitoring needs, but have a need for assistance in instrumental activities of daily living such as homemaking, or transportation, or need environmental adaptions to remain safely in their home; OR

- The person has had a qualifying nursing facility stay of at least 90 days prior to implementation of the revised nursing facility level of care criteria; OR
- The person meets one of the nursing facility level of care criteria described above at admission to a nursing facility and continues to meet at least one criteria at 90 days after admission or on the first quarterly MDS assessment after admission, whichever is later (this is considered a "qualifying nursing facility stay" for ongoing payment of nursing facility services).

Below are case examples of individuals and a discussion of how the nursing facility level of care criteria would apply:

- A person who has up to three ADL dependencies would not meet level of care if they had no dependency in toileting, positioning, or transferring, no cognitive or behavioral needs, and no need for clinical monitoring. This person does not live alone and has not experienced a fall resulting in a fracture, or been determined to be at risk of maltreatment, exploitation or neglect, including self-neglect. In addition, this person does not have any sensory impairment that substantially impacts functional ability and maintenance of a community residence.
- A person with no ADL dependencies would meet the revised nursing facility level of care criteria if the person lives alone and has experienced a fall resulting in a fracture, or has sensory impairment that affects maintenance of community residence.
- A person with one ADL dependency and the need for occasional staff intervention to meet cognitive or behavioral needs would therefore meet the revised nursing facility level of care criteria.
- A person who needs the assistance of another person or constant supervision to complete four activities of daily living (bathing, dressing, eating, and grooming) would meet the revised nursing facility level of care criteria even if they did not live alone, were not at risk of maltreatment or neglect and had no other risk factors such as requiring daily clinical monitoring.

Please refer to Appendix I for a table comparing the current nursing facility level of care criteria and the proposed nursing facility level of care criteria. Copies of DHS Forms 3428, 3428B and 3428C are at Appendix II.

3. 3 Increasing Access to Long-Term Care Services at Home

3.3.1 Introduction

The proposed change to the nursing facility level of care criteria will impact eligibility for Medicaid for some applicants. Most individuals who do not meet the revised nursing facility level of care will lose Medical Assistance payment for nursing facility care and home and community-based waiver services, but will retain eligibility for Medical Assistance coverage. For this group, Minnesota's Medical Assistance state plan benefits can accommodate some of the lower needs for assistance with activities with daily living found in this group. The personal care assistant or PCA benefit is a state plan benefit, as are rehabilitation and home health services. People in need of these services do not have to meet the nursing facility level of care criteria to receive these benefits. Individuals who do not meet the revised nursing facility level of care criteria and who have incomes and/or assets above aged or disabled categorical eligibility limits will lose the opportunity to qualify for Medicaid under the Special Income Standard and/or special deeming rules. These individuals may meet Minnesota's medically needy standard, which allows applicants to demonstrate eligibility by incurring sufficient medical expenses to reduce their income to 75% of the federal poverty level.

For seniors who will not qualify for Medical Assistance by spending down but have an assessed need for one or more of the services provided through the program, Minnesota will provide a set of supportive services called "Essential Community Supports." This program will provide supports for seniors living at home with modest combined income and assets who cannot meet Medicaid financial eligibility thresholds but whose income and assets are insufficient to pay for 135 days of nursing facility care. By making this package of services available, Minnesota will mitigate the effect of the change to the nursing facility level of care criteria and continue its tradition of supporting seniors who are likely to qualify for Medicaid at a point when their long-term care needs are relatively lower and they have limited resources available in order to help them stay in the community. Minnesota also seeks federal financial support for the home and community-based services funded under the Alternative Care program, which is for seniors at the same income levels but who do meet nursing facility level of care. The purpose of these programs is to prevent or delay the need for costly nursing facility care by providing supports at home. Investment in the Essential Community Supports and Alternative Care programs will assist Minnesota and CMS in stabilizing the escalating cost of meeting the long-term care needs of the low-income elderly in cost-effective and preferred community settings.

3.3.2 Alternative Care

The Alternative Care or AC program is a state-funded program that provides home and community-based services to seniors who meet nursing facility level of care but who have income or assets above the MA standards. Through this waiver proposal, Minnesota seeks federal matching funds to support this program. The purpose of the Alternative Care program is to avert or delay the need for Medicaid enrollment and costly nursing facility care for people age 65 or older of marginal financial means who meet the nursing facility level of care criteria. The program provides supports at home and does not require participants to spend down their income and assets to qualify. Alternative Care services are not provided in a congregate setting.

This program is designed to help elderly people to remain in the community as independently and as long as possible and to support informal caregivers. Because this program is focused on a group with a higher need for long-term care services, the Alternative Care program provides an array of home and community-based services (such as chore services, home delivered meals, respite care, companion services, and adult day care) to elderly Minnesotans who are not yet financially eligible for Medicaid, but who need nursing facility level of care.

Enrollees use their own resources and insurance to pay for other health care services such as hospital and physician care. They are also responsible for a monthly premium. Most are Medicare-eligible and receive prescription drug coverage pursuant to Medicare Part D. Many are also eligible for and access Medicare savings programs. Alternative Care is administered by counties and tribal health agencies.

Covered services include:

- Adult day service/ adult day service bath
- Caregiver training and education
- Case management and Conversion case management
- Chore services
- Companion services
- Consumer-directed community supports
- Home health aides
- Home-delivered meals
- Homemaker services
- Environmental accessibility adaptations
- Nutrition services
- Personal care
- Respite care
- Skilled nursing

- Specialized equipment and supplies
- Transportation

A person age 65 or older is eligible for Alternative Care or AC when the following criteria are met:

- The person meets the nursing facility level of care;
- The person is ineligible for Medicaid due to excess income or assets[13];
- The person's income and assets would be inadequate to fund a nursing facility stay for more than 135 days[14];
- The monthly cost of AC services must be less that 75 percent of the funding limits for Elderly Waiver participants with a comparable case mix classification;
- The person chooses to receive home and community-based services instead of nursing facility services;
- The person pays the assessed monthly fee; and
- No other funding source is available for the community-based services (i.e. long-term care insurance).

In state fiscal year 2011 the AC program served 4,504 people and spent a total of $28.6 million. The average monthly cost per enrollee was $780, based on average monthly enrollment of 3,167. Without the AC Program, the probable alternative settings are Medicaid-certified skilled nursing facilities and certified board-and-care homes. The average cost of these alternative settings is $5,020 per person per month, less a resident contribution toward cost of care that is significantly more than the cost of the Alternative Care program. The Alternative Care program is a cost-effective alternative support for maintaining independence and living in the community.

[13] Clients can be served on Alternative Care for up to 60 days while applying for MA

[14] A person is considered financially eligible for Alternative Care if the combined adjusted income and assets are less than the projected nursing facility cost for 135 days, income is greater than 120% FPG, assets are greater than $3,000, and the client did not improperly dispose of assets. Net income and assets are determined by deducting out-of-pocket medical costs, including premiums, predictable medical expenses, unpaid medical bills and burial accounts valued up to $1,500. Rules designed to avoid spousal impoverishment apply. Nursing facility cost is based on the statewide weighted average nursing facility per diem.

3.3.3 Essential Community Supports

Essential Community Supports (ECS) is a new program that will provide services for people who do not meet the revised nursing facility level of care criteria but have an assessed need for one or more of the services provided under the program. Like the Alternative Care program, enrollees' income and assets must be inadequate to fund a nursing facility stay for more than 135 days, and Essential Community Supports services are not available in a congregate setting. Unlike Alternative Care, no monthly fee will be assessed, no age limit applies, and Medical Assistance eligibility does not preclude enrollment. This program will likely include, but will not be limited to, people who may have met the old nursing facility level of care standards. Services are limited to a value of $400 per person, per month. This program is not an entitlement. Total enrollment and expenditures are limited by the state appropriation. The program is designed to meet the needs of this group, while preserving access to the higher cost services for those with higher needs.

The purpose of the Essential Community Supports program is twofold:

1) To help people who must transition out of a Medical Assistance- funded long term care services program due to the implementation of the revised nursing facility level of care to remain in the community independently and as long as possible and to support informal caregivers.

2) To help avert or delay the need for Medicaid enrollment and costly nursing facility care for people age 65 or older who meet program eligibility requirements and have not previously received Medical Assistance funding for long term care services.

Essential Community Supports will be available to the following groups:

- **MA Eligible Transition Group** - People of any age who are financially eligible for Medical Assistance, have an assessed need for one or more of the services provided under the program, do not meet the revised nursing facility level of care criteria, and lost eligibility for Medical Assistance payment of long term care services due to the implementation of the revised nursing facility level of care criteria. To qualify, people must have received long term care services under Medical Assistance prior to the implementation date of the revised nursing facility level of care criteria.

- **MA Ineligible Transition Group** - People of any age who are financially ineligible for Medical Assistance, have an assessed need for one or more of the services provided under the program, do not meet the revised nursing facility level of care criteria, and meet the financial eligibility requirements of the Alternative Care Program. To qualify, people must have received long term care services under Medical Assistance on or immediately prior to the implementation date of the revised nursing facility level of care criteria and have lost eligibility for Medical Assistance payment of long term care services due to the implementation of the revised nursing facility level of care criteria.
- **MA Ineligible Seniors** - People age 65 and older who are financially ineligible for Medical Assistance, have an assessed need for one or more of the services provided under the program, do not meet the revised nursing facility level of care criteria, and meet the financial eligibility requirements of the Alternative Care Program. This group does not include people who received long term care services under Medical Assistance on or immediately prior to the implementation date of the revised nursing facility level of care criteria.

The benefits available under Essential Community Supports were designed by studying the utilization patterns of the lowest need individuals currently enrolled in the Elderly Waiver and CADI program who may not meet the revised nursing facility level of care criteria.[15] Community living assistance is a new service that has been added for the purpose of evaluation to inform Minnesota's efforts to determine what benefits might best be made available through Section 1915(i) authority in the future to assist all Medicaid enrollees who do not meet the nursing facility level of care criteria and need supportive services. ECS will provide service coordination plus one or more of the following services most needed to maintain independence in the community:

1. Service coordination
2. Personal emergency response system
3. Homemaker services
4. Chore services
5. Caregiver support and education
6. Home-delivered meals
7. Community living assistance[16]

[15] The data analysis is included at Appendix III.

[16] Community living assistance is a new service that would be developed for the first time under this demonstration to address needs such as assistance and support for basic living and social skills, household management, medication education and assistance, monitoring of overall well-being and problem-solving.

Services are limited to a value of $400 per month. Those people who were receiving long term care services prior to implementation of the revised nursing facility level of care standards and have lost eligibility for Medical Assistance payment of long term care services due to the implementation of the revised nursing facility level of care standard will receive some care coordination to assist in transitioning out of Medicaid long-term care and into ECS. Service coordination efforts will include assisting participants to access ECS services, as well as other available community supports.

3.4 Transitioning to the Revised Nursing Facility Level of Care criteria

3.4.1 The Revised Criteria Will Be Applied to Waiver Participants at Reassessment

There are three home and community-based waiver programs in Minnesota that utilize the nursing facility level of care determination (Elderly Waiver, Community Alternatives for Disabled Individuals Waiver and Brain Injury Waiver – Nursing Facility). A face-to face Long-Term Care Consultation assessment is performed at application and at least annually thereafter. In addition to determining level of care, the assessment is a critical tool for ensuring that care planning is person-centered and appropriate. Applicants for waiver services must meet nursing facility level of care criteria at application, and must continue to meet nursing facility level of care criteria and financial eligibility at reassessment. The initial assessment used to establish Medical Assistance payment for home and community-based waiver services at application must be the most recent face-to-face Long-Term Care Consultation that occurred no more than 60 days before the effective date of Medical Assistance eligibility for payment of long-term care services. The revised nursing facility level of care criteria will be applied to assessments and reassessments performed on or after the implementation date of the nursing facility level of care changes.

3.4.2 The Revised Criteria Will Be Phased In Over Time for Nursing Facility Residents

Most Medical Assistance (MA) beneficiaries admitted to a nursing facility prior to the implementation date of the revised level of care criteria will be eligible for continued Medicaid payment of their nursing facility costs even if they subsequently fail to meet the revised nursing facility level of care criteria. Medical Assistance payment for nursing facility services will continue to be available to individuals with financial eligibility for Medical Assistance who were admitted before the date the new standard is implemented,

and had a qualifying nursing facility stay of at least 90 days prior to the date of implementation, regardless of the payer.

For admissions occurring on or after the implementation date, the following standards must be met for Medical Assistance payment: the Medical Assistance-eligible individual must meet the nursing facility level of care criteria as determined by the Minimum Data Set (MDS) assessment or through the face-to-face Long-Term Care Consultation (LTCC) assessment at admission, and at 90 days after admission or on the first MDS quarterly assessment after admission, whichever is later, to approve MA payment. Alternatively, individuals at risk due to frailty or vulnerability may meet level of care through a face-to-face Long-Term Care Consultation assessment performed in the facility within 90 days of admission. A person is considered at risk under this clause if the person currently lives alone or will live alone upon discharge and also (1) has experienced a fall resulting in a fracture; or 2) has been determined to be at risk of maltreatment or neglect, including self-neglect; or 3) has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

Medical Assistance payment for nursing facility services is available to people who are eligible for MA and who reside in a nursing facility on the date the new standard is implemented and who have had a qualifying nursing facility stay of at least 90 days prior to the date of implementation, regardless of the payer. For individuals admitted on or after the effective date of implementation, the assessment used to establish Medical Assistance payment for nursing facility services must be the most recent assessment performed that occurred no more than 90 calendar days before the effective date of Medical Assistance eligibility for payment of long-term care services.

Section Four – Public Involvement

4.1 HCBS Partners Panel

The Home and Community-Based Services Partners Panel is a group of experts in long-term support services from the perspectives of aging, disability and mental health. Members represent county government, service providers and advocates, with participation of state agency leaders. The panel will support continuous improvement in the HCBS system by providing a communication link among the system's stakeholders and supporting specific initiatives.

The HCBS Partners Panel grew out of the HCBS Expert Panel, a group of experts convened from 2008 to 2010 to assist DHS in developing its State Long-Term Care Profile and to identify and discuss strategies for simplifying and otherwise improving Minnesota's HCBS system.

4.2 External Stakeholder Workgroup

DHS has convened an external stakeholder workgroup to provide input and develop recommendations on specific aspects of the implementation of the new nursing facility level of care criteria and the ECS program. Selected members were chosen by solicitation through the HCBS Partners Panel. This group met periodically during calendar year 2009 and 2010. This group has reconvened to update the work they completed earlier and prepare for implementation of the nursing facility level of care initiative. Stakeholders were notified upon announcement of the public comment period via email, and again in person at the December 5, 2011 meeting. At the meeting, the group was advised on the content of the waiver request, and was solicited for feedback from their constituent memberships. Many of these groups did offer constructive comments during the public comment period. A summary of the public comments was presented and discussed at the February 6, 2012 meeting. Many of the stakeholder group members are eager to see the progress of the waiver request and the department assured them of timely communication regarding the ultimate waiver request submission. DHS will continue to consult with stakeholders to develop and refine transition protocols, notice protocols and referral protocols. Please refer to Appendix VII for more specific information on the work group's charge and membership.

4.3 Consultation with Tribes

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

DHS has a designated staff person in the Medicaid Director's office who acts as a liaison to the Tribes. Appendix VIII describes Minnesota's tribal consultation policy approved in the Medicaid state plan.

The Tribal Health Work Group was formed to address the need for a regular forum for formal consultation between tribes and state staff. Work group attendees include Tribal Chairs, Tribal

Health Directors, Tribal Social Services Directors, and the state consultation liaison. The Native American Consultant from CMS and state agency staff attend as necessary depending on the topics covered at each meeting. The state liaison attends all Tribal Health Work Group meetings and provides updates on state and federal activities. The liaison will often arrange for appropriate DHS policy staff to attend the meeting to receive input from Tribes and to answer questions.

State law directing DHS to adopt a modified nursing facility level of care standard was first passed by the Minnesota State Legislature in 2009 and amended in 2010 and again in 2011. Since it first passed in 2009 the nursing facility level of care initiative has been included in the legislative summaries provided to Tribal Chairs and Tribal Health and Social Services Directors at the August 2009, August 2010 and August 2011 Tribal Health Work Group meetings.

This nursing facility level of care waiver initiative was discussed at the November 17, 2011 Tribal Health Work Group. DHS staff involved in drafting this waiver proposal attended to make tribal officials aware of the status of the request and to take comments, questions and suggestions regarding the waiver.

On November 22, 2011 a letter was sent to all tribal chairs and tribal health directors requesting their comment on the Department's intent to submit a request to the Centers for Medicare & Medicaid Services to waive the maintenance of effort requirements under the Affordable Care Act in order to implement a modified nursing facility level of care standard. DHS received no comments from tribal officials concerning this waiver.

Those tribes who have taken on the management of home and community-based services as "lead agencies" for their tribal members have also received additional DHS communications forwarded to all lead agencies (counties, tribes, and managed care organizations) about proposed legislative changes.

4.4 Public Notice and Comment

4.4.1 Minnesota State Register Notices Regarding Legislative Actions

A notice is published in the Minnesota State Register annually following the end of each legislative session to inform recipients, providers of services, and the public of certain statutory changes made to the Medical Assistance Program. Since it first passed in 2009, a summary of the nursing facility level of care legislation has been included in the annual notice of statutory changes published in the Minnesota State Register.

4.4.2 Minnesota State Register Notice Requesting Public Comment on Waiver

A request for public comment on this waiver request was published in the Minnesota State Register on November 28, 2011. This comment period provided an opportunity for public and stakeholder input on the proposed modifications to Minnesota's nursing facility level of care standard and process. The state register notice and the eighteen written comments received during the comment period are included at Appendices IV and V.

The DHS response to the comments is included at Appendix VI, and is also reflected in modifications that have been made throughout the main body of the waiver proposal. DHS appreciates the thoughtful comments submitted on the waiver, and has extensively discussed and analyzed the issues raised in these comments and by stakeholders.

4.4.3 Recipient Notices

Each year following the end of the state legislative session, DHS produces a notice to Minnesota health care program enrollees explaining changes made by the legislature that impact the services they receive. All changes are included, with effective dates noted. Because the level of care law was enacted in 2009, and amended in 2010 and 2011, this issue appears in the notices sent to enrollees in each of these years.

The information is organized in the notice under headings designed to help recipients identify changes that may apply to them. The notices were mailed to each household.

Copies of notices mailed by DHS, including the annual legislative notice, are also available online at www.dhs.state.mn.us/healthcare/notices.

Section Five - Organization and Administration

5.1 Organizational Structure of Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) is the state Medicaid agency responsible for providing and purchasing all health care services for Medical Assistance and state-funded medical programs including Alternative Care and Essential Community supports.

5.2 Key Personnel of the Demonstration

Lucinda Jesson is the Commissioner of Human Services and is responsible for directing the activities of the department, which include the publicly funded health care programs.

David Godfrey is the Medicaid Director and has overall responsibility for submission of the waiver document.

Loren Colman is the Assistant Commissioner for the Continuing Care Administration within DHS and has responsibility for administering publicly-funded health care programs for seniors and people with disabilities in need of long-term care services, including administration of nursing facility level of care standards.

Jean Wood is the Director of the Aging and Adult Services Division within the Continuing Care Administration and has responsibility for administering publicly-funded health care programs for older Minnesotans.

Deb Holtz is the Ombudsman for Long-Term Care within the Continuing Care Administration and has responsibility for supervising the advocacy and ombudsman staff at the DHS level, as well as coordination with advocacy staff at county social service agencies.

Alex Bartolic is the Director of the Disability Services Division within the Continuing Care Administration and has responsibility for administering publicly-funded health care programs for Minnesotans with disabilities.

Scott Leitz is the Assistant Commissioner for the Health Care Administration within DHS and has responsibility for purchasing basic health care services for people covered by publicly funded health care programs.

Karen Gibson is the Director of the Health Care Eligibility and Access Division within the Health Care Administration and has responsibility for setting Medical Assistance eligibility policy and oversight of county human services agencies, tribes, and state staff that determine Medical Assistance eligibility.

Section Six – Evaluation

6. 1 Introduction

The proposed evaluation is based on materials prepared by Greg Arling, PHD, Indiana University Center for Aging Research and Regenstrief Institute; Christine Mueller, PHD RN, University of Minnesota School of Nursing; and Robert L. Kane, MD, University of Minnesota School of Public Health and is subject to further development. The evaluation proposal

describes each component of the waiver, poses evaluation questions in order to establish a framework for the evaluation, describes the evaluation design, discusses the potential application of evaluation findings to policy and program improvement, and recommends a project schedule and next steps in refinement of the evaluation plan.

Revised Nursing Facility Level of Care Criteria (NF LOC). This initiative revises the criteria for determining level of care need. Individuals who do not meet level of care criteria after being admitted to the nursing facility will receive transition counseling, follow-up, and tracking through the Return to Community program. The criteria will also be applied when people apply for home and community-based waivers and at the annual re-assessments. The NF LOC initiative is expected to reduce use of nursing facility and home and community-based waiver services and achieve Medicaid savings.

Federal Financial Participation in the Alternative Care Program. This initiative will support seniors who meet nursing facility level of care criteria with a comprehensive set of home and community-based services to promote living at home longer. This initiative is designed to support elderly people in their desire to remain in the community as independently and safely for as long as possible and to support informal caregivers in their efforts to provide care. Connecting higher income, high needs seniors with community services will divert seniors from nursing facilities and inform them of non-institutional care options, encouraging more efficient use of services once full Medicaid eligibility is established.

Federal Financial Participation in the Essential Community Supports Program. This initiative will support seniors who do not yet meet nursing facility level of care criteria and who have incomes and/or resources just above Medicaid eligibility levels with a low cost, high-impact set of home and community-based services to promote living at home longer. This initiative will also support people of all ages who received Medical Assistance-funded long term care services and lost eligibility due to the implementation of the revised nursing facility level of care criteria. The evaluation of this component of Essential Community Supports will inform Minnesota's efforts to determine what benefits might be most effective under a Section 1915(i) approach in the future.

6. 2 Major Program Process and Outcomes

The initiatives differ in design and target populations, yet they have common goals of greater efficiency and cost control through more effective utilization of care. Table 1 lists major program processes and outcomes. The following general questions frame the evaluation.

Did the initiative achieve Medicaid savings? Each initiative promises savings to the Medicaid program by promoting less costly alternatives to institutional care. Cost savings for nursing

facility or other services targeted by the initiatives should not be offset by increases in per person medical costs.

Were services provided more efficiently? Each initiative attempts to deliver care more efficiently through better allocation of resources and lower cost per person served. The nursing facility level of care initiative attempts to appropriately target long-term care resources. The Alternative Care/Essential Community Supports initiative seeks to shore up individual and caregiver resources and promotes community-based alternatives so that more costly acute and long-term care services can be avoided.

Were personal health, functioning, family support, and other individual outcomes maintained or improved by the initiative? The Alternative Care/Essential Community Supports initiative has the explicit goal of promoting consumer choice and independence while maintaining or improving health, functioning and other outcomes. This initiative also promotes individualized community-based alternatives and supports informal caregivers. The nursing facility level of care initiative focuses mainly on more efficient delivery of services while avoiding potential adverse outcomes rather than improvement of positive personal outcomes.

Were unintended adverse outcomes avoided? Limiting access to services runs the risk of unintended adverse outcomes, such as decline in health or functioning, increased acute care or nursing facility utilization. The Alternative Care initiative has well established counseling and tracking processes to avoid adverse events. The nursing facility level of care initiative will offer Essential Community Supports funding as a safety net for people who fail to meet nursing facility level of care criteria but have an assessed need and who, while financially ineligible for Medicaid, are of modest means. The Essential Community Supports funding may provide the supports necessary to avoid adverse outcomes.

The evaluation will focus primarily on program outcomes in the nursing facility level of care initiative. There will be a focus on both processes and outcomes in the Alternative Care and Essential Community Supports initiatives. The evaluation of the Alternative Care and Essential Community Supports initiative will have considerable primary data on the health, functioning, and social supports of people targeted by the program. The evaluation of the nursing facility level of care initiative will rely heavily on claims and other administrative data.

Table 1. Major Processes and Outcomes

Initiative	Major Processes	Major Outcomes
Alternative Care (AC) program serving elderly who need NF LOC but are not yet financially eligible for Medicaid	NF LOC criteria applied consistently across facilities and communities AC Program provided to low-income elderly who need NF LOC but who are not yet financially eligible for Medicaid	Total LTC costs HCBS costs Health Care Costs (Medicare and Medicaid) Medicaid conversion rate Nursing facility utilization rate Hospitalization and ER visits Utilization and costs of AC
Essential Community Supports Program (ECS) serving elderly who meet NF LOC and are not yet financially eligible for Medicaid	NF LOC criteria applied consistently across facilities and communities ECS program provided to low-income elderly who have an assessed need for services included in this program but are not yet financially eligible for Medicaid	Total LTC Costs HCBS costs Health Care Costs (Medicare and Medicaid) Medicaid conversion rate Nursing facility utilization rate Hospitalizations and ER visits

Initiative	Major Processes	Major Outcomes
NF LOC Changes Affecting NF Applicants [Pre-Admission]	NF LOC criteria applied consistently across facilities and communities ECS grants provided to people who do not meet NF LOC and do not meet Medicaid eligibility criteria	Total LTC Costs HCBS costs Health Care Costs (Medicare and Medicaid) Medicaid Costs Medicaid conversion Nursing facility utilization Hospitalizations and ER visits Utilization and Costs of ECS
NF LOC Changes affecting HCBS waivers	NF LOC criteria applied as intended and consistently across communities and waiver types ECS grants provided to people who do not meet NF LOC and do not meet Medicaid eligibility criteria	Total LTC Costs HCBS costs Health Care Costs (Medicare and Medicaid) Medicaid Costs Medicaid conversion Nursing facility utilization Hospitalizations and ER visits Utilization and Costs of ECS

6.3 Evaluation Design and Methods

The initiatives vary in their evaluation questions, major processes and outcomes and data available. Therefore, the evaluation plan will have to be tailored to each initiative. Nonetheless, the evaluation will have common elements.

- The primary focus of the evaluation will be an impact assessment focusing on program outcomes.
- The impact assessment will examine changes in major outcomes between a baseline period before the initiative is introduced and an implementation period after the initiative is introduced. The initiative is slated to begin July 1, 2012. The initiative will require a period

to ramp up as annual assessments are completed for current users of HCBS. The baseline period may extend as far back as 2005 and the implementation period may extend to 2013.

- The most feasible approach for assessing changes in program outcomes for AC and ECS is "before and after" or interrupted time series design that measures trends in outcomes (e.g., Medicaid costs, nursing facility utilization, hospitalizations, etc.) for target populations and controls on a monthly or quarterly basis during the baseline and implementation periods.
- For NF LOC changes affecting NF applicants, identify persons denied nursing facility admission and track them. Compare them to similar matched group who had received nursing facility care under the earlier policy.
- For NF LOC changes affecting HCBS waivers, identify persons denied HCBS and track them. Compare them to similar matched group who had received HCBS under the earlier policy.
- If the initiative is successful, some outcomes should have downward trends, such as declining Medicaid expenditures or nursing facility utilization. Other outcomes should have upward trends, such as increased community discharges from the nursing facility. Some outcomes, on the other hand, should have even trends, particularly unintended adverse outcomes such as emergency department use or hospitalizations, which hopefully would not increase after implementation of any of the initiatives.

6.3.1 Study Samples

The study samples will be drawn from the population of interest for each program, AC and ECS. Each program has a target population, or people the program is intended to affect. Table 2 shows the study samples for each program. Identifying individuals in the target population is important to ensure that before and after comparisons of outcomes are being made for the same types of individuals. For example, if we are to assess Medicaid savings associated with the NF LOC initiative, we need to compare individuals in the baseline period who would have failed to meet the LOC criteria with individuals during the implementation period who failed the criteria. The validity of the before and after comparison is threatened if the comparison group chosen to represent the baseline period differs fundamentally from the group affected by the initiative. Any difference in outcomes between baseline and implementation may result from differences in the characteristics of the groups being compared rather than the effect of the intervention; hence the value of multiple time points before implementation. Also, the validity of the analysis is threatened if we are unable to follow members of the study samples over time, particularly members of the target population who were affected by the initiative.

Table 2. Target Populations and Study Samples

Initiative	Study Sample	Identified From	Period
Alternative Care program Serving elderly who need NF LOC but are not yet financially eligible for Medicaid	Target Population: MA Ineligible>= Age 65 in AC Comparison Group MA Ineligible >=Age 65 who applied and were rejected (presumably for low need); includes ECS participants	Medicaid claims	2012-2016 2006-2011
Essential Community Supports Program (ECS) serving elderly who meet NF LOC and are not yet financially eligible for Medicaid	Target Populations: a) Nursing facility applicants who fail to meet NF LOC criteria prior to nursing facility admission b) Nursing facility residents who fail to meet NF LOC criteria at their most recent assessment prior to Medicaid eligibility c) Persons in the community applying to or referred to ECS MA Ineligible< Age 65 MA Ineligible>=Age 65 Comparison Groups: a) Nursing facility applicants who would have failed to meet NF LOC criteria prior to nursing facility	NF LTCC MDS Medicaid Claims	2012-2016 2006-2011

Initiative	Study Sample	Identified From	Period
	admission b) Nursing facility residents who would have failed to meet NF LOC criteria at admission, at 90 days, or at their most recent assessment prior to Medicaid eligibility MA Ineligible < Age 65 MA Ineligible >= Age 65		
NF LOC Changes Affecting NF Applicants [Pre-Admission]	<u>Target Populations:</u> HCBS applicants who fail to meet NF LOC criteria and HCBS recipients who fail to meet NF LOC criteria on an annual assessment: MA Eligible < Age 65 MA Eligible >= Age 65 <u>Comparison Groups:</u> HCBS applicants who <u>would have</u> failed to meet NF LOC criteria and HCBS recipients who <u>would have</u> failed to meet NF LOC criteria on an annual assessment MA Eligible < Age 65 MA Eligible >= Age 65	NF LTCC Medicaid Claims	2012-2016 2006-2011
NF LOC Changes affecting HCBS waivers	<u>Target Group:</u> ECS and AC Users: MA Eligible < Age 65 (would be eligible if spend down)	NF LTCC Medicaid Claims	2012-2016

Initiative	Study Sample	Identified From	Period
	MA Eligible >= Age 65 (would be eligible if spend down) MA Ineligible < Age 65 MA Ineligible >= Age 65 <u>Comparison Group:</u> HCBS users who would have been eligimated by higher NF LOC criteria		2006-2011

6.3.2 Development of Study Samples

We are basing plans for selection of the study samples on information from initial inquiries. In some cases we feel confident in the operational definitions of study populations and sample frames. For other initiatives study sample definitions will require further investigation.

- The NF LOC initiative involving nursing facility residents has well-defined samples that can be followed over time through the nursing facility MDS system.
- The samples of people affected by the NF LOC criteria during nursing facility pre-admission screening and who never enter a nursing facility will be difficult to follow if they are not financially eligible for Medicaid and do not appear in either the MDS or Medicaid claims data systems. Individuals eligible for Medicare might be followed with Medicare data. People who are neither Medicaid nor Medicare eligible will be the most difficult to identify and track.
- Similarly, people who fail to meet the NF LOC criteria for HCBS waiver services and who do not meet Medicaid eligibility criteria may not be traceable through these administrative systems. The MMIS and LTCC assessments will presumably supply information at intake or annual reassessment on people who meet NF LOC criteria during the baseline period. We should also know from these assessments who met and who failed to meet the new NF LOC criteria after the initiative is implemented. Of greatest concern for follow-up is the group of individuals who fail to meet NF LOC criteria. Medicaid claims could be a follow up source for Medicaid eligibles; whereas the Minimum Data Set (MDS) could serve as source of follow-up for dual eligibles. An information gap will likely exist for people who fail to meet the NF LOC criteria and are neither Medicaid nor Medicare eligible.

- The fallback method for following Medicare beneficiaries (dual-eligible or Medicare only) affected by any of the initiatives is the Medicare claims data. Current plans are to obtain SSN, HIC or other Medicare identifiers for each dual eligible in the study samples. These identifiers would be used to assemble Medicare claims for these individuals for purposes of Medicare service use tracking. Claims data for fee for service Medicare beneficiaries is expected to be more complete and accurate than for beneficiaries in managed care.

6.3.3 Data Sources and Major Variables

The evaluation will draw on different data sources depending on the initiative, study sample or subsample, and variable being measured. The study will require individual-level measures of relevant utilization, expenditures, health status and other outcomes. Data will be drawn from:

- Nursing facility Minimum Data Set (MDS) resident assessments
- Medicaid claims and enrollment data from MMIS
- Medicare inpatient (Medpar), SNF (Medpar), home health, and physician (carrier) claims and denominator files
- Return to Community (RTC) data system standardized assessments of individuals and their caregivers: (a) comprehensive assessment at the stage of transition from the nursing facility; (b) follow-up data collected at 3, 14, 30, and 60 days after discharge; and (c) quarterly phone-based assessments every 90 days thereafter.
- Pre-admission screening and LTCC data systems
- MN CHOICES assessments (Implementation period)
- Health plan data systems for people enrolled in managed care (if available)

Table 3 describes the major outcome variables and the data sources for each variable. Table 4 provides detail on the data source(s) for each major variable by initiative. These are preliminary descriptions. The adequacy of the data sources – completeness, coverage, and consistency over time -- is yet to be determined. For example, availability of data from Managed Care Plans has yet to be established. The MN CHOICES will be replacing the MMIS and pre-admission screening forms and data elements may not map directly between forms. Finally, the data likely contain many nuances that can only be discovered through experience.

6.3.4 Securing and Preparing Data Files

The Minnesota Department of Human Services will provide data from the MDS assessment system, MMIS, and other administrative data such as LTCCC, PCA, AC Program and HCBS waivers. Medicare data will be obtained from the Center for

Medicare and Medicaid Services. The Aging and Disability Resource Center (ADRC) electronic client data and tracking system will provide assessment data on RTC transitioned residents and additional information on people affected by the nursing facility level of care criteria in the nursing facility.

Data sources for the initiatives overlap. Therefore, we will begin by obtaining comprehensive Medicaid, Medicare and MDS data sets. After members of the study samples have been identified, we will create separate analysis data sets for each initiative. Files will be created at the person level by merging data from different sources. Data for different study samples will be aggregated from the person to the nursing facility, community, region or statewide levels as necessary for each analysis. We will be interested in person-level outcomes among those affected by the initiatives. At the same time, we will describe aggregate trends in outcomes over time and across facilities and communities. After merging and linking, data will be de-identified for project analysis.

6.4 Analysis Plan

Much of the analysis will rely on multilevel longitudinal models of change taking into account successive entries and exits of individuals from the study samples through nursing facility or HCBS admissions and discharges, Medicaid enrollment and disenrollment, mortality, or other situations. Researchers at Indiana University's Regenstrief Institute have employed the repeated measures multilevel analysis in a prior study examining the impact of a chronic disease management program (Katz et al. 2009).

Time Series Analysis (Aggregated Data).

The interrupted time series analysis will examine aggregate trends in average monthly utilization, expenditures, and other outcomes in the targeted populations before and after implementation of the initiatives. The time series data will also be adjusted for changes in the size or composition of the target populations as well as annual general population trends, e.g., increases in 65+ or 85+ populations that could affect nursing facility admission rates or use of community care. In addition, Minnesota like other states has experienced an age-adjusted decline in nursing facility days, Medicaid days, nursing facility bed supply, and expansion of Medicaid waivers and state community-based long term care programs. Therefore, the time series analysis will have to take into account the effects of these external events by testing a base case scenario (extrapolation of downward trends under usual care) versus observed trends.

Multilevel Analysis of Individual and Facility Outcomes.

Complementing the time series analysis we will develop and test repeated-measure multilevel models of individual utilization, expenditures, health status change and other outcomes. The analysis will involve hierarchical models for change (Raudenbush, and Bryk 2002; Singer, and Willett 2003) using HLM 6.0 statistical software (Raudenbush, Bryk, and Congdon 2004).

The models will take into account the grouping or nesting of observations (e.g., monthly utilization or expenditures) within individuals. In some models, the nesting of individuals within organizations (nursing facilities) or communities will also be taken into account.

The models will predict outcome Y at time period i for individual j in organization or community k. The model's structural component will contain parameters for the intercepts and slopes of the outcomes as a function of the time period, before/after program implementation, individual characteristics, and organizational or community characteristics (both fixed and time-varying). The slopes of the outcome variables represent their change trajectories. The randomly-varying or stochastic component of the model consists of the residual or error terms associated with time periods and facilities. Different formulations of the stochastic component can be used to test alternative ways of addressing autocorrelation and non-normal distribution of the residuals.

The analysis will rely on Hierarchical Linear Models (HLM) or Hierarchical General Linear Models (HGLM). Dichotomous variables such as community discharge from the nursing facility within 90 days will be modeled with a logit link function assuming a Bernoulli distribution. Count variable such as hospitalizations and ER use will be modeled as a Poisson or negative binomial. Nursing facility, ER and hospitalization expenditures will be treated as continuous variables following a normal distribution after being log-transformed.

Process Analysis.

The major processes to be evaluated for the nursing facility level of care initiative (Table 1) involve the application of the criteria to determine eligibility for services. Further development is needed for methods for assessing reliability of the screening or assessment forms, consistency in applying criteria across communities or agencies, discontinuities between assessment forms, gaming or eligibility creep, or other issues in the application of the criteria.

6.5 Study Limitations

The limitations of the evaluation fall into two general areas: measurement and design. Problems of measurement arise largely from the accuracy and completeness of MDS, claims and other data drawn from state administrative systems, Medicare, or health plans serving study populations. We have described these limitations in earlier sections of the report. We will need to conduct preliminary analysis of the various data sources in order to better understand measurement problems and refine the evaluation plans accordingly. See Next Steps proposed below.

A major threat to the validity of a pre/post or time series design is possibility of external events such as new policies or shifts in the economy that may change outcome trends rather than the initiative itself being responsible for changes in these trends. For example, reductions in community long-term care services or funding could complicate the transition of individuals from nursing facility to community. Another potential threat is selection bias where the types of individuals targeted by the initiatives may change over time making it difficult to draw inferences about trends in service use or health status. For example, nursing facility admissions

may become more functionally impaired over time, making it more difficult to return individuals to the community or raising the cost of a community placement. Finally, data collection on the outcomes of interest may change over time, making it difficult to draw comparisons.

We have no foolproof method for eliminating threats to validity; however, we can take steps to minimize bias.

- Validity threats should be well described and their implications for the credibility of evaluation results should be spelled out prior to beginning the evaluation.
- Findings from multiple methods (quantitative and qualitative) and sources of data should be compared when possible.
- Appropriate statistical approaches should be used to control for potential confounding events or characteristics of people in the study samples, examine outcome trends over time, and take into account the nested or multilevel nature of program outcomes.
- Sensitivity analysis should be carried out to test the effect on program findings of potential measurement bias or design limitations.
- Evaluation results and implications should be qualified to the extent that they might be affected by measurement or design bias.

6.6 Evaluation Timeline

The NF LOC initiative has a proposed implementation of July 2012. Evaluating the effectiveness and outcomes from these types of changes in a health or social program usually takes three-five years of baseline (pre-implementation) data, from 6-12 months for program ramp-up, and 2-5 years of full program operation. Some changes in a program can lead to immediate outcomes, e.g., short-term cost savings or cost shifting. Other outcomes are longer term, particularly if they are mediated by changes in health or functional status, e.g., reduced service availability leading to poorer health leading to nursing facility admission. We recommend this time frame for the evaluation:

Baseline data (5 years prior to implementation)	2006-2011
Begin evaluation	2012
Ramp-up (depending on initiative start date)	2012-2013
Evaluation data collection and analysis	2012-2016
Complete evaluation	2016

6.7 Next Steps

The proposed evaluation plan is very ambitious. It deals with a broad and diverse set of initiatives covering institutional and community long-term care, elderly and younger populations, and people covered by Medicaid only, dual eligibles, and other pay sources. The questions

pursued in the evaluation extend beyond conventional concerns with aggregate Medicaid costs. The evaluation addresses health and functional outcomes, acute care service use and payments, transitions between settings and service packages, rates of Medicaid conversion, and other intended as well as potentially unintended outcomes from these interventions. Although we have gathered considerable information and dealt with numerous design issues, questions remain about the target populations for the intervention, the completeness and accuracy of data, and the capacity to draw valid before and after comparisons of major outcomes. Over the next several months we propose to meet with DHS and stakeholders to refine the evaluation design including further refinement of evaluation questions and objectives, measurement of key variables, data sources, incorporating changes in program policies or implementation plans, and data collection and analysis strategies.

Section Seven – Funding and Budget Neutrality

This section discusses the financial projections presented in Appendix IX. DHS reviewed level of care data for Medicaid recipients enrolled in §1915(c) home and community-based waiver programs in July of 2011 to develop projections of the fiscal impact of the revision on the nursing facility level of care criteria.[17] DHS also reviewed Minimum Data Set or MDS level of care data for all Minnesota nursing facility admissions over the period March 31, 2009 through April 1, 2010. The analysis included both stays that were private pay and those that were paid for by Medical Assistance. Minnesota nursing facilities must administer the federal MDS nursing facility assessment tool to each resident at admission and every 90 days thereafter, as well as upon significant change in health status. The revised nursing facility level of care criteria are aligned with MDS standards. The full face-to-face Long-Term Care Consultation assessment is more comprehensive and takes into account additional categories of potential vulnerability, but the MDS data set is the most complete.

Based on the data surveyed, the majority of the individuals who would fail to meet the revised nursing facility level of care criteria are seniors dwelling in the community. Based on analysis of existing recipients, no Brain Injury-Nursing Facility Waiver participants are expected fail to meet the revised nursing facility level of care criteria, and less than three percent of the CADI waiver participants would fail to meet the revised nursing facility level of care criteria. No CADI waiver beneficiaries are expected to lose eligibility for Medicaid state plan services. The most affected group would be Elderly Waiver beneficiaries over age 65 who reside in the community, with approximately 13% expected not to meet the revised nursing facility level of

[17] As discussed above, the nursing facility level of care is only relevant for Minnesota's Elderly Waiver, Community Alternatives for Disabled Individuals and Brain Injury waiver programs. The nursing facility level of care standard does not apply to Minnesota's Developmentally Disabled or Community Alternatives for Care waivers.

care criteria. This is why the Alternative Care and Essential Community Supports programs are focused on seniors. Of those 13% however, approximately 84% are anticipated to continue to meet financial eligibility requirements for categorical eligibility for state plan services. Those with significant health care expenditures would spend down to MA eligibility.

The financial projections take into account long-term care savings and costs shifting to other state plan services. In total, the modification of the nursing facility level of care criteria is expected to yield an estimated $18 million in savings over the first year, $44 million over the second year and $54 million over the third year. These reductions represent a tiny proportion of statewide long-term care spending, and will most certainly be masked by a number of variables in Minnesota's total long-term care spending. Because this proposal will not increase costs at the federal level, caps on expenditures are not necessary to ensure budget neutrality.

Minnesota proposes to provide ongoing reporting of enrollment, spending and outcomes in the Alternative Care and Essential Community Supports programs, however.

Section Eight – Waiver Authorities Requested

Minnesota requests the following waivers to implement the revised nursing facility level of care criteria under the authority of Section 1115(a)(1) of the Act:

- Minnesota requests a waiver of the requirement in Sections 1902(a)(74) and 1902(gg) of the Social Security Act, as added by section 2001(b) of the Affordable Care Act that the State maintain Medicaid standards, methodologies and procedures that are no more restrictive than those in effect on the date of enactment of the Affordable Care Act. Minnesota requests a waiver of this provision to the extent necessary to enable the State to modify the criteria for nursing facility level of care.
- Minnesota requests a waiver of the requirement in Section 2105(d)(3) of the Social Security Act, as added by section 2101(B) of the Affordable Care Act that the State maintain CHIP standards, methodologies and procedures that are no more restrictive than those in effect on the date of enactment of the Affordable Care Act. Minnesota requests a waiver of this provision to the extent necessary to enable the State to modify the criteria for nursing facility level of care.

Minnesota requests the following waivers to implement the Alternative Care Program and Essential Community Supports Program under the authority of Section 1115(a)(1) of the Act:

- Minnesota requests a waiver of Section 1902(a)(1) of the Act as implemented by 42 CFR § 431.50 to exempt the state from the requirement to administer Medical Assistance uniformly on a statewide basis.

- Minnesota requests a waiver of Section 1902(a)(10) of the Act and 42 CFR § 440.240(b) to allow differences in amount, duration and scope of benefits provided to recipients.
- Minnesota requests a waiver of Section 1902(a)(17) of the act to allow differences in benefits within the aged, blind and disabled category of eligibility.

Under the authority of Section 1115(a)(2) of the Act, Minnesota proposes that expenditures made by the state to permit coverage of a limited package home and community-based services benefits to people who meet the eligibility criteria of the Essential Community Supports and Alternative Care programs, for the period of this waiver, will be regarded as expenditures under the State's Title XIX plan. Specifically, this includes individuals who are either enrolled in Medicaid or whose income and resources are insufficient to cover 135 days of nursing facility care.

Appendix I - Comparison of Current and Revised NF LOC Criteria

Comparing the current bases of Nursing Facility Level of Care (NF LOC) and the proposed specific criteria

Currently, NF LOC decisions depend on professional judgment about whether a person meets one of several general bases for NF LOC determination. There has not been clear and specific criterion available to professionals to establish that basis. As a result, determinations have not been consistent across the state. This proposal provides clear and specific level of care criteria for the several bases of NF LOC by linking the determination to standard items contained within the Long-Term Care Consultation assessment and the MDS. The new criterion greatly simplifies the LOC decision. Improving consistency in LOC determinations will help assure consistent access to services and improve program integrity.

Current: Functional Needs	**OR**	**Current: Restorative and Rehabilitative Treatment**	**OR**	**Current: Cognitive or Behavior**	**OR**	**Current: Frailty or Vulnerability**
Needs ongoing or periodic assistance with hands on care, supervision or cueing from another person in safely or appropriately performing activities of daily living (ADLS); **OR** Needs ongoing or periodic assistance with hands on care, supervision or cueing from another person in safely or appropriately performing instrumental activities of daily living (IADLS)		Active restorative or rehabilitative treatment needed, **OR** Episodes of active disease processes requiring immediate clinical judgments, **OR** Receives medication requiring professional dosage adjustment or pre-administrative monitoring, **OR** Requires direct care by licensed nurses during evening and night shifts		The person has *impaired cognition*: • Short term memory loss • Disorientation of person, place, time or location • Impaired decision-making ability **OR** *Frequent history of the following behavior* symptoms: • Wandering • Physical abuse of others • Resistive to care • Behavior problems requiring some supervision for safety of self or others • Severe communication problems		*Self neglect:* The person has not or may not obtain goods or service necessary to ensure reasonable care, hygiene, nutrition and safety, or to avoid physical or mental harm or disease; **OR** *Neglect, abuse, or exploitation:* The person's caregiver(s) or other persons cannot provide reasonable care to the person, or the person has been or may be physically and/or verbally abused, or the caregiver(s) or other persons have or may mismanage the person's funds and/or possessions; **OR** The person has experienced frequent or recent hospitalization, nursing facility *admissions*, falls, or overall frailty.
Proposed Operational Criteria: Functional Limitation	**OR**	**Proposed Operational Criteria: Clinical Need**	**OR**	**Proposed Operational Criteria: Cognition or Behavior**	**OR**	**Proposed Operational Criteria: Frailty or Vulnerability**
A high need for assistance in four or more ADLs; **OR** A high need for assistance in one ADL that requires 24 hour staff availability (toileting, positioning, transferring, mobility)		A need for clinical monitoring at least once a day		Significant difficulty with memory, using information, daily decision making, or behavioral needs that require at least occasional intervention.		A qualifying NF admission of at least 90 days **OR** Living alone AND risk factors are present (maltreatment, neglect, falls, or substantial sensory impairment)

Appendix II - DHS Forms 3428, 3428B and 3428C

Minnesota Long Term Care Consultation Services Assessment Form
Filling this form with Adobe Acrobat

What you need

In order to **fill in and save** the data on this form you need one of the following:

- Adobe Acrobat 6, 7 or 8 Standard
- Adobe Acrobat 6, 7 or 8 Professional

If you only have Acrobat Reader or Adobe Reader you will be able to fill in but **not** save the form data.

Downloading the form

For access and completion of these forms, you must copy the form(s) onto your hard drive. Do not use the version on the web page for completing and merging.

1. Open one of the forms on the web page
2. Click on the "disc" icon found on the toolbar
3. Save the document to your hard drive.

To fill out a form

1. Open the form (saved on your hard drive) on the following page. Select the Hand tool.
2. Move the cursor inside the first field, and click. The I-beam pointer allows you to type text. The arrow pointer allows you to select a button, a check box, a radio button, or an item from a list. After entering text do one of the following:
   - Press *Tab* to go to the next form field to enter data.
   - Press *Shift-Tab* to go to the previous form field.
   - Press *Enter* (Windows) or *Return* (Macintosh) to travel down the page.
   - Use the *Space Bar* for fields that need a check mark.

To save the completed form with the data

Once you have filled in the appropriate fields, choose *File* > *Save As* to save a copy of the form with the data. Type a filename such as the person's name or PMI number and click the *Save* button. You may print this form. The next time you use this file name you will be typing over the saved data. In order to save the old data and the new data you will need to use *Save As* and save the file with the new data under a new name.

To clear all data from a form

Click the *Clear Form Data* button at the top of the form. This will erase all the data from all the fields of the form, creating a blank form.

To populate DHS-3427, DHS-3427T or DHS-4166 with data from this form

1. Open a copy of this form (DHS-3428 or DHS-3428A) that you have filled in.
2. Choose *File* > *Form Data* > *Export Data from Form* (Acrobat 7); or choose *Forms* > *Manage Form Data* > *Export Data* (Acrobat 8). Acrobat will create a data file that you will use to populate these forms. You will be able to throw this data file away when you are finished, so choose a temporary filename and location you can remember, and then click the *Save* button.
3. Close the copy of DHS-3428 or DHS-3428A that you have open, and open a blank DHS-3427, DHS-3427T or DHS-4166.
4. Choose *File* > *Form Data* > *Import Data to Form* (Acrobat 7); or choose *Forms* > *Manage Form Data* > *Import Data* (Acrobat 8).
5. Select the file that you created in step 2, above, and click on the *Select* button.

You can print a copy of this form. To save the completed form, see "How to save the completed form with the data."

To print a form

Choose *File* > *Print*. If you have difficulty printing the form, or output does not look as expected, check the *Print as Image* option in the Print dialog box.

To turn pages

Click the *Previous Page* or *Next Page* buttons on the toolbar at the top of the screen, or press the Right or Left Arrow keys on the keyboard.

To enlarge or reduce the view of the page

Click on the page with the Magnifying Glass tool to enlarge the view of the page. Press *Ctrl-0* (Windows) or *Command-0* (Macintosh) to fit the page on the screen. Press *Ctrl-2* (Windows) or *Command-2* (Macintosh) to fit the width of the page on the screen.

Minnesota Department of **Human Services**

DHS-3428-ENG 11-11

Minnesota Long Term Care Consultation Services Assessment Form

A. Assessment Activity Information

			R1	R2
LTC SD 83	A.1	NF Track #_____		
LTC SD 9	A.2	Date of Referral (Mo/Day/Year)_____/_____/_____		
LTC SD 26	A.3	Reason(s) for Referral _____/_____ (from pg. 4)		
LTC SD 11	A.4	Type of Assessment Activity ☐ →		
LTC SD 12	A.5	Date of Assessment Activity _____/_____/_____		

01 Telephone Screen
02 Face to Face Assess (P)
03 Visit/Early Intervention (P)
04 Relocation /Transition (P)
05 Document Change Only
06 Reassessment (P) ☐ R1 ☐ R2
07 Case Mgmt/Admin. Act
08 BI/CAC/CADI Reassess 65th birthday (P)

A.6 Reason for late assessment (if more than 10 working days from referral date above):
_____

A.7 Location of assessment/reassessment: ☐

01 Person's residence (if not relative's home)
02 Relative's home
03 Hospital
04 Board and lodge
05 Nursing facility/certified boarding care
06 ICF/DD
07 RTC
08 County office
09 Telephone assessment
98 Other (SPECIFY)_____

A.8 Sources used for Section B.
☐ Person
☐ Record review
☐ Other

B. Client Information

Ba. Personal Information

LTC SD 1-3 Ba.1 What is your name? _____
FIRST M. I. LAST

LTC SD 109 Ba.2 What is your current address? _____

City _____ State _____ Zip code_____

LTC SD 13 Ba.3 Assessor: Identify these counties. ☐ (COS) ☐ (COR) ☐ (CFR) ☐ (LTCC) LTC SD 14

Ba.4 What is your telephone number? (_____)_____

LTC SD 7 Ba.5 What is your date of birth? (Mo/Day/Year) _____/_____/_____
Reminder: Form # DHS-3428C is required for all clients under age 18.

Ba.6 What is your Social Security #? _____

Ba.7 Are you a Veteran? ☐ Yes ☐ No

Bb. Informant Information

Complete Section Bb. only if client is not source of information.

Bb.1 Informant's name: _____
FIRST M. I. LAST

Bb.2 Informant's address: _____

City _____ State _____ Zip code_____

Bb.3 Informant's Phone: (_____)_____

Bb.4 Informant's relation to person: ☐

01 Family member (SPECIFY)_____
02 Friend/neighbor
03 Hospital staff
04 Other (SPECIFY)_____

Section Ba. continued

R1 R2

Ba.8 Do you have any of the following kinds of health insurance:

LTC SD Section H

	No	Yes	Don't know
Medicare - Part A	☐	☐	☐
Medicare - Part B	☐	☐	☐

If yes to either, do you have your Medicare card or member information handy?

Medicare ID#_____

Medicare - Part A Effective date(s) ____/____/____ to ____/____/____

Medicare - Part B Effective date(s) ____/____/____ to ____/____/____
MM DD YY MM DD YY

Medical Assistance	☐	☐	☐

LTC SD 4 Membership (PMI) #_____
(AS SHOWN ON THE MHCP MEMBERSHIP CARD)

Veterans Administration insurance	☐	☐	☐
Private health insurance	☐	☐	☐
Other health insurance (SPECIFY)	☐	☐	☐

_____

LTC SD 5 Ba.9 County Reference Number: _____

Ba.10 Medical Assistance Status: ☐

01 Eligible	03 Eligible w/deeming	05 MHCP App submitted - Date submitted _____
02 Eligible in 180 days	04 SIS/EW	09 Ineligible

LTC SD 54 Ba.11 Disability Certification Source: ☐

01	Social Security Administration (SSA)
02	State Medical Review Team (SMRT)
03	No certification for disability

LTC SD 8 Ba.12 Person's gender: ☐ F/M

Ba.13 Person's primary language?

☐ English

☐ Other (SPECIFY)_____ Can the person:

	Yes	No
Speak English?	☐	☐
Understand English?	☐	☐
Were interpreter services used to complete the assessment?	☐	☐

Ba.14 What is your race or ethnic background? You may choose more than one ***(Read all categories before taking answer)***: Would you say that you are:

☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ American Indian or Alaska Native
☐ Pacific Islander or Native Hawaiian
☐ White
☐ Other (Specify) _____

RI R2

Ba.15 What is your marital status? *(Read all before taking answer)*

LTC SD 25 ☐

01 Single, never married	04 Married
02 Divorced	05 Legally separated
03 Widowed	99 Unknown

Ba.16 Person's current housing type:

LTC SD 33 ☐

01	Homeless	09	Own Home, Apartment
02	ICF/DD	11	NF/Certified Boarding Care
03	Hospital	12	Noncertified Boarding Care
04	Board & Lodge	16	Correctional facility
05	Foster Care		

LTC SD 35 Ba 17 Current program license ☐

02 ICF/DD	08 Housing with Services, class F
05 Foster care, corporate	09 None
06 Foster care, family	11 Nursing facility
07 Housing with Services, Class A	

Ba.18 Person's current living arrangement:

LTC SD 27 ☐

01	Living alone	03	Living with family/friend/significant other		
02	Living with spouse/parents	04	Living in congregate setting	05	Homeless

Ba.19 Do you have a legal representative such as a guardian or conservator?

☐ Yes ☐ No ☐ Don't know

Ba.20 Legal Representative status, check only one:

LTC SD 15 ☐

ADULTS (age 18 years or older)
01 Is a competent adult
02 Capacity to give informed consent is in question, referral to Adult Protection if indicated
03 Has a private guardian
04 Has a public guardian
11 Health conservator
MINORS (age 17 years or younger)
05 Parent(s) are legal representative
06 Child Protection Order in place - county has legal custody, parent may retain parental rights
07 Has a court appointed Guardian Ad Litem (GAL)
08 Has public guardian
09 Has private guardian
10 Is an emancipated minor by order of the court 98 Other

If yes above: Name: _____

Address _____

Phone (work/home) (____)_____ (____)_____

Ba.21 If you have a court appointed guardian or conservator, what areas does the guardian or conservator have authority over?

☐ personal needs ☐ the estate ☐ both

Ba.22 If a conservator of the person is appointed, what authority has the court granted the conservator? (A court appointed guardian has all the following powers)
Check all that apply.

☐ 01 To have custody of the person; establish place of abode
☐ 02 To provide for care, comfort, and maintenance needs, including food, clothing, shelter, health care, social and recreational requirements, training, education, and habilitation or rehabilitation
☐ 03 To take reasonable care of clothing, furniture, vehicles, and other personal effects
☐ 04 To give consent for necessary medical or other professional care, counsel, treatment or service, except for psychosurgery, electroshock, sterilization, or experimental treatment unless first approved by order of the court
☐ 05 To approve or withhold approval of any contract, except for necessities, which the person wishes to enter into
☐ 06 To exercise supervisory authority in a manner which limits civil rights and restricts personal freedom only to the extent necessary to provide needed care and services

Ba.23 Who can we contact in case of emergency? *(ASK:)* Do you have an address book handy? **R1** **R2**

Name: _____

Address _____

Relationship _____ Phone (work/home) (_____)_____

C. Assessment Information *(Complete items C.1 through C. 5 without interviewing person)*

C.1 Referral source:

☐ Self	☐ Clinic	☐ Clergy	☐ Crippled Children's Servicer
☐ Immediate family	☐ Hospital	☐ Dentist	☐ Regional Treatment Center
☐ Other relative	☐ Mental health facility	☐ Psychiatrist	☐ Other professional
☐ Friend	☐ Public health nurse	☐ Physician	☐ Neighbor
☐ County financial worker	☐ Social services	☐ Nurse	☐ Veteran's hospital
☐ Other health agency	☐ Income maintenance	☐ Psychologist	☐ ICF/DD facility
☐ Nursing home	☐ Attorney	☐ Social worker	☐ Other (SPECIFY)_____

LTC SD 24 C.2 Who was present at all or part of assessment, including the person, caregiver, interviewers and others.

☐☐
☐☐
☐☐
☐☐
☐☐
☐☐

01 - Client	08 - Qualified mental health professional	13 - Conservator/Guardian	19 - Health plan coordinator
02 - Family	09 - NF staff	14 - Consulting physician	20 - Ombudsman
03 - LTCC consultant	10 - Primary physician	15 - ICF/DD staff	21 - RRS
04 - Social worker	11 - Home care or community based service provider	16 - Services for children with handicaps	22 - Interpreter, English
05 - Public health nurse	12 - Advocate	17 - Case manager	23 - Interpreter, ASL
06 - Hospital discharge planner		18 - Legal counsel	98 - Other
07 - Qualified mental retardation professional			

Name	Relationship to Person
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

LTC SD 26 C.3 In assessor's opinion, what is the primary and secondary reason for the person's request for assessment or referral: (Choose 1 or 2 reasons)

☐☐

01 Change in functional capacity	08 Abuse, neglect or exploitation	14 Health risk assessment
02 Behavioral or emotional problem	09 Requested relocation to community from any facility	15 Coordination of new and acute services
03 Disorientation or confusion	10 Housing inadequate/inappropriate	16 Health status change
04 Current services not adequate	11 Reassessment (P)	17 Transition to housing with services consult
05 Permanent loss of caregiver	12 Subacute or rehabilitative care needed (90 days or less)	98 Other problems (SPECIFY)
06 Caregiver exhaustion/need for respite or other supports	13 Annual LTC assessment for under age 65 consumer	_____
07 Temporary absence or inability of caregiver		

C.4 Is the person able to participate in the interview?
☐ Yes (Skip to D) ☐ No (Go to C.5)

C.5 Describe in detail why person is unable to participate. (If it is suspected the person is not cognitively intact, but can verbalize or communicate at all, go to section H. 10, p. 20, and attempt MSQ. If person has an MSQ score consistent with the presence of dementia (≥ 10), complete the rest of the assessment with an informant and verify information already received.)

Comments/Community Support Plan Implications

D. Independent Living: Instrumental Activities Of Daily Living (IADLs)

R1 | R2

List all sources of information for IADLS, using the following codes: Person (C), Informant (I), Medical record (R), Observation (O). If informant, complete below

D.1 Who is source of information? ***(Complete below)***

Name: _____

Address: _____

City _____ State ____ Zip code_____

Phone: (_____)_____

Assessor: Definitions for coding:

Some help (or supervision): the person needs physical help from one or more persons during part of the activity, or *occasional* reminders or instructions (cueing), but the person is typically able to participate.

A lot of help (or supervision): The person needs physical help from one or more person during *all parts* of the activity; the person needs *constant* reminders or instructions, or the person needs *simultaneous* help from more than one person for some or all of activity.

Now I want to ask you some questions about how you are managing everyday tasks such as shopping or paying bills. For each question, I have a set of possible answers that I would like to read. Then we can go over them and discuss which one fits best for you.
Sources:_____

LTC SD 60 ☐ D.2 How well are you able to answer the telephone? Would you say that you:

01 need no help or supervision COMMENTS:
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

LTC SD 61 ☐ D.3 How well are you able to make a telephone call? Would you say that you:

01 need no help or supervision COMMENTS:
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

LTC SD 62 ☐ D.4 Now I would like to know about how you manage shopping for food and other things you need. Would you say that you:

01 need no help or supervision COMMENTS:
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

LTC SD 63 ☐ D.5 How well are you able to prepare meals for yourself? Meals may include sandwiches, cooked meals and TV dinners. Would you say that you:

01 need no help or supervision COMMENTS:
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

		R1	R2

LTC SD 64 D.6 How well can you manage to do light housekeeping, like dusting or sweeping? Would you say that you:

01 need no help or supervision
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

COMMENTS:

LTC SD 65 D.7 How well can you do heavy housekeeping? Heavy housekeeping includes activities like yard work, or emptying the garbage, but not including laundry. Would you say that you:

01 need no help or supervision
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

COMMENTS:

LTC SD 66 D.8 What about your ability to do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes? Would you say that you:

01 need no help or supervision
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

COMMENTS:

LTC SD 67 D.9 How about your ability to take your own medication? Would you say that you:

01 need no help or supervision
05 don't take medications
06 need medication setup only
07 need verbal or visual reminders only
08 need medication setups and reminders
09 need medication setups and administration

COMMENTS:

LTC SD 68 D.10 Are you diabetic? If yes, how do you control your diabetes?

01 not diabetic
02 no insulin require; diet controlled only
03 oral medications
04 sliding scale insulin and oral medications
05 scheduled daily insulin
06 scheduled daily insulin plus daily sliding scale

COMMENTS:

LTC SD 69 D.11 Now I want to know about your ability to handle your own money, like paying your bills, or balancing your checkbook. Would you say that you:

01 need no help or supervision
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

COMMENTS:

LTC SD 70 D.12 How well are you able to use public transportation or drive to places beyond walking distance? Would you say that you:

01 need no help or supervision
02 need some help or occasional supervision
03 need a lot of help or constant supervision
04 can't do it at all

COMMENTS:

Comments on Functional Strengths/IADLs/Community Support Plan/Supervision Implications:

E. Caregiver Supports/Social Resources

R1 R2

E.1 Check sources of information used for Informal Support/Social Resources Section.

☐ Person ☐ Other (SPECIFY) _____

E.2 Is there someone who regularly helps you care for your home or yourself, or who regularly helps with errands or other things? ☐ Yes **(Complete Section O)** ☐ No

Caregiver's Name_____

E.3 Do you have someone who could stay with you for awhile if you needed to or if you were sick? ☐ Yes (Complete below) ☐ No

Name: _____

Address _____

Relationship _____ Phone (work/home) _____

E.4 Is there anybody who you would NOT want to be involved with your care if you were sick or needed help? ☐ Yes (Complete below) ☐ No

Name	Relationship

E.5 Do you have someone you confide in when you have a problem?
☐ Yes (Complete below) ☐ No

Name	Relationship

E.6 Did you talk to friends, relatives, or others on the telephone as often as you would want in the past week (either they called you or you called them?) (Not applicable to paid helpers)
☐ Yes ☐ No

E.7 Did you spend some time with someone who does not live with you as often as you would want? That is, you went to see them or they came to visit you or you went to do things together? ☐ Yes ☐ No

E.8 What is a typical day like for you? ***(or ASK:)*** What do you usually do, starting from the morning?

E.8a What, if anything, would you change about your typical day?

	R1	R2

E.9 What activities or things do you enjoy doing? Are there activities that you enjoy that you would like to do more frequently? Is anything needed to support or help you do these activities?

E.10 Are you able to attend religious services or practice your religion as often as you like?

☐ Yes Name of church/synagogue: _____
☐ No ☐ Do not attend religious service

E.11 Would you like to continue to live where you are now or is there somewhere else you would prefer to live?

☐ Continue to live here
☐ Prefer to live somewhere else (Specify) _____
☐ Don't know

E.12 If you became ill or could no longer continue to live at home, do you have any thoughts about where you would like to go?

☐ Home
☐ Smaller home or apartment
☐ Relative's home (Specify) _____
☐ Board and lodge
☐ Boarding care facility
☐ Nursing home
☐ Other (Specify) _____
☐ Don't know

Comments on Social Resources/Community Support Plan Implications:

F. Health Assessment

F.1 Check sources of information used for this section:

☐ Person ☐ Record Review ☐ Other (Specify) _____

F.2 Who is your regular doctor? (Also ASK:) Are you seeing any other doctors or specialists of any kind? ☐ Don't know

	Name	Specialty	Address	Phone
Regular:				
Other:				
Other:				

How often have you seen your doctor or specialist in the last 6 months? _____

For what reason(s)?

LTC SD 55 F.3 Subjective Evaluation of Health *(address to person only)*

R1 R2

Overall, would you rate your health as excellent, good, fair, or poor?

04 Excellent	03 Good	02 Fair	01 Poor	00 No response

Health Conditions

F.4 Do you have any health problems? How do they affect you and how long have you had them?
(ASK:) For instance, has a doctor ever told you that you have any of the following health problems?

Cardiovascular
- ☐ Chest Pain
- ☐ Ankle edema
- ☐ Shortness of breath
- ☐ Hypertension
- ☐ Other _____

Respiratory
- ☐ Difficulty breathing (rest/exertion/pain)
- ☐ Asthma
- ☐ Cough (dry/productive)
- ☐ COPD (Emphysema)
- ☐ Other _____

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Bowel problems
- ☐ Gall bladder problems
- ☐ Other _____

Hearing
- ☐ Decreased acuity
- ☐ Earaches
- ☐ Hearing aid
- ☐ Other_____

Skin Rashes
- ☐ Stasis ulcers
- ☐ Dermatitis
- ☐ Shingles
- ☐ Decubitus ulcer
- ☐ Other _____

Infectious Diseases
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV positive (AIDS)
- ☐ STD
- ☐ Other _____

Genitourinary
- ☐ Difficult/frequent urination
- ☐ Frequent bladder infections
- ☐ Dribbling/incontinence
- ☐ Dialysis (type)
- ☐ Other _____

Neurological
- ☐ CVA (Stroke)
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Dizziness
- ☐ Dementia (type)
- ☐ Paralysis
- ☐ Traumatic brain injury
- ☐ Other _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Other _____

Visual
- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Corrective lens
- ☐ Other_____

Gynecological
- ☐ Breast changes
- ☐ Nipple discharge
- ☐ Vaginal discharge/bleeding
- ☐ Other _____

Musculoskeletal
- ☐ Osteoporosis
- ☐ Amputation
- ☐ Back pain
- ☐ Arthritis (type)_____
- ☐ Fractures
- ☐ Other_____

Cancer
- ☐ Type _____

Other
- ☐ Allergies (type)_____
- ☐ Drug Sensitivities (type) _____
- ☐ Anemia (type)_____
- ☐ Other _____

Comments on Health/Community Support Plan Implications:

F.5 (Record person's diagnoses, if known:)

R1 R2

	Diagnosis	ICD-9 Code
Primary:		
Secondary:		
History of DD? ☐ Y/N If yes, what is the diagnosis?:		
History of MI? ☐ Y/N If yes, what is the diagnosis?:		
History of BI? ☐ Y/N If yes, what is the diagnosis?:		

Medication Use

F.6 Are you currently taking any medication? *(Also ASK:)* Could you show me the drugs you are currently taking? Are there any medications you keep in a special place, like the refrigerator? Do you take any nonprescription drugs on a regular basis, like aspirin, vitamins, or laxatives?

☐ Yes (Complete below) ☐ No (Skip to Section F.9) ☐ Don't know

Name	Dosage	Frequency

F.7 How do you remember to take your medications? *(Do not read list. Check all that apply.)*

☐ Calendar ☐ Egg Carton, Envelopes ☐ Caregiver gives them ☐ RN setup
☐ Pill Minder ☐ Follows directions on label ☐ Other (Specify) _____

F.8 Assessor: Are you concerned that person is: (Check if Yes)

☐ Not taking meds on time?
☐ Not taking proper number of meds?
☐ Not getting Rx properly filled?
☐ Not getting meds needs reevaluated?
☐ Not getting meds due to cost?
☐ Affected by drug side effects?
☐ Taking prescriptions from too many physicians?
☐ Using outdated meds?
☐ Refusing to take meds?
☐ Having other medication problems?
(SPECIFY)_____
☐ Info re: Prescription Drug Program given

Comments on Medications/Community Support Plan/Supervision Implications

Special Equipment/Assistive Devices

R1	R2

F.9 Do you have any of the following special equipment or aids? ***(ASK:)*** Do you use (name of aid)? Code "None" if no devices used OR needed
(Explain device to person. If person doesn't have it, ASK:) Do you need any of this equipment?

	Yes	Needs
Dentures	☐	☐
Cane	☐	☐
Walker	☐	☐
Wheelchair (manual, electric)	☐	☐
Brace (leg, back)	☐	☐
Hearing aid	☐	☐
Glasses/contact lenses	☐	☐
Lift chair	☐	☐
Hospital bed	☐	☐

	Yes	Needs
Medical phone alert	☐	☐
Supplies e.g., Incontinence pads	☐	☐
Bedside commode	☐	☐
Bathing equipment	☐	☐
Transfer equipment	☐	☐
Adaptive eating equipment	☐	☐
Other	☐	☐

(Specify)_____

None ☐

Comments/Plan Implications

Medical Treatments/Therapies

F.10 Do you regularly receive any of the following medical treatments, such as:
(Code "None" if no treatment received OR needed)

	Yes	Needs
Bedsores treatment	☐	☐
Bowel care	☐	☐
Catheter care	☐	☐
Colostomy care	☐	☐
Dialysis at home	☐	☐
Dialysis outpatient	☐	☐
IV therapies	☐	☐
Ostomy care	☐	☐
Oxygen	☐	☐
Pacemaker	☐	☐

	Yes	Needs
Respiratory treatment	☐	☐
Suctioning	☐	☐
Wound care	☐	☐
Occupational therapy	☐	☐
Speech therapy	☐	☐
Respiratory therapy	☐	☐
Physical therapy	☐	☐
Diabetes education	☐	☐
Other	☐	☐

(Specify)_____

None ☐

Overall Health Assessment/Plan for Skilled Nurse Visits

Alcohol/Tobacco/Substance Use

R1 R2

F.11 Do you drink any alcoholic beverages including beer and wine or do you never drink alcohol? ☐ Drinks alcohol ☐ Never drinks alcohol *(SKIP # 12 & 13)*

F.12 On average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day? _____ *(Probe for frequency)*

F.13 Has alcohol caused you any problems? ☐ Yes ☐ No
(IF YES:) Please describe. _____

F.14 Do you smoke or use tobacco? ☐ Yes ☐ No
If yes, how much do you smoke or use and how often? *(Probe for frequency per day.)*_____
_____

F.15 Do you use any other substances such as marijuana, cocaine or amphetamines?
☐ Yes ☐ No If yes, which? _____

Assessor:

F.16 Are you concerned about the person's alcohol/tobacco/substance use? ☐ Yes ☐ No

Comments/Care Plan Implications for Substance Abuse

Medical Utilization

LTC SD 30 F.17 Is the person transferring or did transfer from an acute care facility (hospital) to nursing facility services? ☐ Y/N

LTC SD 32 F.17a PAS 30-day exempt? ☐ Y/N

LTC SD 73 F.17b In the past year, have you gone to a hospital emergency room? ☐ Yes ☐ No
If yes, how many times? ☐ Why?_____

LTC SD 72 F.18 In the past year, have you stayed overnight or longer in a hospital? ☐ Yes ☐ No
If yes, how many times? ☐ Why?_____

LTC SD 74 F.19 In the past THREE years, have you spent any time in a nursing facility? ☐ Yes ☐ No
If yes, how many times? ☐ Why?_____

Nutrition

F.20 How is your appetite? Would you say that it is good, fair or poor?
☐ Good ☐ Fair ☐ Poor

F.21 What is your current weight? _____

F.22 What is your height?_____

F.23 Have you gained or lost weight in the last 6 months?
☐ No ☐ **Gain** ☐ **Loss** *(Describe gain or loss. 10% change is significant.)*
_____

F.24 Do you have any problems that make it difficult to eat? For example, do you have:

RI R2

None ☐

	Yes		Yes
Dental problems?	☐	Can't eat certain foods?	☐
Swallowing problems?	☐	Any food allergies?	☐
Nausea?	☐	Any other problems with eating?	☐
Taste problems?	☐	(Describe) _____	

F.25 Are you on any of the following special diets:

None ☐

	Yes		Yes
Low salt	☐	Calorie supplement?	☐
Low fat?	☐	Other special diet?	☐
Low sugar?	☐	(Describe) _____	

F.26 Briefly describe what you usually eat during the day and evening and when you like to eat your meals.

Morning: _____ Time: _____

Afternoon: _____ Time: _____

Evening: _____ Time: _____

F. 27 Where do you usually eat your meals?

Home/residence	☐	Restaurants/fast food	☐
At family member's residence	☐	Meals at congregate meal sites	☐

Comments on Nutrition/Plan Implications

G. Functional Assessment: Activities of Daily Living (ADLs)

The use of form DHS-3428C (Supplemental Form for Assessment of Children under 18) is required for all clients under age 18. List all sources of information for ADLS, using the following codes: Person (**C**), Informant (**I**), Medical record (**R**), Observation (**O**). Enter value of score in first box in left margin. Check as "dependence" in second box in left margin if value is asterisked.

If informant: Name _____ Sources: _____

Activities Of Daily Living (ADLs)

(Address to person if possible. Person may look at questions. The purpose of these questions is to determine actual capacity to do various activities. Sometimes, caregivers help with an item regardless of the person's ability. Ask enough questions to make sure the person is telling you what they can or cannot do. If informant is used, include help in the form of supervision or cueing.

Now I want to ask you some questions about how you eat, dress, bathe, and get around. For each of these questions, I have a set of possible answers. I would like to read them all and then we can go over them and discuss which one fits best for you. (Read all choices before taking answer).

G. ADLs

RI R2

LTC SD 39 G.1 Dressing

Value Dep

How well are you able to manage dressing? By dressing, we mean laying out the clothes and putting them on, including shoes, and fastening clothes. Would you say that you:

Comments

00 • can dress without help of any kind?

01 • need and get minimal supervision or reminding?

*02 • need some help from another person to put your clothes on?

*03 • cannot dress yourself and somebody dresses you?

*04 • are never dressed?

LTC SD 40 G.2 Grooming

Value Dep

Now I have some questions about how you manage with grooming activities like combing your hair, putting on makeup, shaving, and brushing your teeth. Would you say that you:

Comments

00 • can comb your hair, wash your face, shave or brush your teeth without help of any kind?

01 • need and get supervision or reminding or grooming activities?

*02 • needs and get daily help from another person?

*03 • are completely groomed by somebody else?

LTC SD 41 G.3 Bathing

Value Dep

How well can you bathe or shower yourself? Bathing or showering by yourself means running the water, taking the bath or shower without any help, and washing all parts of the body, including your hair and face. Would you say that you:

Comments

00 • can bathe or shower without any help?

01 • need and get minimal supervision or reminding?

02 • need and get supervision only?

03 • need and get help getting in and out of the tub?

*04 • need and get help washing and drying your body?

*05 • cannot bathe or shower, need complete help?

RI R2

LTC SD 42 G.4 Eating

Value Dep ☐☐

How well can you manage eating by yourself? Eating by yourself means drinking and eating without help from anybody else, but you can use special utensils and straws. It also means cutting most foods on your own. Would you say that you:

Comments

00 • can eat without help of any kind?

01 • need and get minimal reminding or supervision?

*02 • need and get help in cutting food, buttering bread or arranging food?

*03 • need and get some personal help with feeding or someone needs to be sure that you don't choke?

*04 • need to be fed completely or tube feeding or IV feeding?

LTC SD 43 G.5 Bed Mobility (Positioning on DHS-3428C)

Value Dep ☐☐

How well can you manage sitting up or moving around in bed? Would you say that you:

Comments

00 • can move in bed without any help?

01 • need and get help sometimes to sit up?

*02 • always need and get help to sit up?

*03 • always need and get help to be turned or change positions?

LTC SD 44 G.6 Transferring

Value Dep ☐☐

How well can you get in and out of a bed or chair? Would you say that you:

Comments

00 • can get in and out of a bed or chair without help of any kind?

01 • need somebody to be there to guide you but you can move in and out of a bed or chair?

*02 • need one other person to help you?

*03 • need two other people or a mechanical aid to help you?

*04 • never get out of a bed or chair?

LTC SD 45 G.7 Walking (Mobility on DHS-3428C)

Value Dep ☐☐

How well are you able to walk around, either without any help or with a cane or walker, but not including a wheelchair? (If asked, clarify that independence in walking refers to the ability to walk short distances around the house. Independence in walking does not include climbing stairs.) Would you say that you:

Comments

00 • walk without help of any kind?

01 • can walk with help of a cane, walker, crutch or push wheelchair?

*02 • need and get help from one person to help you walk?

*03 • need and get help from two people to help you walk?

*04 • cannot walk at all?

	RI	R2

☐ G.8 Wheeling

Comments

00 • Does not use wheelchair, or receives no personal help with wheeling.

01 • Needs and receives help negotiating doorways, elevators, ramps, locking or unlocking brakes or uses power driven wheelchair.

02 • Needs and receives total help with wheeling.

LTC SD 57 G.9 Communication

Comments

☐

00 • Communicates needs.

01 • Communicates needs with difficulty but can be understood.

02 • Communicates needs with sign language, symbol board, written messages, gestures or an interpreter. (Do not code ESL)

03 • Communicates inappropriate content, makes garbled sounds, or displays echolalia.

04 • Does not communicate needs.

LTC SD 56 G.10 Hearing

Comments

☐

00 • No hearing impairment.

01 • Hearing difficulty at level of conversation.

02 • Hears only very loud sounds.

03 • No useful hearing.

04 • Not determined.

LTC SD 58 G.11 Vision

Comments

☐

00 • Has no impairment of vision.

01 • Has difficulty seeing at level of print.

02 • Has difficulty seeing obstacles in environment.

03 • Has no useful vision.

04 • Not determined.

LTC SD 52 G.12 Orientation

RI R2

Orientation is defined as the awareness of an individual to his/her present environment in relation to time, place and person. See H.7 and H.10 for memory/orientation information.

Comments

00 • Oriented.

01 • Minor forgetfulness.

02 • Partial or intermittent periods of disorientation.

03 • Totally disoriented; does not know time, place, identity.

04 • Comatose.

05 • Not determined.

LTC SD 46 G.13 Behavior

Value Dep

Comments

00 • Behavior requires no intervention.

01 • Needs and receives occasional staff intervention in the form of cues because the person is anxious, irritable, lethargic or demanding. Person responds to cues.

*02 • Needs and receives regular staff intervention in the form of redirection because the person has episodes of disorientation, hallucinates, wanders, is withdrawn or exhibits similar behaviors. Person may be resistive, but responds to redirection.

*03 • Needs and receives behavior management and staff intervention because person exhibits disruptive behavior such as verbally abusing others, wandering into private areas, removing or destroying property, or acting in a sexually aggressive manner. Person may be resistant to redirection.

*04 • Needs and receives behavior management and staff intervention because person is physically abusive to self and others. Person may physically resist redirection.

LTC SD 47 G.14 Toileting

Value Dep

How well can you manage using the toilet? ***(Using the toilet independently includes adjusting clothing, getting to and on the toilet, and cleaning one's self. If reminders are needed to use the toilet this counts as some help.)*** Would you say that you:

Comments

00 • can use the toilet without help, including adjusting clothing?

*01 • need some help to get to and on the toilet but don't have "accidents"?

*02 • have accidents sometimes, but not more than once a week?

*03 • only have accidents at night?

*04 • have accidents more than once a week?

*05 • have bowel movements in your clothes more than once a week?

*06 • wet your pants and have bowel movements in your clothes very often?

LTC SD 53 G.15 Self-Preservation

☐ Does the individual have the judgement and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation?

Comments

00 • Independent.
01 • Minimal supervision.
02 • Mentally unable.
03 • Physically unable.
04 • Both mentally and physically unable.

RI **R2**

LTC SD 48 G.16 Special Treatments *(Check all that apply.)*

☐

00 No TX.
01 Tube Feedings
02 One or more TX such as:

☐ Intravenous Fluids
☐ Intravenous Medications
☐ Blood Transfusions
☐ Drainage Tubes
☐ Symptom Control for Term. Ill
☐ Isolation Precautions
☐ Hyperalimentation/Hickman Catheter
☐ Oxygen & Respiratory Therapy
☐ Ostomies & Catheters
☐ Wound Care/Decubiti
☐ Skin Care
☐ Other _____

LTC SD 49 G.17 Clinical Monitoring

00 Less than once a day 01 1-2 shifts 02 All shifts

☐

G.18 Special Nursing: Use for AC & Waiver Case Mix Classification Worksheet

In order to code this item "yes", the person must receive ***either*** tube feeding only, or a combination of other Special Treatment ([02] in G.16 ***and*** 02 in Clinical Monitoring in G.17 above. ☐ Y/N

LTC SD 50 G.19 Neuromuscular Diagnosis. Also complete on page 10, F.5.
☐ Y/N

Count number of ADL Dependency boxes checked in G.1, 2, 3, 4, 5, 6, 7 and G.14 . Dependency in these activities is indicated by an asterisk. For children under 18, use form # DHS-3428C to determine the number of age-appropriate ADL dependencies. Total number of ADL Dependencies from this form or DHS-3428C:

Use with AC & Waiver Case Mix Classification Worksheet form #DHS-3428B

LTC SD 51 G.20 ☐ **Case Mix Classification:** Completion required only for the EW, CAC, CADI and BI-NF Waivers and the AC program as part of budget process. Use form number DHS-3428B & DHS-3428C for classification

LTC SD 84 G.20a **Case Mix Amount:** Complete for CAC program, requests for higher rates under "conversion" program types or requests to exceed the limits for people under 65.

$ ☐

LTC SD 107 G.21 CDCS Amount $_____

Comments on Functional Strengths/ADLs/Community Support Plan/Supervision Implications:

H. Emotional & Mental Health

H.1 Check sources of information used for EMOTIONAL/MENTAL HEALTH Section.

☐ Person ☐ Informant ☐ Other (Specify) _____

H.2 Does person have a recent history of receiving mental health services? ☐ Yes ☐ No

(If yes: Describe.)_____

LTC SD 19 H.3 Is there a history of mental illness diagnosis? ☐ Y/N

LTC SD 19a If so, what is it?_____

LTC SD 21 H.4 Does the person have a mental health targeted case manager? ☐ Y/N

If yes, name _____

Emotional Assessment

H.5 Now I have some questions about how you have been feeling during the past month.

	Yes	No		Yes	No
Are you satisfied with your life today?	☐	☐	Have you had difficulty sleeping?	☐	☐
Have you been depressed, or very unhappy?	☐	☐	Seen or heard things that other people didn't see or hear?	☐	☐
Have you been feeling like you have too much energy or can't stop being busy?	☐	☐	Become physically aggressive, or made any threats to harm anyone?	☐	☐
Have you been anxious a lot or bothered by your nerves?	☐	☐	Made any threat to harm or kill yourself?	☐	☐

H.6 Are you receiving any mental health services or counseling?

☐ Yes ☐ No (If yes, complete below)

Name of provider	Comments
_____	_____
_____	_____

RI R2

H. Emot/MH

H.7 Next, I'd like to ask you some questions about your memory and ability to find things and follow through on simple tasks. In the past month, have you:

None ☐

	Yes		Yes
Frequently misplaced items such as your purse (wallet) or glasses?	☐	Lost your way around the house, e.g., can't find the bedroom or bathroom?	☐
Failed to recognize family members or friends?	☐	Had other problems with your memory?	☐
		(Specify) _____	

Comments on Memory/Plan Implications

OBRA Level I and II

LTC SD 31 H.8 OBRA Level I completed ☐ Y/N

H.8a **Assessor:** In your opinion, does the person . . .

	Yes	No		Yes	No
Appear to be depressed, lonely or dangerously isolated?	☐	☐	Does the person need supervision? (If yes, specify how much, e.g., constant, at night only) _____	☐	☐
Have cognitive deficits that pose a threat to his/her ability to remain in (or return to) the community?	☐	☐	Show suicidal ideation?	☐	☐
			Demonstrate other behavior problems?	☐	☐
			(Specify) _____		

H.9 Does the person require a:

☐ Mental health referral

LTC SD 37 ☐ Mental health evaluation ☐ Y/N **OBRA Level II Referral: MI**

LTC SD 37 ☐ Referral for developmental disabilities assessment ☐ Y/N **OBRA Level II Referral: DD**

☐ None

Mental Status Evaluation

H.10 *(Ask person only. Write in answers to questions. Do not try to score until after evaluation. Score 1 for each incorrect response. In scoring, a "No Response" is treated as incorrect. A correct response is 0.* ***For the memory phrase, have the person repeat the phrase twice before continuing.)*** Now, I'm going to read you a list of questions. These are questions that are often asked in interviews like this and we are asking them the same way to everyone. Some may be easy and some may be difficult. Let's start with today's date.

Orientation-Memory-Concentration Test (Katzman et al., 1983)

Items	Maximum Errors	Score		Weight		Weighted Score
1 What year is it now?	1	_____	x	4	=	_____
2 What month is it now?	1	_____	x	3	=	_____
Repeat this phrase after me: Memory phrase: John Brown, 42 Market Street, Chicago						
3 About what time is it? (Within 1 hour)	1	_____	x	3	=	_____
4 Count backwards 20 to 1	2	_____	x	2	=	_____
5 Say the months in reverse order	2	_____	x	2	=	_____
6 Repeat the memory phrase (Once)	5	_____	x	2	=	_____

Total Weighted Error Score: _____
(Write in box at left)

LTC SD 59 ☐ Maximum weighted error score = 28. INTERPRETATION: A score of 10 or more is consistent with the presence of dementia, excluding REFUSED: Score 29, NA: Score 30

Comments on Mental and Emotional Health/Community Support Plan/Services and Supervision Implications:

R1	R2

I. Self Preservation & Safety *(Ask caregiver or assessor's opinion)*

I.1 Do you think (NAME OF PERSON) would be able to evacuate safely if there was a fire?
☐ Yes ☐ No Why not?_____

I.2 Does (NAME OF PERSON) ever smoke carelessly, leave the stove on, leave the doors unlocked, or do anything else which puts her/himself in danger?
☐ Yes What steps have been taken or need to be taken to make things safe?
_____
☐ No

I.3 Do you think the person is capable of getting help in an emergency? ☐ Yes ☐ No

Environmental Assessment

I.4 *(Ask person only):* Are you concerned about your safety or ability to get around in your home or neighborhood? ☐ Yes ☐ No

LTC SD 71 ☐ I.5 Have you experienced any falls in your home or while out in the community?
00 No 01 Yes

If no, ask: Does concern about your balance or falling affect your daily activities or access to the community? 00 No 02 Yes

Assessor Evaluation of Environment

I.6 Assessor, please indicate the specific area(s) in which there are potential safety or accessibility problems for the person. Check "None" if no potential problems.

Yes	Area
☐	Structural damage
☐	Barriers to access (including steps and stairs)
☐	Electrical hazards
☐	Signs of careless smoking
☐	Other fire hazards
☐	Dangerous floors? Scatter rugs
☐	Unsanitary conditions/odors
☐	Insects or other pests
☐	Poor lighting

Yes	Area
☐	Insufficient hot water/water
☐	Insufficient heat
☐	Shopping not accessible
☐	Transportation not accessible
☐	Telephone not accessible
☐	Neighborhood environment unsafe
☐	Other

(Specify) _____
None ☐

	R1	R2

Abuse/Neglect Screen: *(Ask person only)*

I.7 Have any of these things happened to you? If no, ask if person has concerns/fears about any.

Y	N	Concern	
☐	☐	☐	Someone mismanaging your money
☐	☐	☐	Someone hurting you physically (e.g. hitting, slapping, pushing, kicking)
☐	☐	☐	Someone touching you in a way that makes you uncomfortable
☐	☐	☐	Someone being emotionally or psychologically abusive to you

Assessor Evaluation of Neglect

		Yes	No
I.8	Is there evidence of neglect by self?	☐	☐
	Is there evidence of neglect by caretaker? Evidence may include chronic poor hygiene, malnutrition, sores, etc.	☐	☐

Comments on Safety/Community Support Plan, Abuse Prevention/Services and Supervision Implications:

J. Assessment Results: Recommendations and Choices

J.1 In the assessor's judgement, does this person require the level of care provided by a facility?
☐ Yes ☐ No

LTC SD 82 J.2 What level of care would be most appropriate?

☐

01 May be appropriate for ICF/DD (including RTC/ICF/DD)	05 Extended Stay Hospital
02 Nursing Facility/Certified Boarding Care	06 In NF but may be appropriate for ICF/DD
03 Psychiatric Inpatient Hospital	07 No facility level of care
04 Acute Hospital	

J.3 Professional Conclusions (Answer the following yes or no)

		Y/N
LTC SD 86	• The person has an **ADL** condition or limitation.	☐
LTC SD 87	• The person has an **IADL** condition or limitation.	☐
LTC SD 88	• The person has a complicated condition.	☐
LTC SD 89	• The person has impaired cognition.	☐
LTC SD 90	• The person has a frequent history of behavior symptoms.	☐
LTC SD 91	• The person has not or may not ensure his/her own care, hygiene, nutrition or safety.	☐
LTC SD 92	• The person has been, or may be neglected, abused, or exploited by another person.	☐
LTC SD 93	• The person is generally frail.	☐
LTC SD 94	• The person is experiencing frequent institutional stays	☐
LTC SD 95	• The person has a hearing impairment that with or without correction causes functional limitations.	☐
LTC SD 96	• The person is in need of restorative or rehabilitative treatments.	☐
LTC SD 97	• The person's health is unstable.	☐
LTC SD 98	• The person needs direct care services by a nurse during evenings or night shifts for special treatments.	☐
LTC SD 99	• The person requires complex health care management.	☐
LTC SD 100	• The person has a visual impairment not corrected by contacts or glasses.	☐

J.4 What ***cost effective*** alternatives were offered to the person and caregiver? (Check all that apply.)

RI **R2**

- ☐ 01 Remain at home with services
- ☐ 02 Remain at home without services
- ☐ 03 Out of home in community with services
- ☐ 04 Out of home in community without services
- ☐ 05 Uncertified boarding care
- ☐ 06 Nursing facility
- ☐ 07 ICF/DD
- ☐ 08 Short-term NF (less than 90 days) return to community with services
- ☐ 09 Short-term NF (less than 90 days) return to community without services
- ☐ 10 Acute care
- ☐ 98 Other decision
- ☐ 99 Not applicable

LTC SD 77 J.5 **Assessment Results** The person is informed they can choose institutional or community services. ☐ Y/N

(Assessor: Choose code from J.5 for answering J.6, J.8, J.9, J.10)

- 01 Person will remain in, or return to, the community with at least one AC or waiver service.
- 02 Person will remain in, or return to, the community with services not funded by AC or the waiver programs.
- 03 Person will remain in, or return to, the community without services.
- 04 Person will/resides in a nursing facility or certified boarding care.
- 05 Person will/resides in a noncertified boarding care.
- 06 Person will/resides in an ICF/DD.
- 07 Hospital discharge to a nursing facility - short stay of 90 days or less.
- 08 Hospital discharge to a nursing facility - long stay of 91 days or longer.
- 09 Person will/receives long-term hospitalization.
- 10 Person is changing to a different program.
- 11 Person is reopening to the same program (use if ever opened to the program).
- 13 Person continues on the same program at reassessment.
- 18 Transition planning (ongoing) or AC conversion case management
- 28 Person opened from a CADI or BI list

Exit Reasons When using Exit Reason in 75A (see J.11 below), an Assessment Result Code must also be completed in 75B on the Long Term Care Screening Document to indicate what happened to the person after closing under the waiver, AC, MSHO or MSC+.

- 19 Person exited EW or AC due to changes in financial eligibility.
- 20 Person exited because condition worsened; program can no longer meet the person's needs.
- 21 Person exited because condition improved; no level of care.
- 22 Person exited because no longer meets other eligibility criteria.
- 23 Person exited by choice.
- 24 Person exited for other reason(s).
- 25 Person exited waiver, services NEVER used.
- 26 Person exited; county changes.
- 31 Exit, non-payment of AC premium.
- 33 Person exited because of AC estate claim recovery.
- 34 Person exited because of AC premium changes.

Other

- 29 Undecided
- 30 Person died.
- 32 Updated AC financial.
- 35 MSHO, MSC+ and SNBC health risk assessment
- 36 Elected Elderly CDCS
- 37 Elected Elderly Non-CDCS Services from CDCS
- 39 Refusal of health risk assessment
- 41 CADI waiver access
- 42 BI-NF waiver access
- 43 NF visit every 3 years
- 44 BI-NB waiver access
- 47 No longer need waiver access
- 98 Other
- 99 Not applicable - No family

LTC SD 78 J.6 What is the person's choice? ☐

LTC SD 79 J.7 What is the guardian's choice? ☐

LTC SD 106 J.8 CDCS ☐ Y/N

LTC SD 80 J.9 What is the family/caregiver's choice? ☐

LTC SD 81 J.10 What is the LTCC team recommendation? ☐

LTC SD 38 J.10a BI/CAC referral? ☐ Y/N

LTC SD 29 J.10b Assessment team ☐

01 County/Tribal agency 02 Health Plan 03 County Subcontracting for Health Plan 04 County Inter-Disciplinary Team

LTC SD 75 J.11 What is the final action (Assessment Result) that will be taken?

A ☐ B ☐

LTC SD 76 J.11a Effective Date ____/____/____ MM DD YY

J. Results

LTC SD 85 ☐☐ J.12 The reason(s) provided are used for RSC, CDCS, or CADI or BI waiting/planning lists. If the person was assessed for relocation from a facility and is NOT returning to the community, indicate reason(s) for continuing institutional stay. If the person was terminating CDCS services, indicate reason why. If the person is placed on a waiver program waiting/planning list, indicate the reason(s):

RI R2

01 AC or waiver funding unavailable	06 Caregiver temporarily unavailable
02 Case mix/CDCS budget cap doesn't meet person's needs	07 Vulnerable situation
	08 Caregiver exhaustion
03 Health status	09 Client choice
04 Lack of housing	10 Rehabilitation not complete
05 Services not available	11 Involuntary exit from CDCS

J.13 Is the person being placed on a waiver program waiting list?

☐ Yes List program(s): _____

☐ No

J.14 If person is in or will be admitted to a nursing home, what is the projected length of stay?

☐ 30 days or less ☐ 31-90 days ☐ 91-180 days ☐ longer than 180 days

J.15 Will person in NF/CBCF receive AC conversion case management or Relocation Services Coordination? ☐ Yes ☐ No

Anticipated discharge date: ____/____/____ (MM DD YY)

Date of next contact with person/caregiver: ____/____/____ (MM DD YY)

Name of person to contact: _____

Short-term goals to facilitate discharge: _____

LTC SD 36 ☐ J.16 Planned program license

02 ICF/DD	08 Housing with Services, class F
05 Foster care, corporate	09 None
06 Foster care, family	11 Nursing facility
07 Housing with Services, Class A	

LTC SD 34 ☐ J.17 Person's planned housing type:

01 Homeless	09 Own Home/Apartment
02 Institution ICF/DD	11 NF/Certif. Boarding Care
03 Hospital	12 Noncertif Boarding Care
04 Board & Lodge	16 Correctional facility
05 Foster Care	

LTC SD 28 ☐ J.18 Person's planned living arrangement:

01 Living alone	03 Living with family/friend/significant other	05 Homeless
02 Living with spouse/parents	04 Living in congregate setting	

J.19 Waiver /AC eligibility criteria (all questions must be answered yes for AC or waiver programs)

	Y/N	
LTC SD 101	☐	• The person requires one or more AC or waiver service to delay or prevent institutionalization.
LTC SD 102	☐	• The person's needs can be met in the community in a satisfactorily safe and cost effective manner.
LTC SD 103	☐	• No other payor is responsible to cover services authorized and billed to the waiver or AC

LTC SD 104 J.20 Program type

R1 R2

00	None	06	CADI conversion	12	BI-NB conversion
01	BI-NF diversion	07	CAC diversion	18	MSHO/MSC+ No program (comm. non-NHC)
02	BI-NF conversion	08	CAC conversion	19	MSHO/MSC+ NF resident
03	EW diversion	09	AC diversion	22	Temporary AC
04	EW conversion	10	AC conversion	28	SNBC
05	CADI diversion	11	BI-NB diversion		

J.21 Signature of assessor(s)

A._____ ____/____/____ MM DD YY

B._____ ____/____/____ MM DD YY

Signature of case manager/care coordinator _____ ____/____/____ MM DD YY

Assessors' Initials: **A. R1** Date ____/____/____ **R2** Date ____/____/____

B. R1 Date ____/____/____ **R2** Date ____/____/____

Case Mgr's Initials **R1** Date ____/____/____ **R2** Date ____/____/____

LTC SD 23 J.22 Assessor/Case manager NPI/UMPI number _____

J.23 If one person conducted the initial LTCC assessment indicate date: ____/____/____ MM DD YY

Name of team member consulted: _____

Notes:

J.24 Reassessment Due **R1** Date: ____/____/____ **R2** Date: ____/____/____

Note: A reassessment is due any time during the period one month prior to, and up to two months after, the 65th birthday for persons on the BI, CADI, or CAC waiver.

K. Service Plan Summary

R1 R2

Sources: I - Informal F - Formal Q - Quasiformal C - Customized Living Service

LTC SD 108 **Service Codes: Code service and source.** Complete plan to reflect all services. If an informal caregiver is providing support, please code at least one of those supports. If quasiformal services are or will be received, please code at least one of those supports. Use "C" to identify the services in the customized living services bundle for Elderly Waiver recipients. The MMIS Screening Document will allow up to 18 service codes to be entered. Enter the service code and the source code.

Service Code	Source Code: C, I, F, or Q
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐

01 Grocery Shopping
02 Chore Services
03 MA Transportation
04 Home Delivered Meals
05 Congregate Dining
06 Homemaker/Housekeeper
07 Money Management
08 Arranging Medical Care
09 Deaf/Hearing loss services
10 Companion/Friendly Visitor
11 Nurse Visits
12 Home Health Aide Visits
13 Physical Therapy
14 Occupational Therapy
15 Speech Therapy
16 Respiratory Therapy
18 Personal Care
19 Foster Care
20 Adult day care
21 Respite care
22 Independent living skills
23 Structured day program (BI)
24 Mental health services
25 Supplies/Equipment
26 Home modification
27 Caregiver training
28 Nutritional counseling
29 Hospice
30 Not receiving formal services
31 Assisted living (not used with EW)
32 Residential Care
33 Behavioral Services
34 NF
35 Case management
36 Voc/Support employment
37 Therapeutic day TX
38 Relocation Service Coordination (RSC)
39 24-hour supervision (not used with EW)
40 CDCS
41 Paid CDCS Parent/Spouse
42 Extended HHA
43 Extended RN
44 Extended LPN
45 Extended supplies and equipment
46 Extended PCA
47 Waiver/AC transportation
49 Adult day care bath
50 Transitional services
51 Prevocational services
52 Personal emergency response system
53 Delegated medication administration
54 Delegated health related
55 Arranging transportation
56 Individualized socialization support
57 Personal assistance, not PCA
58 24 hour supervision for intermittent and unscheduled support
59 24 hour supervision for clinical monitoring over 24 hours
60 24 hour supervision for dementia/ orientation/mental health /behavior
61 Less than 24 hour supervision
62 Laundry
63 Requested CIL visit
64 50 hour Direct Staff/Medication management assistance
65 GRH Room/board payment
66 PCA supervision
67 Cognitive rehab therapies
68 Service animal
69 Blind/Vision loss services
70 Respite care out-of-home
71 Vehicle modification
72 Adaptive equipment
73 Disease management
74 Family training
75 Adult protection sevices
76 Child protection services
77 Telemedicine services
78 ASL interpretor
79 Chemical health
80 Private duty nursing
81 Extended private duty nursing
82 Vent dependent
83 PERS Pendant only
84 AC Discretionary Services
85 24 Hour Supervision for 50 hours/ ADLS/medication management
86 24 Hour Supervision for 50 hours/ 3 ADLS/medication management
87 24-hour emergency assistance
88 Caregiver living expenses
89 Housing access coordination
90 Caregiver assessment (EW/AC)
98 Other

L. Alternative Care Information

			R1	R2
LTC SD 109	L.1	Gross Income $ _____		
	L.2	Gross Assets $ _____		
	L.3	AC Adjusted Income $ _____		
	L.4	AC Adjusted Assets $ _____		
LTC SD 110	L.5	AC Fee Waiver Reason		

☐

03 Married couple is requesting an asset assessment under the spousal impoverishment provision.
04 Person is residing in a NF and receiving Case Management only.
05 Person is found eligible for AC but is not yet receiving AC.
06 Person income/assets are below minimal amounts.
07 CDCS budget reduced by previous non-CDCS fee amount

LTC SD 111 L.6 Medicare eligibility ☐ Y/N

LTC SD 112 L.7 AC Fee Assessed ☐ Y/N

SA 16 L.8 AC Fee Payment Method

☐

00 The client is paying the monthly fee
01 A representative payee is appointed
02 Fee is automatically withdrawn from a financial account
03 The family is involved in the financial management of payments
04 Another method acceptable to the lead agency to ensure prompt fee payments is used
05 Client is making a partial payment
06 No fee

SA 17 L.9 AC Partial Payment $ _____

SA 18 L.10 AC Required Fee Payment $ _____

SA 19 L.11 AC Fee Effective date: ____/____ (MM / YY)

M. Notes

N. Reassessment Notes

O. Caregiver Assessment

R1 | R2

(Introduce yourself to caregiver.) (NAME OF REFERRAL OR PERSON) told us you were the person most involved in helping with (NAME OF PERSON's) care, so we have a few questions for you.

Relationship to care receiver:_____

O.1 First, how often do you give care to (NAME OF PERSON)? Would you say you give care:

☐ Every day ☐ Less than once a week ☐ At least once a week
☐ Several times a week ☐ Don't know

O.2 What kind of help do you give (NAME OF PERSON)? *(ASK:)* Do you give.

	Yes	Comments
Personal care (such as help with bathing, dressing, using the toilet, getting in and out of the bath, and feeding)	☐	_____
Housekeeping (such as help with meal preparation, cleaning and laundry)	☐	_____
Transportation	☐	_____
Shopping and errands	☐	_____
Supervision for safety	☐	_____
Money management	☐	_____
Other	☐	_____

(SPECIFY)_____

O.2a How long have you been helping (NAME OF PERSON) with this care? _____

O.3 In the last two weeks, how many hours did you spend giving care to (NAME OF PERSON)?
_____ hours in last two weeks

O.4 Are you employed full-time, part-time, or are you not employed?
☐ Full-time ☐ Part-time ☐ Not working

O.5 If you were unable to continue with care, who would take your place?
☐ Nobody ☐ Other (SPECIFY) _____

O.6 How is your own health? Would you say it is excellent, good, fair or poor?
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ No response

O.7 Considering the care you provide for (NAME OF PERSON), I would like to ask you if various aspects of your life have become worse, the same, or better. Let's start with...

	Worse	Same	Better	Don't Know	Comments/ Plan Implications
a. Relationship with (PERSON)	☐	☐	☐	☐	_____
b. Relationships with other family members	☐	☐	☐	☐	_____
c. Relationships with friends	☐	☐	☐	☐	_____
d. Your health	☐	☐	☐	☐	_____
e. (IF APPLICABLE:) Your work.	☐	☐	☐	☐	_____
f. Your emotional well-being	☐	☐	☐	☐	_____

	R1	R2

O.8 Is there anything that makes it difficult for you to provide care to (person's name)?
☐ Yes (DESCRIBE)_____

☐ No

Do you have any concerns about caring for (person), either about yourself, other family members or (person name)_____

_____

Assessor: O.9 List any factors that may limit caregiver:

	Yes		Yes
Job restricts caregiving	☐	Caregiver has difficulty making appropriate decisions	☐
Family responsibilities restrict caregiving	☐	Caregiver financially dependent upon person	☐
Limited knowledge to manage care	☐		
Caregiver is physically impaired	☐	Caregiver may have mental health/substance abuse	☐
Person's needs are heavy phisical burden for caregiver	☐	Other (SPECIFY) _____	☐
Caregiver's finances limit caregiving potential	☐	None	☐

O.10 How would you rate your level of burden in caring for (NAME OF PERSON)?
☐ None ☐ Low ☐ Medium ☐ High

O.11 What caregiver services are you presently receiving? (e.g. respite, care planning, training, information, care coordination, coaching, etc.)
☐ None ☐ Other _____

O.12 What services or community support would help you, the caregiver, to keep providing care for (NAME OF PERSON) to help keep him/her living in the community?

O.13 Would you like to be contacted by a community organization that can give you more information and assistance with caregiving?
☐ Yes ☐ No

Assessor: If the caregiver is presently receiving supportive services or answered "yes" to O.13, code 27-F in Section K of this form and in Section G on LTC SDoc (Services Plan)

Comments On Caregiver/Community Support Plan Implications:

Minnesota Department of **Human Services**

AC, BI, CADI, EW Case Mix Classification Worksheet

How To Arrive At A Case Mix Classification

The completed assessment form (DHS-3428) includes many items of information about a client, but only a few of these items are used in determining the case mix classification. Use form DHS-3428C, Children's Supplemental Form to determine age appropriate ADL dependency scores. Then return to this form for additional steps.

Step 1

Review scores in the eight Activities of Daily Living (ADLs) from the LTCC Assessment (DHS-3428) to determine the total number of key ADLs in which the client is considered "dependent". The ADLs and the dependency scores are:

Value Coded for Item	Not Dependent	Dependent
Dressing	0-1	2-4
Grooming	0-1	2-3
Bathing	0-3	4-5
Eating	0-1	2-4
Bed Mobility (Positioning)	0-1	2-3
Transferring (Mobility)	0-1	2-4
Walking	0-1	2-4
Toileting	0-0	1-6

Step 2

Determine the ADL Category as follows:

Low ADL = Dependent in 0-3 key Activities of Daily Living
Medium ADL = Dependent in 4-6 key Activities of Daily Living
High ADL = Dependent in 7-8 key Activities of Daily Living

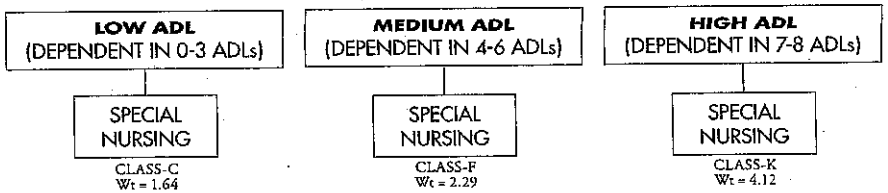
LOW ADL (DEPENDENT IN 0-3 ADLs)	MEDIUM ADL (DEPENDENT IN 4-6 ADLs)	HIGH ADL (DEPENDENT IN 7-8 ADLs)

In order to arrive at the appropriate case mix classification, the following next steps must occur in the order in which they are listed. An individual can only be classified in one case mix. After determining the ADL category for the individual:

Step 3

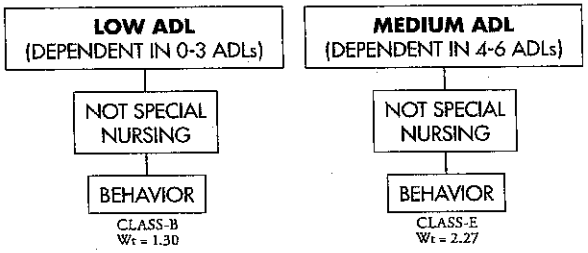
Special Nursing Case Mix Categories

If Tube Feeding (01) OR other Special Treatment (02) in combination with Clinical Monitoring every 8 hours (02), resulting case mix is **Low ADL = C, Medium ADL = F, High ADL = K.**



Step 4

If NOT Special Nursing, for High ADL individuals only, skip to Step 7. For Low and Medium ADL individuals, review the score in the **Behavior** item from the assessment. If the score is 02 or greater, the resulting case mix is **Low ADL = B, Medium ADL = E.**



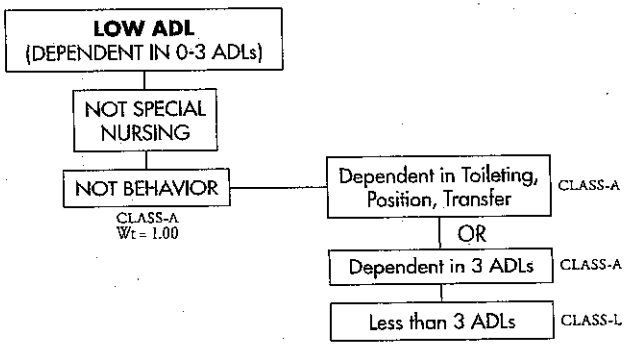
Step 5

If NOT Special Nursing and NOT Behavior:
Low ADL = A, Medium ADL = D.

Step 6

Very Low ADL

For individuals aged 65 and over only who are classified as Case Mix A after completing Steps 1-5, additional review of ADLs is required. An individual with **NO ADL dependency, no dependency in Toileting (>00), or Positioning (>01), or Transferring (>01) and less than 3 dependencies in Bathing, Dressing, Grooming, Walking or Eating** is classified as Case Mix L.

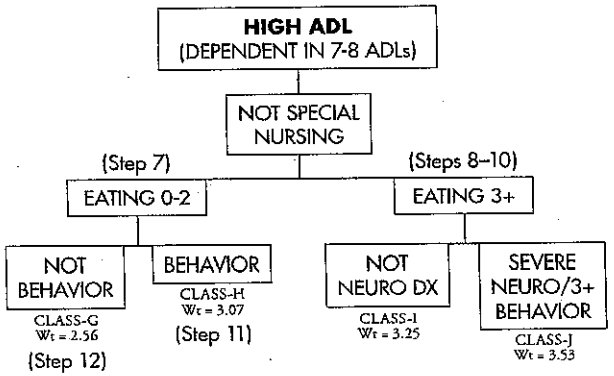


Step 7

High ADL Classifications

Classification of individuals in the High ADL category who did not meet the Special Nursing criteria specified in Step 3 begins with a review of the assessment score for **Eating**. (Individuals with High ADLs and Special Nursing needs are classified as Case Mix K under Step 3). See more information about Case Mix G, H, I and J classification in Steps 7 through 12.

If the score in Eating is 02 or less, skip Steps 8-10 and proceed to Step 11. If the score in Eating is 3 or more, go on to Step 8.



Step 8

High Score in Eating Plus Neurodiagnosis

When an individual has a **score of 3 or more in Eating**, consider whether the individual also has a diagnosis from the following list. The list of **neuromuscular diagnoses** included in this category is taken from the publication "International Classification of Diseases," 9th Revision, Clinical Modification (ICD-9-CM), commonly referred to as the ICD-9 Code Book. The **list of codes** is as follows:

- Diseases of nervous system excluding sense organs (320-359 excluding 331.0)
- Cerebrovascular Disease (430-438 excluding 437)
- Fracture of skull (800-804 excluding cases without intracranial injury)
- Spinal cord injury without evidence of spinal bone injury (952)
- Injury to nerve roots and spinal plexus (953)
- Neoplasms of the brain and spine (170.2; 170.6; 191; 198.3; 198.4; 213.2; 213.6; 225; 237.5; 237.6; 239.6)

If any **diagnosis** included within the list of codes above appears in the Diagnosis Section, the classification is **High ADL = J**

Step 9

High Need in Eating and Behavior

If the individual has no diagnosis from the above code list, review the score on the assessment form for **Behavior**. If the score is 3-4, the classification is **High ADL = J**

Step 10

If there is no diagnosis from the above code list and if the score on the Behavior is not 3-4, proceed to the alternative box marked **Not Neuro Diagnosis** and mark the classification **High ADL = I**

Step 11

If the score on the assessment form for **Eating** is 2 or less, proceed to the box marked Behavior. If the score is 2 or more for **Behavior**, the classification is **High ADL = H**

Step 12

If the assessment form score does not meet the criteria for Behavior, proceed to the alternative box marked Not Behavior and mark the classification **High ADL = G**

See the Case Mix Classification Summary on page 4 for a short description of each case mix.

Notes on Special Treatments

For a coding of Special Treatments, **the medical record** must establish that:

1. The physician has performed a medical evaluation of the client's immediate and long-term needs, as related to the special treatments;
2. A registered nurse has assessed the health needs of the client as they relate to the need for special treatments, and has communicated these needs to a physician;
3. A registered nurse has implemented the delegated medical functions and the nursing functions, which may be performed in collaboration with other health team members, or may be delegated by the registered nurse to other nursing personnel; and
4. A registered nurse has periodically reassessed the health needs of the client as they relate to the need for special treatments, and has regularly communicated these needs to a physician.

Special treatments can include:

Oxygen and Respiratory Therapy

Special measures to improve respiratory function. Standby oxygen would not be coded unless actually administered.

Ostomies and Catheters

Code if routine care is provided by licensed staff.

Wound Care/Decubiti

Includes wound and decubitus dressings and care, ostomy dressings and warm moist packs ordered for inflamed areas. The medical record must establish that:

1. The physician or a registered nurse has documented the presence of a wound;
2. A written wound treatment plan has been developed;
3. Progress notes indicating the client's response to treatment have been recorded by licensed nurses; and
4. The physician has documented periodic reassessment of the status and treatment of the wound and determined the need for continued wound care.

Skin Care

Recognized therapeutic and preventive measures in response to an identified medical condition or an identified high risk factor(s) which is related to a medical condition or a functional disability. The client's medical record must establish that:

1. The physician has identified the medical condition or a registered nurse has identified the high risk factor(s) for which skin care is needed;
2. A written plan for skin care has been developed;
3. Progress notes indicating the client's response to treatment have been recorded by licensed nurses; and
4. The physician has documented periodic reassessment of the status of the client's medical condition.

Symptom Control for the Terminally Ill

A program designed by a physician, registered nurse, and the client for ongoing management of pain, nausea, or other disabling symptoms.

The medical record must establish that:

1. A physician has diagnosed a terminal illness;
2. A written symptom control program has been developed;
3. Progress notes indicating the client's response to treatment have been recorded by licensed nurses; and
4. The physician has documented periodic reassessment of the status of the client's medical condition as it relates to the symptom control plan.

Isolation Precautions

Procedures in accordance with the "Guideline for Isolation Precautions in Hospitals," written by Julie S. Garner, RN, MS, and Bryan P. Simmons, MD, reprinted by the U.S. Department of Health and Human Services, Public Health Service, Center for Disease Control, from Infection Control, July/August 1983 (Special Supplement); 4 (suppl): p.p. 245-325. The medical record must establish that:

1. A physician has diagnosed the disease or infectious agent;
2. Progress notes indicating that the isolation precautions are being followed and have been recorded by licensed nurses; and
3. The physician has documented periodic reassessment of the client's medical condition as it relates to the need for isolation precautions.

Other Treatments

Other treatments for which the same medical record requirements can be and have been met with respect to assessment, written treatment planning, monitoring of progress, periodic reassessment of the condition and/or treatment and communications.

Notes on Clinical Monitoring

Clinical monitoring includes nursing procedures emanating from the client's diagnosis and medically unstable condition and high risk condition(s). The medical record must establish that:

1. The physician has identified the medically unstable condition for which the clinical monitoring is needed;
2. A registered nurse has completed an assessment identifying the high risk condition(s);
3. A written plan for clinical monitoring has been developed;
4. Systematically recorded measurements (such measurements may be collected by licensed or unlicensed nursing personnel) have been made;
5. The clinical monitoring data has been interpreted by a registered nurse and communicated to the physician; and
6. The physician has documented periodic reassessment of the client's medical status and documented the need for continued clinical monitoring.

Scale:

00 = Less than once a day, less than once every 24 hours

01 = One or two shifts a day, at least once every 24 hours

02 = Monitoring on every shift, at least once every 8 hours

Notes on Special Nursing

"Special Nursing" is calculated by either:

01 = Tube Feeding (special treatment)

or 02 = Other Special Treatment

and 02 = in Clinical Monitoring

Case Mix Classification Summary

A – Low ADL

B – Low ADL Behavior

C – Low ADL Special Nursing

D – Medium ADL

E – Medium ADL Behavior

F – Medium ADL Special Nursing

G – High ADL

H – High ADL Behavior

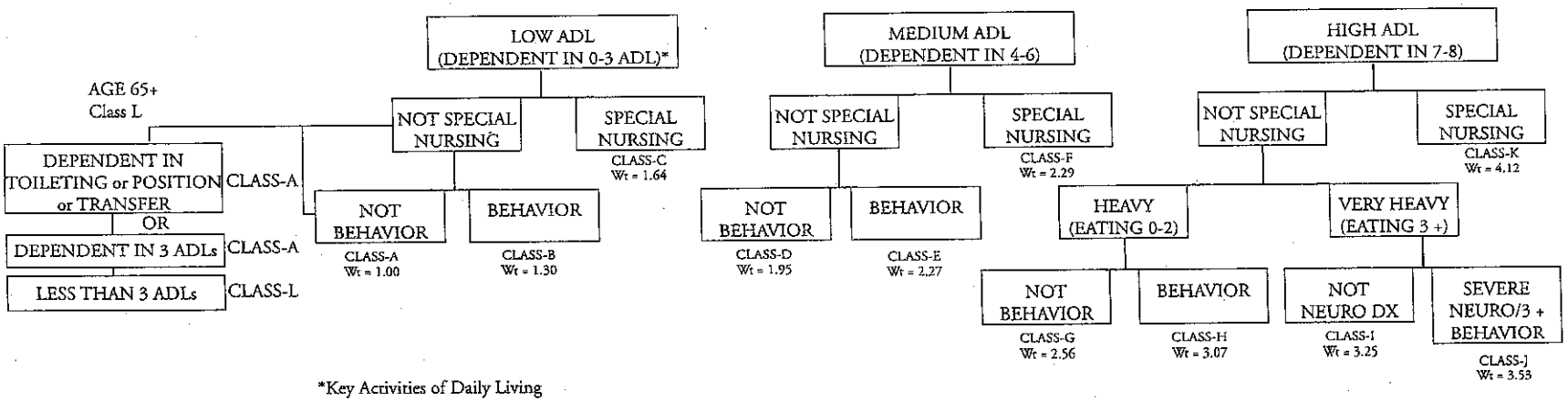
I – Very High ADL (Eating 3-4)

J – High ADL, Severe Neurological Impairment/3+ Behavior

K – High ADL Special Nursing

L – Very Low ADL/Age 65+

Case Mix Classification



*Key Activities of Daily Living

DHS-3428C (11/01)

Minnesota Long Term Care Consultation Services Form:
Supplemental Form for Assessment of Children under 18
Determination of Age-Appropriate Dependencies

Name _____

Instructions:

ACTIVITIES OF DAILY LIVING * Indicates Dependency

				R1	R2
LTC SD Block 33. Value ☐ Dep. ☐	**Dressing**	Comments	Assessor's Score		
	• Independent		00		
	• Intermittent supervision or reminders. May need physical assistance with fasteners, shoes or laying out clothes		01		
	• Constant supervision, but no physical assistance. (N/A 0-48 months)		*02		
	• Physical assistance or presence of another at all times, but child is able to physically participate. (N/A 0-36 months)		*03		
	• Totally dependent on another for all dressing. Child is unable to physically participate. (N/A 0-12 months)		*04		
LTC SD Block 34. Value ☐ Dep. ☐	**Grooming**	Comments	Assessor's Score		
	• Independent		00		
	• Intermittent supervision or reminders		01		
	• Help of another to complete task, but child is physically able to participate. (N/A 0-48 months)		*02		
	• Totally dependent on another for all grooming needs. Child is physically unable to participate. (N/A 0-24 months)		*03		
LTC SD Block 35. Value ☐ Dep. ☐	**Bathing**	Comments	Assessor's Score		
	• Independent		00		
	• Intermittent supervision or reminders		01		
	• Needs help in and out of tub		02		
	• Constant supervision, but child does not need physical assistance. (N/A 0-60 months)		*03		
	• Physical assistance of another, but child is physically able to participate. (N/A 0-48 months)		*04		
	• Totally dependent on another for all bathing. Child is physically unable to participate. (N/A 0-12 months)		*05		
LTC SD Block 36. Value ☐ Dep. ☐	**Eating**	Comments	Assessor's Score		
	• Independent		00		
	• Intermittent supervision or reminders		01		
	• Needs constant supervision and/or assistance in setting up meals, i.e. cutting meat, pouring fluids. (N/A 0-60 months)		02		
	• Needs physical assistance. Child can partially feed self. (N/A 0-24 months)		*03		
	• Needs and receives total oral feeding from another. Child is physically unable to participate. (N/A 0-12 months)		*04		
	• Receives tube feeding.* Child has documented incidents of choking or reflux on a weekly basis or more that is related to diagnosis or disability.		*05		

*Remember to code tube feeding as Special Nursing using 3428B.

The number of dependencies indicated on this worksheet will determine the initial classification of "Low, Medium or High" ADL dependencies. Further steps are the same as outlined on DHS-3428B (Case Mix Classification Worksheet).

LTC SD Block 38 Value ☐ Dep. ☐

Transfers

Comments | Assessor's Score | R1 | R2

- Independent _____ 00
- Needs intermittent supervision or reminders, i.e. cuing or guidance only. _____ 01
- Needs physical assistance, but child is able to participate. Excludes carseat, highchair, crib for toddler age child. (N/A 0-30 months) _____ *02
- Needs total assistance of another, and child is physically unable to participate. (N/A 0-18 months) _____ *03
- Must be transferred using a mechanical device, i.e. Hoyer lift. _____ *04

LTC SD Block 39 Value ☐ Dep. ☐

Mobility (walking)

Comments | Assessor's Score

- Independent. Ambulatory without device. _____ 00
- Can mobilize with the assist of a device, but does not need personal assistance. _____ 01
- Intermittent physical assistance of another. (N/A 0-24 months) (This does not include supervision for safety of a child under age 5.) _____ *02
- Needs constant physical assistance of another. Includes child who remains bedfast. (N/A 0-12 months) _____ *03

LTC SD Block 37 Value ☐ Dep. ☐

Positioning (bed mobility)

Comments | Assessor's Score

- Independent. Ambulatory without device. _____ 00
- Needs occasional assistance from another person or device to change position less than daily. _____ 01
- Needs intermittent assistance of another on a daily basis to change position. Child is physically able to participate. _____ *02
- Needs total assistance in turning and positioning. Child is unable to participate. (N/A 0-9 months) _____ *03

LTC SD Block 41 Value ☐ Dep. ☐

Toileting

Comments | Assessor's Score

- Independent _____ 00
- Intermittent supervision, cuing or minor physical assistance such as clothes adjustment or hygiene. No incontinence. (N/A 0-60 months) _____ *01
- Usually continent of bowel and bladder, but has occasional accidents requiring physical assistance. (N/A 0-60 months) _____ *02
- Usually continent of bowel and bladder, but needs physical assistance or constant supervision for all parts of the task. (N/A 0-60 months) _____ *03
- Incontinent of bowel and bladder. Diapered. (N/A 0-48 months) _____ *04
- Needs assistance with bowel and bladder programs, or appliances (i.e. ostomies or urinary catheters). _____ *05

Minnesota Long Term Care Consultation (LTCC) Services Form:

Supplemental Form for Assessment of Children under Age 18

Determination of Age-Appropriate Dependencies

Purpose of Form: This form is a supplement to the LTCC screening form and is to be used when screening children under age 18. It provides a guide for determination of age-appropriate dependencies for the eight Activities of Daily Living (ADLs).

A child **may not** be found dependent in an activity of daily living if, because of the child's age, the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age.

Each ADL has a:

- Written description of the need for assistance/supervision for that ADL
- Age in months noted as N/A
- Value associated with assessed need
- Place for comments
- 2 boxes on left hand side to document the value and if the need is considered a dependency (Blocks 33-41 on the LTCC Screening Document)

Process for completion

1. During the LTCC Screening, use this supplemental form to document information about the ADLs of children under age 18.
2. The assessment indicates the child has a dependency in an ADL. The next step is to determine the child's age in months.
   - If the child's age is within the age appropriate designation in the ADL description, a dependency cannot be assessed in that ADL and it is coded as 00.
   - If the child's age is older than the age appropriate designation, the child may be assessed as dependent in that ADL.
3. Total the number of ADL dependencies to determine the classification of "Low, Medium, or High' ADL dependencies on the CASE Mix Worksheet.

Return to page 1

Appendix III - Data analysis supporting Essential Community Supports benefits

Analysis Used to Determine ECS Services: Original service analysis for EW/AC

Service agreements were available for 46% of the 2008 EW sample population that did not meet the proposed changed LOC criteria. We assumed the service distribution was similar across the program population regardless of purchase and delivery model.

Using service agreement information, services were arrayed and included the percentage of the "ineligible" recipients in each service. Highlighted services were selected based on utilization (homemaker, e.g.) as well as on a policy decision to include chore and caregiver support services. Case management is required under EW and AC, and is also required under the proposed ECS approach. Since this analysis, Personal Emergency Response Service (PERS) has been separated from other specialized equipment (previously called extended supplies and equipment) by requiring a specific procedure code.

EW Recipient Percent	Service Name	AC Recipient Percent
6.7%	Adult Day Care: 15 Min	5.9%
0.3%	Adult Day Care: Day	1.1%
[redacted]	[redacted]	none
[redacted]	[redacted]	[redacted]
54.9%	Case Management, Paraprofessional	
2.1%	CDCS	
0.2%	CDCS Background Checks	
2.1%	CDCS Mandatory Case Management	
[redacted]	[redacted]	
3.2%	Companion Services	[redacted]
18.0%	Customized Living	
5.1%	Customized Living 24 Hour	
0.2%	Foster Care, Corporate	
0.6%	Foster Care, Family	
[redacted]	[redacted]	[redacted] %
0.3%	Home Health Aide or CNA	
[redacted]	[redacted]	[redacted]
1.1%	Homemaker Service, Per Diem	
1.3%	Modifications/Adaptions	
2.2%	Nursing Care, in home by RN, per Diem	
0.6%	Personal Care Services	
0.3%	Personal Care, Extended 1:1	
38.9%	PPHP/MSHO/MSC+ Home Care Services	
0.3%	Residential Care Services	
0.5%	Respite In Home 15 Min	
0.3%	RN Reg Extended1:1	
0.5%	Supervision of PCA	
[redacted]	[redacted]	[redacted]
0.3%	Transportation noncommercial mileage	
8.9%	Transportation, Extended-one way trip	

Analysis Used to Determine ECS Services: Reanalysis Using 2011 Sample

Claims for the July 2011 sample of all individuals in all programs who did not meet LOC criteria were analyzed for services provided in the previous FY (FY11). This analysis verified the services most often used by individuals who would not meet the proposed level of care. For example, approximately 55% of CADI individuals received homemaker service. In addition, there was sufficient information about other services such as independent living service to suggest the addition of the proposed service called "Community Living Assistance Service" to be developed as part of the demonstration.

Appendix IV - State Register Notice

Department of Human Services

Health Care Administration

Request for Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver

The Minnesota State Legislature has directed the Minnesota Department of Human Services (DHS) to apply for any necessary federal authority to implement a more restrictive nursing facility level of care (NF LOC) standard.

The NF LOC standard is used to determine eligibility for:

- Medical Assistance (MA) payment for nursing home services
- Medical Assistance payment for home and community-based service programs that provide alternatives to nursing home services. These programs include the Elderly Waiver (EW), the Community Alternatives for Disabled Individuals (CADI) waiver and the Traumatic Brain Injury-NF (TBI-NF) waiver programs
- The NF LOC criteria also applies to the state-funded Alternative Care (AC) program for people age 65 and older who do not meet Medical Assistance income and asset limits

The "maintenance of effort" (MOE) provisions in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (together known as the Affordable Care Act) require states to maintain eligibility standards, methodologies, and procedures for Medicaid pending implementation of coverage changes that become effective in January 2014. The Medicaid MOE provisions relating to adults expire when an exchange established by the state under section 1311 of the Affordable Care Act is fully operational. The MOE provisions for children under age 19, in both Medicaid and CHIP are effective through September 30, 2019. Based on the Centers for Medicare & Medicaid

Services' guidance on its interpretation of the MOE requirement in section 2001(b)(a) of the Affordable Care Act, modifications making the NF LOC standard more stringent may require a waiver of the MOE requirement.

In accordance with state law, DHS intends to submit a request to waive the MOE provisions in order to adopt a modified NF LOC standard for adults for the period preceding January 2014 and for children for the period preceding October 1, 2019. Failure to secure federal waiver authority to adopt a modified NF LOC standard in Minnesota will result in an additional 1.67 percent rate reduction for all long-term care providers, excluding nursing facilities, from July 1, 2012 to December 31, 2013.

Through the waiver DHS, will also request federal matching funds for the Alternative Care and the Essential Community Supports programs, two programs that provide home and community-based services for seniors whose incomes are too high to qualify for Medical Assistance but who have inadequate income and assets to pay for 135 days of nursing facility care. Both programs are designed to help seniors with needs for long-term care services stay in the community longer.

DHS is announcing a 30-day comment period on the Long Term Care Realignment Section 1115 Medicaid waiver request. A copy of the waiver request can be found on the DHS website at www.dhs.state.mn.us/healthcare/waivers. To request a paper copy of the waiver request, please contact Quitina Cook at (651) 431-2191. Written comments may be submitted to Jan Kooistra at the address below. Comments must be received by December 28, 2011.

Jan Kooistra

Minnesota Department of Human Services

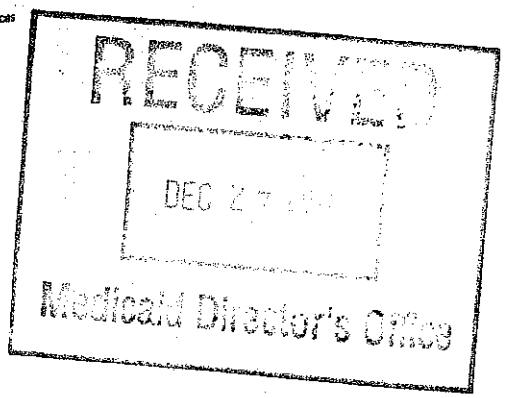
PO Box 64983

St. Paul, MN 55164-0983

Appendix V - Public Comments

The Long-Term Care IMPERATIVE

A Minnesota Collaboration for Changes in Older Adult Services



Date: December 22, 2011

To: Jan Kooistra
Minnesota Department of Human Service
P.O. Box 64983
St. Paul MN 55164-0983

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Re: Comments on Long-Term Care Realignment Section 1115 Waiver Proposal

The Long-Term Care Imperative is a legislative collaboration between Care Providers of Minnesota and Aging Services of Minnesota, the state's two long-term care trade associations. The Long-Term Care Imperative is pleased to have the opportunity to offer the following comments on the Long Term Care Realignment Section 1115 Medicaid Waiver request.

We have many concerns with the Level of Care policy passed by the Legislature which the Department of Human Services (DHS) intends to implement as soon as next July 1 if approved by the Centers for Medicare and Medicaid Services (CMS). We provide detail on many of those concerns in the following sections. To the extent that CMS shares any of these concerns, revising the waiver request to address them may be helpful. We understand that many of these issues are unlikely to be fully resolved by the time of submission of the waiver request, and we look forward to working closely with you to resolve them over the next several months.

Before providing detail our concerns about implementation of the level of care policy, we would like to offer our strong support to one aspect of the waiver application- the request for federal financial participation on Alternative Care (AC) and the new Essential Community Supports (ECS) program. Federal support for these programs seems like an appropriate use of federal funding to assist the state in serving people in community settings. We would also note that if approval of federal funding is achieved, the state will experience a financial benefit, and we will strongly suggest that the state respond by increasing the ECS benefit amount and the services eligible under ECS, in order to address the gaps that are going to occur as the result of the level of care policy.

Now, for the detail on our concerns about implementation of level of care:

I. Transitions

We are concerned about the implications of this change on the thousands of seniors currently receiving services through nursing facilities and waiver programs. It appears that there has not been sufficient transition planning for those who would be impacted by this change, especially in situations where there is no family caregiver available and/or no "home" to return to once the senior is discharged from their current location.

- Is there a way to "grandfather" in current recipients of EW/CADI services, who have already severed their "relationship" to alternative housing/services?
- Can this be moved upstream so that individuals will know in advance how to plan for services rather than at the point where the services are needed?

The processes developed to both remove currently eligible Medicaid clients using the revised Nursing Facility Level of Care (NF LOC) and adjudicate NF LOC on an on-going basis upon implementation are insufficient and will jeopardize client health and place unfunded burdens on providers.

- The DHS implementation plan does not currently address certain basic things required for both the client and provider to make informed decisions:
    - DHS must articulate the specific appeal rights under the Department of Health and Level of Care statutes for all Medicaid or potential Medicaid clients determined not to meet NF LOC.
    - DHS must create a process where providers receive payment for 1) services provided during an appeal, and 2) services provided while waiting for Lead Agencies, DHS, etc. to perform their duties.
        - Currently, functions including screenings, re-assessments, and financial eligibility determinations that are performed by Lead Agencies, do not always occur in an expedient manner. Likewise the state will be relying on the both the federally mandated RAI-MDS schedule and screenings to judge level of care for nursing facility residents How these determinations are incorporated into placing someone into an appropriate setting when level of care is lost.
        - The level of care policy does not account for costs to providers during the initial level of care process or the appeals associated with the new NF LOC.
        - The time lags associated with start of services and actual determination of NF LOC will cause issues with placement, unless DHS properly aligns the state desire to reduce costs and services with financial risks NF LOC presents to providers.

II. Data

It is concerning to us that there would be such a significant policy change made without a transparency regarding analysis of the data on who is affected by the change today, who will be affected in the future, and what unintended consequences this policy changes may have.

- Specifically, how will individuals be cared for if they are poor enough to be eligible for Medicaid by income and assets, assessed by professionals as needing assistance, but no longer eligible based upon proposed clinical criteria?
- The waiver request must better articulate the assumptions regarding Medicaid clients assumed to stay enrolled even though they will be assigned a higher spend-down.
- The waiver request does not specify the actual number of people by program who will (the Projected Fiscal Effects on Minnesota's Medicaid Program document and pages 39-40 of the waiver request do not make this clear):
    - Lose NF LOC benefits, but retain state plan services.
    - Lose Medicaid eligibility all together.
    - The true extent to which the ECS and AC programs will meet the needs of those losing either NF LOC benefits or State Plan services
- Other data areas that DHS needs to spell out include:
    - The break out of those EW clients expected to not meet the new NF LOC requirements and whether the clients currently reside in a Housing with Services (HWS) Setting or in the community.
    - The break out of those CADI clients expected to not meet the new NF LOC requirements and whether the clients currently reside in a Housing with Services (HWS) Setting or in the community.
    - The MDS 3.0 and LTC Assessment Crosswalks need to be published and understood.

III. Health and Safety

The proposal assumes that individuals who are no longer eligible to receive nursing facility care, or services under the elderly waiver (EW) or community alternatives for disabled individuals (CADI) waiver will have adequate resources to live safely in the community. Given the lack of transparent data, we question that assumption. It is unclear what obligation current providers will have to ensure that their clients who no longer qualify for reimbursement due to level of care are discharged to a safe environment, which is required by regulation. There does not appear to be an exceptions process to take into account unique circumstances such as the consumer with limited funds, no community housing option, moderate dementia and no spouse and/or family available for caregiving.

IV. Access to Services

In rural communities, where the choices in the spectrum of care are not as robust, this change to who is eligible for specific older adult services, could have far more dramatic consequences. If a consumer is no longer eligible for a nursing facility stay, there are limited community-based services or supported housing for them in many rural communities. Their choices will then be to either move away from their family/friends in their home community, or wait for their conditions to deteriorate so they could become eligible once again.

Current clinical guidelines for eligibility for Medicaid nursing facility level of care have rarely led to conflict. In general, they are both clear and generous enough to permit eligibility whenever clinicians see a need for assistance in daily life. The proposed guidelines are, by intent, less generous, but also more subjective. For example, what are "high needs for assistance"? What is "need for clinical monitoring"? What is "significant difficulty"? Even "living alone" is subject to interpretation, in terms of consistency or competence of others in the home.

V. Consumer rights

There are federal requirements relating to discharge notices and timeframes for notices and appeals that must be followed by nursing facilities. We are unsure if these requirements have been incorporated into this process. We are also uncertain about the appeal rights for individuals who will no longer or newly assessed as being ineligible for reimbursement for these specific Medicaid services—do patients appeal through the human services appeal process, the administrative process or both? Is there a role for the long term care ombudsman to represent these consumers? Who will have the right to appeal on behalf of the typical impaired applicant for Medicaid? If the people impacted by this level of care change are also enrolled in health plans, is there an appeal process through their health plan?

The Departments of Health and Human Services and the state ombudsman for long term care need to work together to ensure that policy guidance regarding appeals and notice of discharge is clear.

VI Process

The population currently eligible for nursing facility level of care often has changing conditions that require changes in service plans. Similarly, the criteria for eligibility must recognize varying levels of need over time. Criteria should both enable individuals deemed eligible to remain eligible for some time, even if their condition improves, until it is clear the condition will not

likely decline again. Individuals deemed ineligible based on clinical criteria should have timely opportunity to be re-assessed if their condition worsens. The level of care changes need to have "real time" flexibility to allow recipients to move back into eligibility as their condition/needs change.

Some criteria, such as living alone, are not health related. It is unclear what process could be used to assess such a variable. If an adult child comes to stay with a frail parent, will there need to be a process to determine how long that person has stayed to cause loss of eligibility? Other criteria, such as difficulty with memory or using information, may be assessed by different types of professionals in different ways. Is that a judgment for a neuropsychologist (gold standard), an occupational therapist observing functional testing , or a nurse, social worker or physician using a cognitive screening tool? "Need for clinical monitoring" can be judged only by estimated risk of lack of monitoring or by evidence of benefits of monitoring (which is unlikely known until monitoring is provided). What process could be used to make such a judgement about risk and benefit? What if there is a demonstrated need for daily monitoring, but the eligible individual refuses such monitoring (in a home setting)?

VII. Intersecting Systems Changes

The level of care changes are but one systems change being proposed by the Department of Human Services. There are other changes underway relating to payment, assessment, benefits, and eligibility that will clearly intersect with the level of care change being proposed. There has been no public presentation of data in a comprehensive fashion regarding: who is impacted by various proposals, will reduced eligibility for coverage for home and community based services lead to physical declines causing subsequent need for nursing home care, will reduced eligibility for Medicaid increase costs to other types of state and local government services besides state health plans (e.g. vulnerable adult services, court systems, police and fire services). Will these changes cause measurable declines in quality of health care outcomes, such as re-hospitalization rates? Individuals enrolled in MSHO who are no longer MA eligible—do they have to be dis-enrolled?

DHS has spent considerable resources on MnChoices. However, at this point, the system does not allow for provider access. Given the strict time constraints associated with NF LOC, DHS is advised to determine a method for providers to access the assessment findings regarding NF LOC that MnChoices will create.

VIII. General Policy Considerations:

a. Is this good public policy? We would summarize our concerns as being critical of the proposed policy for its difficulty to successfully implement. We anticipate extraordinary challenges and costs for providers and others who must deal with those who become or are newly deemed ineligible despite clear need for assistance and lack of income or savings to purchase help. We also anticipate conflict between those assessed for eligibility and government agents, conflict between providers try to shift responsibility for such seniors and conflict between seniors and their family members. Conflict has costs not factored into the analysis of this policy.

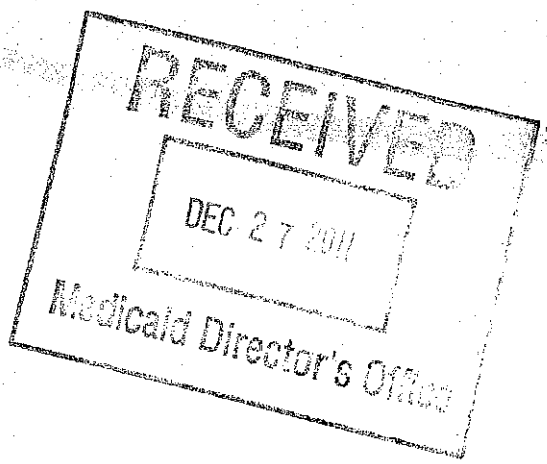
a. Given the risks associated with the proposed policy and the, to our knowledge, lack of prior input by non-government employees (e.g. academic experts or professional societies) into the eligibility criteria, we ask that proposed criteria be thoroughly tested prior to acceptance as policy. This could be accomplished by adopting criteria from another state that has experience in their use or testing proposed criteria against current criteria concurrently. Without such evidence, we strongly object to implementation as a testing process.

   If state health plans must reduce spending for elderly Medicaid eligible by about $25 million over the next three years, but cannot safely implement level of care change policies, alternative solutions besides provider rate reductions should be considered. One possibility would be raising the income threshold for those eligible for waiver services. In other words, some or the budgetary pain could be shared across a large number of seniors rather than applied to a few newly ineligible seniors or at the expense of providers, some disproportionately to the point of bankruptcy. Another alternative that could be considered would be better targeted reductions in payments to providers, based upon ability to absorb such reductions (due to payor mix or non-patient fee revenue).

IX. Corrections/Suggestions:

- Top paragraph on page 8 of waiver contains incorrect percentages. The entire paragraph is difficult to follow, and is misleading to the general reader.

AARP



December 21, 2011

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

Dear Ms. Kooistra,

AARP, on behalf of our more than 650,000 members in Minnesota, is submitting the following comments in response to Minnesota Department of Human Service's (DHS) Medicaid Long term Care Realignment Section 1115 Waiver proposal, hereinafter referred to as the "waiver proposal".

While the waiver's stated goal appears consistent with AARP's priorities of improving access to home and community based alternatives for long term services and supports (LTSS) and in making services available to individuals before they become eligible for Medicaid, we have a number of serious concerns and questions that must be addressed before Minnesota submits its application to the Centers for Medicare & Medicaid Services (CMS) for approval.

AARP supports ensuring that people have the services and supports they need so they can live in their homes and communities. In addition, we fully support reducing the incidence of persons with low care needs being inappropriately served in institutional settings. As AARP Public Policy Institute's State Long Term Services and Supports Scorecard recently highlighted, 14.5 percent of nursing home residents in Minnesota had low care needs compared to the U.S. average of 12.8 percent, a ranking of 32nd in the nation.

In addition, we acknowledge and support DHS's efforts to mitigate the potential of harm this proposal may have on individuals – current as well as potential beneficiaries-- by providing some home and community-based services (HCBS) through the Alternative Care Program (AC) and the new Essential Community Supports (ECS) program.

Nevertheless, we remain concerned about the adverse impact this proposal may have on some Medicaid applicants and beneficiaries who will lose eligibility for services they are currently receiving or who will not become eligible for services they might have otherwise received. We are particularly troubled that the

majority of individuals who would fail to meet the revised Nursing Facility Level of Care (NF-LOC) criteria are ***seniors living in their homes or community settings such as assisted living or other supportive residential settings***, with the group most affected being Elderly Waiver (EW) beneficiaries. What is particularly disconcerting is the potential for disruption of care as these individuals transition to other, less robust and possibly inadequate, programs. If these individuals fall through the cracks during these transitions and no longer have the services and supports they need to remain in the community, there is real potential for harm and costly and unnecessary institutionalizations. AARP strongly believes that in order to mitigate service disruptions, avoid harm to vulnerable persons, and prevent people from actually becoming frailer and qualifying for NF-LOC sooner than otherwise, there will need to be appropriate and sufficient supports made available for impacted individuals.

It will be important to clearly establish what services will be made available to assist people who are currently receiving Medicaid waiver services with their transitions to the Alternative Care and Essential Community Supports (ECS) programs. For example, how will DHS assist a person in a nursing home for less than 90 days who no longer meets LOC criteria but may no longer have a home to go back to? What about someone who has resided in an assisted living facility or other supportive residential setting who may no longer meet LOC but may no longer have a home to return to? What provisions will DHS make for someone who is currently receiving waiver services to ensure that they are linked with ECS?

We would like to see additional details about service utilization by current EW beneficiaries to determine whether the services proposed to be offered to them do, in fact, reflect utilization patterns, and are thus sufficient to meet their needs. We would also urge DHS to provide greater detail about the number of beneficiaries who will continue to qualify for Medicaid based on income. DHS's waiver proposal (page 29) states that the AC "initiative has well established counseling and tracking processes to avoid adverse events." We recommend that similar processes be instituted with respect to ECS. In addition, AARP strongly urges that there be effective monitoring and regular public reporting on extent of the waiver's impact. Specifically, we would recommend that DHS report regularly and in real time on the number of individuals who have lost services, what has been the result of the loss of services, including information on current residences of all impacted individuals.

While the waiver proposal does not request waiver expenditure caps or participant caps, the ECS program, as proposed, limits the value of services to $400 per month per individual and total expenditures are limited by the available

appropriation. While this seems to raise the potential of a waitlist, the waiver proposal does not address this. We would like to know whether there is a potential for a waitlist, or is the state implying that these programs will be entitlements?

Another element that seems to be missing from the DHS evaluation is monitoring the impact on individuals who retain eligibility for state plan services, but lose access to HCBS waiver services. This may be of particular concern for those adults under 65 years of age who will not have access to either the AC or ECS programs. How does DHS plan to monitor the impact of the loss of HCBS services on this population? What impact does this loss of services have on outcomes? DHS' assumption appears to be that state plan services such as personal assistants, rehabilitative services and home health services will meet their needs. How does DHS plan to test that hypothesis?

In addition, we are concerned about the financial impact on seniors living in the community who have benefited from the Supplemental Income Standard (SIS) and spousal impoverishment protections under the Elderly Waiver (EW), who now may have to spend down to 75% of the federal poverty level to remain eligible under MA through the medically needy category. Has DHS considered whether seniors will have adequate resources to pay for all of their household expenses after meeting the spend down, in order to continue living independently in the community? Also, we do not believe the proposal addresses the impact on differing asset and income levels for elderly couples under EW versus MA. It will be important to consider whether these changes could impact couples' decisions to enroll in MA, possibly leaving them without services altogether.

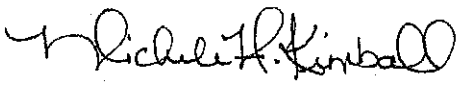
Finally, while we appreciate the Department's goal that changes to the NF-LOC will make LOC decisions more objective, we believe there remains ample room for subjectivity with the new criteria depending on who is making the determination. For example, there could be varying interpretations of what it means to have occasional staff intervention for those with behavioral needs, depending on one's occupational perspective. Given the potential for subjectivity, inappropriate placements to institutional settings could continue. To address these concerns, we would urge the Department to consider the application of the 1915 (i) state plan option. This option allows states to require eligibility criteria that are more stringent for institutional services than criteria used for community services, but also permits states to target populations with specific services packages designed to serve their needs. We understand the potential challenge to our State given that the 1915 (i) prohibits waitlists, but nevertheless, we believe this is an option worth exploring especially in the context of the more restrictive NF-LOC criteria.

In conclusion, AARP continues to have a number of concerns and questions regarding the impact of this proposal on many of Minnesota's most vulnerable citizens and the potential loss of services and disruption of care for many elderly citizens in our state. As indicated above, we would like to work with the Department to access additional data on EW utilization patterns, populations impacted, and in general, questions around how the Department will address the transition plan for those who will no longer qualify for services, as well as plans for how the Department will effectively monitor the impact of these changes.

Thank you for the opportunity to provide comments on the Medicaid Long Term Care Realignment Section 1115 Waiver proposal. Please provide information on the data requested above to Mary Jo George, AARP Associate State Director of Advocacy at mgeorge@aarp.org or 651-271-6586.

Thank you.

Sincerely,



Michele Kimball
Senior State Director

Kooistra, Jan M (DHS)

From: Steve Larson <stevel@arcmn.org>
Sent: Tuesday, December 27, 2011 10:28 AM
To: Kooistra, Jan M (DHS)
Subject: comments 1115 waiver
Attachments: AH Final Comments on 1115 waiver NF LOC 12-22-11 887726 (2).docx

The Arc Minnesota supports and endorses the comments made by Anne Henry.

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Public Policy Director
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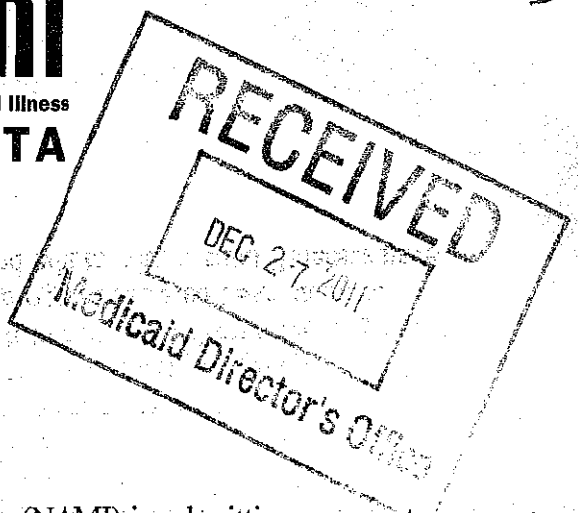
Join The Arc of Minnesota's Action Alert Network! Contact me for details!

J.K

NAMI
National Alliance on Mental Illness
MINNESOTA



December 22, 2011

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

Dear Ms. Kooistra:

The National Alliance on Mental Illness of Minnesota (NAMI) is submitting comments in response to your request for comments to implement a more restrictive nursing facility level of care (NF LOC) standard. As you know, the NF LOC standard is used to determine eligibility for the Community Alternatives for Disabled Individuals (CADI) Waiver, which is a program that supports people with mental illnesses to live in the community.

NAMI is very concerned that the proposed NF LOC standards are so restrictive and subject to interpretation that many people with a serious mental illness will be deemed no longer eligible for the CADI program. We have been told that as an alternative they could utilize the PCA program; however, as you know this program has also been changed significantly with the end result being that children and adults with mental illnesses have access to a very limited number of minutes per day.

Our specific concerns are as follows:

Functional Needs: The proposed criteria appear to require hands-on assistance thus eliminating people who may need cueing to meet their daily needs. Whether you need help bringing the spoon to your mouth or need to be cued to eat – the bottom line is that without this assistance you don't eat. This change completely eliminates the eligibility for people who live with a serious mental illness. It's important to note that the commitment criteria include a person's inability to obtain food, clothing, shelter, or medical care as a result of their illness. So a person with a mental illness would be ill enough to receive court ordered treatment but not have an illness that is serious enough to receive a CADI waiver.

Restorative and Rehabilitative Treatment: The proposed criteria have been changed to require daily monitoring. This eliminates weekly medications that are injected and require a nurse to deliver it which is needed by some people with a serious mental illness. People with a serious mental illness need medication management, but not necessarily on a daily basis. They will no longer meet eligibility criteria under this section.

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651-645-2948 or 1-888-NAMI-HELPS www.namihelps.org

Cognitive or Behavior: We would assume that most people with a serious mental illness would become eligible for the CADI waiver under this section. The proposed criteria, however, offer even less clarity. How will the department interpret "significant" or "occasional?" There is no longer any mention of disorientation which could have included someone experiencing delusional thoughts or psychosis. There is no mention of safety which in the past could have included people who were suicidal or had self-injurious behaviors. The focus is on behaviors and not symptoms. Knowing that the purpose is to reduce the number of people who can qualify, we believe that this will result in people with mental illnesses not being able to qualify for this program.

Frailty or Vulnerability: The changes to these criteria will eliminate any possibility of someone with a serious mental illness qualifying under it. The focus in on physical symptoms and no longer includes aggression, recent hospitalizations, cutting or otherwise hurting oneself, or even self-neglect. There is no recognition that a person with a serious mental illness could be living with another person, either in a family member's home or in a corporate foster care home, and need a CADI waiver. You've changed the criteria so that they have to be living alone. Again, some of these concerns appear under the commitment act and yet they do not appear here under the waiver program.

Knowing that children with a serious mental illness use the CADI waiver, we are perplexed as to what this means for them. At first glance it appears that they will no longer qualify as well.

NAMI Minnesota is deeply disappointed that at nearly every turn there are efforts to create barriers to the very programs that keep people with serious mental illnesses out of our hospitals and nursing homes. First the PCA program and now the CADI waiver – how are people to receive the supports that they need to remain in the community? There are no waivers specifically for people with mental illnesses and this fact appears to be lost on the department. There are already enough people with a serious mental illness on our streets, in our jails, and other inappropriate settings. Changing the NF LOC so that they will be unable to qualify for the CADI waiver will simply increase the number of people in inappropriate settings. We are deeply disappointed and are totally opposed to the proposed NF LOC standards.

Sincerely,

Sue Abderholden, MPH
Executive Director

Kooistra, Jan M (DHS)

From: Anni Simons <asimons@arcmn.org>
Sent: Tuesday, December 27, 2011 12:41 PM
To: Kooistra, Jan M (DHS)
Subject: Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver Request
Attachments: Comments on 1115 Waiver NF - LOC. 12.27.11.doc

The MN Consortium for Citizens with Disabilities (MN-CCD) is a broad-based coalition of more than 100 organizations of persons with disabilities, providers and advocates, dedicated to improving the lives of people with disabilities. We address public policy issues that affect people with disabilities by collaborating with others, advocating, educating, influencing change and creating awareness for understanding. Through our disability services advocacy efforts we work very closely with the Minnesota Disability Law Center. Attached you will find the comments submitted by the Minnesota Disability Law Center in response to the Long-Term Care Realignment Section 1115 Medicaid Waiver Request. The MN-CCD strongly supports and endorses these comments. Thank you for the opportunity to comment on this waiver request.

Anni Simons
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To: Jan Kooistra, Department of Human Services Federal Relations
jan.kooistra@state.mn.us

From: Anni Simons, MN Consortium for Citizens with Disabilities

Re: Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver Request

Date: December 22, 2011

The MN Consortium for Citizens with Disabilities (MN-CCD) is a broad-based coalition of more than 100 organizations of persons with disabilities, providers and advocates, dedicated to improving the lives of people with disabilities. We address public policy issues that affect people with disabilities by collaborating with others, advocating, educating, influencing change and creating awareness for understanding. Through our disability services advocacy efforts we work very closely with the Minnesota Disability Law Center. Below you will find the comments submitted by the Minnesota Disability Law Center in response to the Long-Term Care Realignment Section 1115 Medicaid Waiver Request. The MN-CCD strongly supports and endorses these comments. Thank you for the opportunity to comment on this waiver request.

1. Loss of Medicaid Coverage

An unknown number of Minnesotans who now have coverage under our Medicaid program, Medical Assistance, will lose that coverage if this 1115 waiver proposal is approved.

The appendix entitled "Projected Fiscal Effects on Minnesota's Medicaid Program" shows that at least 137 persons are expected to lose Medical Assistance (MA) coverage entirely during the twelve months beginning July 1, 2012. Those numbers increase in succeeding years. This request should not be granted because it violates the Affordable Care Act which prohibits changes in standards, methodologies and procedures which result in a loss of Medicaid coverage for adults until 2014 and for children until 2019. The Affordable Care Act seeks to increase the number of people with health coverage and therefore requires states not to eliminate coverage for Medicaid recipients in anticipation of changes which become effective in 2014. Minnesota should not be allowed to terminate Medicaid coverage for an unknown number of seniors and persons with disabilities.

Further, we question the DHS estimates of the number of persons who will actually lose Medicaid coverage due to the loss of the special income standard for seniors and other more favorable treatment of income and assets compared to the medically needy requirements for those with incomes over 100% FPL to spenddown to 75%

FPL (explained in Appendix V of the 1115 waiver proposal.). Because the individuals affected by the change in nursing facility level care (NF LOC) are relatively low-income to begin with, meeting higher spenddown requirements (an average of $394/mo. for seniors being terminated from the Elderly Waiver (EW)) will put these people in a position of choosing between paying their rent and paying for health coverage. People need both a place to live and health coverage and therefore, we believe that DHS underestimates the actual number of seniors who will lose health coverage because they will not be able to pay their increased spenddown and still have enough to live on in their homes in the community. In addition, we disagree with the DHS contention that no persons under age 65 now eligible for the "Community Alternatives for Disabled Individuals" (CADI) home and community based waiver services (HCBW services) will lose MA coverage. Loss of Medicaid is especially likely for those whose families now benefit from the HCBW services treatment of spousal income and assets and the children who qualify under the TEFRA-MA option.

2. The Proposed NF LOC Changes are not Consistent with the 1115 Waiver Standards for a Demonstration to Further the Purposes of the Medicaid Program

Section 1115 demonstration waiver authority under the Social Security Act (42 U.S.C. 1315) was enacted to allow states to waive certain provisions of federal Medicaid law in order to create an "experimental, pilot, or demonstration project" if it is cost effective, efficient, and not inconsistent with the purposes of the Medicaid Act. Terminating health coverage and restricting access to important community services for low income seniors and persons with disabilities is contrary to and certainly does not further the purpose of the Medicaid Act.

3. Lack of Specific Data on Impact of the Changes Proposed

DHS should include as an appendix the data used to develop the NF LOC proposal and to design the Essential Community Support service. Detailed information about the incomes and assets of those who will be affected by the changes, including the family incomes of children eligible through the TEFRA option and the services used by those who will be terminated from eligibility for HCBW services is available and should be provided to the public. This data should also be part of the 1115 proposal submitted to CMS.

4. Alternative Services under the MA State Plan and Essential Community Supports (ECS) are not adequate to meet the needs of those terminated from eligibility for HCBW services because they no longer meet the NF LOC

For those under age 65, DHS estimates nearly 680 (3% of CADI enrollees, page 40 of the 1115 waiver proposal) individuals are projected to lose CADI HCBW services and will be left with inadequate alternatives under the MA state plan and are ineligible for Essential Community Supports. The listed MA state plan services are also inadequate for seniors and ESC services are similarly unavailable to those seniors who remain eligible for MA state plan coverage, but not HCBW services.

a. MA State Plan Services are not a substitute for HCBW services to be terminated.

The 1115 waiver request asserts that personal care assistant (PCA) services and home health aide services are MA State Plan options which will meet the needs of those eliminated from HCBW services who remain eligible for MA. These two state plan services will not fill the gap left when EW and CADI HCBW services are terminated for the following reasons:

i. PCA services require meeting criteria even stricter than the proposed nursing facility level of care criteria. Many who do not qualify under the proposed NF LOC will not qualify for PCA services

The PCA program was substantially cut in 2009 by tightening the definition of dependency to remove prompting and cuing for those with cognitive limitations such as brain injury or intellectual or developmental disabilities. The definition of dependency now requires that a person need hands-on physical assistance or require constant cuing and supervision throughout the performance of the activity of daily living (ADL). Persons with cognitive limitations who need only prompting and cuing are not eligible for PCA assistance. In addition, the Level 1 behavior category for those who are a danger to themselves, to others or engage in property destruction have been cut to only 30 minutes per day for PCA assistance. This means individuals with behavioral issues and mental health conditions either get no assistance each day because it is difficult to impossible to arrange for a PCA to come to your home to work for half an hour given the low rate paid or the thirty minute segments are grouped into one 2½ hour period one day per week. This service is simply inadequate to meet the gap caused by the loss of CADI Waiver services, especially since those limited to 30 minutes of PCA can qualify for extended PCA under CADI.

ii. Home Health Aide under the MA State Plan

A Home Health Aide visit is not a substitute for all the EW and CADI services eliminated. The Home Health Aide visits (usually twice per week) include such tasks as setting up medication, assisting with foot care, assisting the person with bathing and checking for skin breakdown. These are a limited set of more medically oriented services which do not substitute for assistance with instrumental activities of daily living such as food preparation, shopping and chore service, accompanying the person to appointments or elsewhere outside the home. Providing limited services does not compensate for the loss of other supports such as equipment and supplies. In a sample of 500 persons who will lose CADI eligibility, DHS data reveals that most people used CADI services such as homemaker, extended equipment or supplies, transportation, home delivered meals which are not available through the MA State Plan.

b. Essential Community Supports (ECS) unavailable to most who would lose HCBW services

ECS services are not available at all to persons under age 65 or to anyone of any age eligible for MA state plan services. The types of services allowed under ECS are not covered in the MA state plan. Yet, these are the very services needed by most, if not all, persons who now receive HCBW services and will have that eligibility terminated under this 1115 waiver proposal. Because federal Medicaid match is sought for ECS, these services should be available for all MA recipients terminated from HCBW services, as well as those who lose MA coverage altogether. Also, home delivered meals should be listed as an ECS for all ages, since this service is used by many who will lose it if this 1115 waiver request is approved. The ECS services are provided under EW and CADI and thus could be added to the state plan under 1915i discussed below in #6 or through a 1115 waiver request.

5. NF LOC Criteria Does Not Adequately Cover Mental Health Conditions

The new NF LOC criteria should be revised to better cover mental health conditions. The criteria will be used to determine eligibility for the CADI waiver which is our state's only HCBW service available for those whose primary diagnosis is a mental health condition. DHS recently indicated that about 60% of those qualifying for CADI waiver services have a history of a mental health condition. There are significant terminology issues involving the need for staff assistance and clinical monitoring of symptoms not reflected in the criteria. For example, to what extent does the "need for clinical monitoring" criterion include symptom management for those with a mental illness; or does it refer primarily to medical monitoring such as blood pressure, medications, blood sugar? Similarly, the risk factors for 'vulnerability' include maltreatment, neglect, falls, or sensory impairment, but do not include vulnerability related to mental health symptoms such as hallucinations or paranoia that would represent risk factors to a person with a mental illness.

6. Reserve the Institutional Level of Care for Those with Higher Needs and Continue Current Eligibility Policy for Community Services under the HCBW Services through 1915i

We understand and support tightening the criteria for nursing facility services, but oppose continuing to tie eligibility for the HCBW services (EW, CADI, and Brain Injury) to the nursing facility level of care criteria. It is very clear that it makes sense from a fiscal and social policy perspective to provide services to a wider group to maintain people in the community and to avoid or at least delay institutional care.

Our state can separate the institutional level of care criteria used for nursing facility services from the criteria used for eligibility for HCBW services. We urge that our state pursue the 1915i option established by the Deficit Reduction Act of 2005 as amended by the ACA or similar approach to separate institutional level of care from eligibility for community support services. This option would allow Minnesota to proceed with tightened nursing facility level of care criteria while providing access to community support services as offered through the HCBW service programs at current levels through the medical assistance state plan. We believe this would be a wiser policy which would not result in denying needed community support services. Other requests or restructuring would be needed to assure that no persons lose MA coverage, even under the 1915i approach.

7. Due Process Notice and Appeal Rights Concerns

The time period for notice for those who lose eligibility for HCBW services is inadequate and must be provided at least 90 days before the loss of services. People who would lose EW and CADI services under this 1115 waiver request are vulnerable and relying on those services to maintain themselves in their homes or residential settings. If they are going to lose services and need to make other arrangements, a 90 day notice period is needed with a 30 day period allowed to request services pending appeal as was done with the PCA cuts adopted in 2009, § 256B.0659 subdivision 30 (2).

Thank you for the opportunity to provide comments on the Long-Term Care Realignment Section 1115 Waiver Proposal. We urge that DHS publicly respond to the comments made during this comment period and include specific data listed in comment #3 to CMS.

Kooistra, Jan M (DHS)

From: Harris, JaPaul <jharris@midmnlegal.org>
Sent: Tuesday, December 27, 2011 4:11 PM
To: Kooistra, Jan M (DHS)
Subject: 1115 Wavier Proposal Comments
Attachments: Senior Law Project 1115 Wavier Comments.docx; Senior Law Project PDF 1115 Wavier Comments.docx.pdf

Dear Ms. Kooistra

Please find attached for your review and consideration Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver Request from the Senior Law Project. If you have any questions please feel free to contact me at (612) 746 – 3624 or jharris@midmnlegal.org.

JaPaul J. Harris
Supervising Attorney, Senior Law Project
Legal Aid Society of Minneapolis
430 First Avenue, Suite 300
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LEGAL AID SOCIETY OF MINNEAPOLIS
SENIOR LAW PROJECT
JaPaul J. Harris ▪ (612) 746-3624 ▪ jharris@midmnlegal.org

To: Jan Kooistra, Department of Human Services Federal Relations
jan.kooistra@state.mn.us

From: JaPaul J. Harris , Senior Law Project
jharris@mindmnlegal.org

Re: Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver Request

Date: December 27, 2011

The Senior Law Project represents elderly citizens over the age of 60 in protecting their basic rights and benefits. Many seniors contact our office seeking assistance in obtaining and maintaining health care services to be able to live independently. On behalf of our clients, we submit the following comments on your departments 1115 Medicaid Waiver Request regarding Long Term Care.

Under its wavier, DHS does not fully evaluate the number of persons who will actually lose Medicaid coverage due to the loss of the special income standard for seniors, and other more favorable treatment of income and assets as compared to the medically needy requirements for those with incomes over 100% FPL to spend down to 75% FPL.[1] Seniors affected by the nursing facility level of care are on fixed incomes and are relatively low income. Requiring low income seniors to meet a higher spend down requirement would place them in a position to choose between equally important necessities. They would be forced to choose between paying their household expenses, including rent, and paying for health coverage. DHS analysis does not consider whether low income seniors would have sufficient resources to pay for all of their household expenses after meeting their spend down requirement. In addition, DHS underestimates the actual number of seniors who will lose health coverage because they cannot pay an increased spend down and have enough income to live independently in the community. The proposal also does not address the impact on differing asset and income levels for elderly couples under Elderly Waiver versus Medical Assistance.

[1] The appendix entitled "Projected Fiscal Effect on Minnesota's Medicaid Program" shows that under the waiver request, the average monthly value of Elderly Waiver spend down's expected to be $394.00.

The Senior Law Project is also troubled about the harmful effect this proposal may have on particular Medicaid applicants and beneficiaries who stand to lose eligibility for services they currently receive or may have received. The majority of individual who will fail to meet the revised Nursing Facility Level of Care (NF – LOC) criteria are seniors living independently in their homes or community settings with the greatest effect coming to those who are Elderly Waiver (EW) beneficiaries.

We believe that this request violates the Affordable Care Act which prohibits until 2014 changes in eligibility standards, methods and procedures resulting in a loss of Medicaid coverage for adults.[2] Particularly, the appendix entitled "Projected Fiscal Effect on Minnesota's Medicaid Program" demonstrates that 137 persons are expected to lose Medical Assistance (MA) coverage entirely during the twelve months beginning July 2012, with an additional 312 persons expected to lose MA coverage beginning in July 2013.

Finally we believe that the MA State Plan Services are not a substitute for HCBW services that will be terminated. The 1115 waiver request asserts that personal care assistant (PCA) services and home health aide services are MA State Plan options that will meet the needs of those eliminated from HCBW services and remain eligible for MA. We believe that the two state plan services will not fill the gap left when EW and HCBW services are terminated.

Minnesota's PCA services requirements are more stringent than the proposed nursing facility Level of Care criteria.[3] Many who do not qualify under the proposed NF LOC also will not qualify for PCA services. The PCA program was substantially cut in 2009 by restricting the definition of dependency to remove prompting and cuing for those with cognitive limitations such as brain injury or intellectual or developmental disabilities. A person now must need hands-on physical assistance or require constant cuing and supervision throughout the performance of an activity of daily living (ADL). Under the new PCA laws, persons with cognitive limitations who need only prompting and cuing are not eligible for PCA assistance. In addition, the Level 1 Behavior category for those who are a danger to themselves or to others, or

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[2] The Maintenance of Effort (MOE) provisions in the Affordable Care Act generally ensure that States' coverage for adults under the Medicaid program remains in place pending implementation of coverage changes that become effective in January 2014. The MOE provisions in the Affordable Care Act specify that existing coverage for adults under the Medicaid program generally remains in place until the Secretary determines that an Exchange established by the State under section 1311 of the Affordable Care Act is fully operational in 2014, and for children in 2019. Sections 1902(a)(74) and 1902(gg) of the Social Security Act contains the Medicaid MOE provision. As a condition of receiving Federal Medicaid funding, States must maintain Medicaid "eligibility standards, methodologies, and procedures" that are no more restrictive than those in effect on March 23, 2010 (the date of enactment of the Affordable Care Act).

[3] In its wavier Minnesota requests to modify its nursing facility Level of Care standard to allow entrance into a nursing facility and the HCBS wavier for individuals demonstrating one or more of the following: 1) A higher need of assistance in four of more activities of daily living (ADL); 2) a high need for assistance in one ADL that require 24 hour staff availability; 3) a need for daily clinical monitoring; 4) significant difficulty with cognitive behavior; qualifying nursing home facility admission of 90 days; or 5) is living alone and risk factors are present.

engage in property destruction, has been cut to only 30 minutes per day for PCA assistance. The effect of this cut is that individuals with behavioral issues and mental health conditions either get no assistance each day due to the problematic nature of arranging for a PCA to come into a home to work for only half an hour, or the time is grouped into one 2½ hour period one day per week.

In regards to Home Health Aide under the MA State Plan, a Home Health Aide visit is not a substitute for the EW services being eliminated. The Home Health Aide performs such tasks as setting up medication, assisting with foot care, assisting the person with bathing, and checking for skin conditions. The role of a Aide is limited to medically oriented services. In contrast, EW provides help with instrumental activities of daily living such as food preparation, shopping and chore service, accompanying the person to appointments or elsewhere outside the home. The loss of EW and HCBW services will create a void in services for many seniors.

The Senior Law Project supports tightening the criteria for nursing facility services. However, we believe that tying eligibility for HCBW services to the nursing facility Level of Care criteria does not advance the goals of maintaining people in the community, and avoiding or at least delaying the need for institutional care. We request that the State look at other options to separate nursing facility Level of Care from eligibility for community support services. We believe that Minnesota can develop a better system to tighten nursing facility level of care criteria and still providing access to community support services at current levels through the medical assistance state plan. We believe this would be a sensible policy that would not deny seniors needed community support services.

Thank you for the opportunity to provide comments on the Long-Term Care Realignment Section 1115 Waiver Proposal. We urge that DHS publicly respond to the comments made during this comment period.

Sincerely,

JaPaul J. Harris
Supervising Attorney
Legal Aid Society of Minneapolis, Senior Law Project

LEGAL AID SOCIETY OF MINNEAPOLIS
SENIOR LAW PROJECT
JaPaul J. Harris ▪ (612) 746-3624 ▪ jharris@mldmnlegal.org

To: Jan Kooistra, Department of Human Services Federal Relations
jan.kooistra@state.mn.us

From: JaPaul J. Harris , Senior Law Project
jharris@mindmnlegal.org

Re: Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver Request

Date: December 27, 2011

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The Senior Law Project supports tightening the criteria for nursing facility services. However, we believe that tying eligibility for HCBW services to the nursing facility Level of Care criteria does not advance the goals of maintaining people in the community, and avoiding or at least delaying the need for institutional care. We request that the State look at other options to separate nursing facility Level of Care from eligibility for community support services. We believe that Minnesota can develop a better system to tighten nursing facility level of care criteria and still providing access to community support services at current levels through the medical assistance state plan. We believe this would be a sensible policy that would not deny seniors needed community support services.

Thank you for the opportunity to provide comments on the Long-Term Care Realignment Section 1115 Waiver Proposal. We urge that DHS publicly respond to the comments made during this comment period.

Sincerely,

J. Paul J. Harris

J. Paul J. Harris
Supervising Attorney
Legal Aid Society of Minneapolis, Senior Law Project

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RECEIVED
DEC 28 2011
Medicaid Director's Office

December 27, 2011

VIA FACSIMILE (651) 431-7420
AND U.S. MAIL

Jan Kooistra, Federal Relations
Minnesota Department of Human Services
Division HC; Location CD-4
P.O. Box 64983
St. Paul, MN 55164-0983

Re: Comments on Long-Term Care Realignment Section 1115
Medicaid Waiver Request

Dear Ms. Kooistra:

As a disability and elder law attorney, I represent adults across Minnesota with a wide variety of health conditions which result in disabilities. Many people contact us seeking assistance to obtain health and long-term support services to be able to live as independently as possible in their community. On behalf of our clients with disabilities, we submit the following comments on your department's 1115 Medicaid Waiver Request regarding long-term care realignment.

Studies have shown that states with more restrictive eligibility criteria for HCBS waiver do indeed contribute to a continuing institutional bias in the Medical Assistance program. See for example Kassner, E. & Shirley, L. (2000, April), *Medical Financial Eligibility for Older People: State Variations in Access to HCBS Waivers and Nursing Services*, AARP: Policy & Research for Professionals in Aging (Pub. ID: 2000-06). Therefore, the Departments waiver request is in violation of the U.S. Supreme Court's decision in *Olmstead* prohibiting state policies that create an institutional bias, and this waiver request therefore makes the state vulnerable to a legal challenge.

We specifically also concur in all of the additional comments submitted by Anne Henry of Disability Law Center, including that this request violates the ACA MOE requirement, the fact that the department likely has not adequately assessed the number of people

who will lose waiver services if this request is granted, requesting DHS's supporting data, inadequate alternatives under the MA State Plan, NF LOC criteria not adequately covering mental health conditions, and due process concerns. For the reasons stated above and in her comments, we request that the Department not submit this HCBS waiver request.

Thank you for the opportunity to provide comments on the Long-Term Care Realignment Section 1115 Waiver Proposal. We urge that DHS publicly respond to the comments made during this comment period and include its specific supporting data used to develop this waiver request.

Sincerely,

CHESTNUT CAMBRONNE PA

David A. Rephan

David A. Rephan

DAR/dp

MINNESOTA Psychological Association

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RECEIVED
DEC 28 2011
Medicaid Director's Office

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

Re: Proposed changes to nursing facility Level of Care criteria

December 22, 2011

Dear Ms. Kooistra:

We wish to express our concerns with the proposed changes to nursing facility level of care criteria on a number of grounds. The most comprehensive is the lack of inclusion of any aspects of mental health in the definition. As we know, many individuals at a nursing facility level of care have serious and persistent mental illness, which must be reflected in the determination of the quantities and kinds of services required to appropriately provide care. If this important variable is left out of the equation, the numbers will not add up, and vulnerable people will be without needed services. Hopefully our care systems have evolved beyond the mind/body dichotomy to recognize the synergistic impact of mental illness on physical safety and functionality that must be considered for quality care.

In the introduction to the new guidelines, it mentions that the new criteria will add a higher degree of specificity and uniformity because they are based on the Long-Term Care Consultation assessment. If this assessment tool is to be used as the response variable, this, too, is of concern. It contains very few measures that touch on symptoms of mental illness or cognitive dysfunction. Only one question in the assessment addresses psychotic illness. No mental health treatments are detailed in the assessment tool. The additional global concern is that the new definitions lack the kind of measurement and specificity that can ensure that certain populations are not inadvertently disadvantaged in terms of services so that services are fairly distributed by region and population based upon need.

In addition to these global concerns, there are concerns about some specific aspects of the criteria. In the functional area, it does not include limitations to ADLs that are a function of cognitive or perceptual difficulties, such as hallucinations and delusions. A "high need" is not well defined, and the requirement for 4 ADLs virtually precludes anyone with mental illness that causes functional impairment being qualified for services. While the definitions talk about whether individuals "can" feed and groom themselves, it does not evaluate whether they do so. Many individuals with mental illness have the physical capacity to complete ADLs, but require significant supervision or they remain in a state of self-neglect.

The shift in criteria to Clinical Need requires a very high degree of dysfunction for someone who has mental illness, equivalent to a hospital level of care rather than nursing

facility. Individuals may have a clear clinical need for medication assistance and observation but not need it on a daily basis.

In the area of Cognitive or Behavioral concerns, it would be helpful to be more descriptive of what constitutes "significant difficulty" with memory. Cognitive difficulties need to include cognitive dysfunction related to psychotic processes as well as memory difficulties. Individuals with schizophrenia demonstrate predictable patterns of cognitive impairment that interfere with processing of information, decision making, apprehending key features in problem solving, etc. Cognitive and perceptual difficulties as a function of an active psychotic process must be considered. Definitions based on so-called behavior difficulties need to move beyond aggression towards self and others and include at minimum support for behaviors that promote basic safety and self-care.

The vulnerability category is also problematic. It does not take into consideration other types of recent admissions such as hospital admissions, crisis services, day treatment, or IRTS services, or being jailed for nuisance crimes. It also does not include risk factors related to mental illness, especially vulnerability to abuse, exploitation, and failure to address health needs.

There are many difficulties with the proposed nursing facility level of care criteria and they require much more definition and specificity. We would be happy to offer assistance in this process

Best regards,

Joy Piccolino, Psy.D., LP
President
Minnesota Psychological Association

Daniel Christensen, Psy.D., LP
President Elect
Minnesota Psychological Association

Trisha A. Stark, Ph.D., LP
Executive Director
Minnesota Psychological Association

Kooistra, Jan M (DHS)

From: Julian J. Zweber <julianzweber@qwestoffice.net>
Sent: Wednesday, December 28, 2011 8:42 AM
To: Kooistra, Jan M (DHS)
Subject: Comments on Section 1115 Realignment Waiver Request
Attachments: Comments on 1115 Realignment Waiver Request.pdf

Jan,
Attached please find my comments on the proposed waiver. Please include my comments in the final submission to CMS.
Julian J. Zweber
--
Julian J. Zweber
Attorney at Law
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St. Paul, MN 55108-5252
651-646-4354
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JULIAN J. ZWEBER
ATTORNEY AT LAW

ENERGY PARK FINANCIAL CENTER
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SAINT PAUL, MINNESOTA 55108-5252

(651) 646-4354
FAX 646-4539

December 28, 2011

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

Re: Comments on Proposed Long-Term Care Realignment
Section 1115 Medicaid Waiver Request

Dear Jan:

As requested by the Notice published in the State Register on November 28, 2011, here are my comments regarding the proposed Section 1115 Long-Term Care Realignment Waiver Request to be submitted to CMS in January. My comments are based on approximately 26 years of working with the elderly and their children with disabilities in obtaining needed and necessary health care benefits through government programs. Please include my comments in any submission to CMS.

1. This proposal clearly violates both the letter and the spirit of the Maintenance of Efforts requirements set forth in the Affordable Care Act of 2010. CMS guidance clearly identifies increasing nursing facility level of care criteria as a violation of the ACA MOE.

2. Although wearing the language of reform and experimentation, research and demonstration, the clear motivating purpose of this waiver request is to reduce medical assistance caseloads in both Minnesota nursing homes and home and community based waivered programs, thereby providing cost containment for the Minnesota health care programs. The purpose is to save money, not to provide benefits "as far as practicable" for those "whose income and resources are insufficient to meet the costs of necessary medical services." See 42 U.S.C. § 1396-1.

3. Section 1115 of the Social Security Act gives the Secretary authority to waive provisions of the Medicaid Act if the Secretary determines that the initiative proposed in the waiver request is a "research and demonstration project" that "furthers the purposes" of the Act. This waiver request clearly violates the purpose of the medical assistance program as stated in 42 U.S.C. § 1396-1, namely to provide benefits as far as practicable for those "whose income and resources are insufficient to meet the costs of necessary medical services." This waiver request is pointed in the opposite direction of that purpose.

4. Without any showing that Minnesota lacks the resources to continue complying with ACA MOE requirements, this waiver request asserts that Minnesota must reform its programs to "contribute to the sustainability of medicaid long-term care services." This waiver request reflects the political impasse that prevents the Governor and the

Republican leadership of the Minnesota Legislature from finding the resources necessary to continue the funding of medical assistance programs at current levels.

3. The basic premise of this waiver request in disingenuous. It starts with the assertion that current medical assistance statutes and programs in Minnesota allow and require that medical assistance pay for services and benefits beyond the actual needs of the served populations. This is preposterous. None of the current programs and statutes allow the served populations to receive benefits in excess of demonstrated needs. Minnesota has a highly regulated nursing home system that evaluates care needs in nursing homes on a regular basis. The same is true of all the home and community based services. Improving the "efficiency, equitability, and accuracy" of the screening process for receipt of benefits does not require increasing nursing facility level of care. The Minnesota Department of Human Services and state statutes regulate the reimbursement rates payable to health care providers at each level of care for each medial assistance program. These rates take into account the amount of care provided at each level of care. Health care providers who provide a lower level of care are paid a lower rate. Removing low need individuals from access to nursing facilities is strictly a cost containment move designed to remove the individuals from both nursing home programs and home and community based programs.

4. The waiver request also asserts, again without any factual support, that the needs of the people can be met in less expensive settings. This is equally preposterous. Every study undertaken by the Minnesota Department of Human Services in the past decade to determine whether sufficient long-term care services are available in the various parts of this State, show serious gaps in dealing with various needs in most parts of the State. The Legislature over the past two biennniums has responded to this problem by cutting reimbursement rates for health care providers. This only makes the availability of affordable long-term care services less available throughout the state. The waiver request only exacerbates this current problem.

5. The requirement that the Commissioner of Human Services submit this waiver request was part of the political bargain struck between the Governor and the Republican leadership of the Minnesota Legislature to balance the state budget for the current biennium and allow the shutdown of State government to end in July of this year. This waiver request, no matter how explained and justified as a necessary step to improve delivery of services paid by the medical assistance program should be seen as nothing more than a cost containment strategy to reduce medical assistance caseloads and deliver fewer medical assistance benefits to fewer people. The request should be denied in full on that basis alone.

6. I remember when Minnesota waiver requests in the 90's were denied on the grounds that the waiver would reduce or deny benefits to people who otherwise would be entitled to benefits. I believe the same standard should apply to waiver requests submitted under the current language of Section 1115. This request should be denied in full on the grounds that it seeks to deny benefits to people who otherwise would be entitled to benefits under the federal medical assistance statutes and the ACA MOE.

Yours very truly,

Julian J. Zweber

jjz/ms

Pluto Legal PLLC
100 E. Highway 14
Tyler, MN 56178
507-247-5900
Fax-507-247-5868

Date: December 28, 2011

To: Jan Kooistra

From: Pluto Legal, PLLC

Re: Long Term Care Realignment Section 1115 Waiver request

Fax #: 1-651-431-7420

Pages: (2) including cover sheet

Comments:

Dear Jan:
Following please find comment from Lisa Pluto regarding the Waiver request. Due to time constraints we were unable to get it in the mail to you prior to the deadline. Please include our comments in any submission to CMS. Thank you.

Please call if you have any questions 1-507-247-5900.

Traci Sherman
Legal Assistant
Pluto Legal PLLC
100 E. Hwy 14
Tyler, MN 56178
507-247-5900
Fax-507-247-5868

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Pluto
Legal, PLLC

December 28, 2011

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

VIA FACSIMILE (651-431-7420)

RE: Comments on Proposed Long-Term Care Realignment Section 1115 Medicaid Waiver Request

Dear Jan:

Pluto Legal works with Elderly and Disabled clients to assist them in obtaining health care and long term care services to allow them to continue to live in the community. On behalf of our clients, we would like to submit the following comments to be included in any submission to CMS.

1. This proposal is requesting a waiver of the Maintenance of Effort requirement of the Affordable care act of 2010. The Affordable Care Act specifically states that a state cannot create eligibility requirements that are more restrictive than those in place on the date of enactment of the Act. Not only does this proposal directly impact the eligibility of the most vulnerable populations of our state, but the request outlines the number of individuals whom they expect to be impacted. The affordable Care Act was passed to increase the number of people with health care coverage, not to eliminate coverage for whole populations. This proposed Waiver, if approved, would violate the intent, and language of the Act.

2. There is no working safety net to catch the individuals who would be left with inadequate or insufficient medical coverage by the implementation of stricter eligibility requirements. The request mentions other programs that are in place or will be implemented to act as a safety net for those losing eligibility, however; these programs are either slated for funding cuts, or they do not have the resources to fulfill the needs that are currently served by Home and Community Based Waivers. Some of the programs eligibilities are also tied to the Nursing Facility Level of Care, or have age limitations that would not allow our clients to qualify.

3. The waiver is supposed be considered a "research and demonstration project". According to Appendix V, the state recognizes that research may be flawed because there will be individuals that fall through the cracks. The appendix mentions only 1 group of people that they know they can follow, those who reside in a nursing facility already. To claim that this is in any way a research project is absurd when they admit to have only 1 group of test subjects. This also raises the concern that some of the persons who would have previously been determined to be eligible for medical assistance, and thereby receiving medical care and monitoring for decreases if functioning or ability to reside outside of the facility, may be ignored by the system until something serious enough occurs to involve other agencies.

On behalf of our clients and the elderly throughout our great state of Minnesota, we request that the Waiver be denied as a whole.

Lisa K. Pluto Esq.
Attorney at Law
lpluto@plutolegal.com

LKP/tjs

Kooistra, Jan M (DHS)

From: Margaret.Holm@co.hennepin.mn.us
Sent: Wednesday, December 28, 2011 4:37 PM
To: Kooistra, Jan M (DHS); Berg, Ann M (DHS)
Subject: Fw: NF/LOC Eligibility Changes

The email addresses I had for you didn't work, so you didn't get this previously.

Margaret Holm
Administrative Secretary
Human Services and Public Health Department
A-1500 Government Center; MC 150
612 348-7905
612 348-2856 (fax)

"Our children are watching us. They put their trust in us. They're going to be like us. So let's learn from our history and do it differently."
The Dixie Chicks

----- Forwarded by Margaret A. Holm/HSPH/Hennepin on 12/28/2011 04:35 PM -----

NF/LOC Eligibility Changes

Todd A. Monson to: Jan.M.Kooistra, Ann.M.Berg 12/28/2011 04:30 PM

Sent by: **Margaret A. Holm**
Cc: Alex.E.Bartolic, Todd A. Monson, Kathy Rogers

Here are the comments from the Hennepin County Human Services and Public Health Department staff regarding the NF/LOC eligibility changes. If you have any questions or need more information, please contact Kathy Rogers, 612-348-2370. Thank you for the opportunity to comment.

Impact of ADL criteria on people with 0-3 ADLs:
People with 0-3 ADLs often need some assistance in the morning to bath and dress to start the day or need some assistance to prep for a meal or monitor for choking and manage secretions during meal times; they would no longer meet NF LOC. These individuals would not need clinical monitoring and would not meet new NF criteria elements in the frail and vulnerable (sub bullets of 5th bullet on page 18), e.g., people with cerebral palsy, multiple sclerosis, or muscular dystrophy.

In addition, individuals with chronic mental health diagnosis that no longer require behavior interventions nor meet the 0-3 ADLs but who benefit from the services provided by the waiver could be excluded from the waiver. Currently individuals with chronic MH reside in Board and Care Settings or in their own apartment; the waiver provides the needed services and structure to live independently in the community.

ADL criteria and frequency/intensity of need:
The predictability, frequency, duration, and intensity are important to assess relative to each ADL and are not considered when determining NF LOC. While there is an attempt to accommodate unpredictable care via critical ADL which "can not be scheduled", the current tool does not allow consideration of an ADL when there is a high intensity, frequency, and duration associated with an ADL. For example - if a person has spasticity, difficulty eating due to heavy secretions, or

dysphagia (swallowing problems) due to neuromuscular diseases or trauma from stroke, they would not be eligible for NF LOC. Even though this ADL can be life threatening, it would not meet minimum ADL requirements, it is an activity that can be scheduled, and would not require clinical monitoring. If NF LOC considered intensity and duration of ADL intervention in addition to unpredictability, heavy eating could be allowable as a NF LOC determinant.

Criteria for 24 hour staff availability:
To restate "requires 24 hour staff availability" as "requires 24 hour/day caregiver presence" see the DHS document "Comparing the Current Bases of NF LOC and Proposed Specific Criteria" and recommend to *even further define as "a need for intermittent care"*. When stated "24 hour *staff* availability" it bases the need only on the formal care provided. LOC is determined by a need for care whether formal or informally provided. The "LTC Realignment Section 1115 Waiver Proposal" as stated in bullet three on Page 18, states this LOC determinant more acceptably (in long hand). It is when it is abbreviated and translated to other DHS documents to communicate proposed changes that it loses intent and is misinterpreted.

High need criteria:
It would be helpful to define "a high need" as specific codes on the ADLs or a "dependency rating" on the ADLs in the LTCC document.

Frailty or vulnerability criteria/falls:
Falls need to be considered beyond just fractures, e.g., falls can be the result of low blood sugar and, while may not result in fracture, put the client in serious risk if not able to get off the floor to seek assistance after a fall.

Self neglect criteria:
Since neglect includes "self neglect" there should be some criteria that raises it to a level that can be measured.

Clinical need criteria:
1. It would be helpful if "clinical monitoring" was further defined by specific tasks or set of tasks, and
2. Delegated tasks could be more tightly defined by adding "need for interpretation of results by a professional staff on a daily basis" if that is the determined need.

Cognition or behavior criteria:
Two improvements would be to define "significant difficulty" with memory, and also define "occasional intervention" for behavioral needs, e.g., how often and what intervention, include redirection, etc?

Todd Monson
Area Director
Human Services and Public Health Department
A-1500 Government Center; MC 150
612-348-4464
612-348-2856 (fax)

----- Forwarded by Margaret A. Holm/HSPH/Hennepin on 12/23/2011 08:23 AM -----

NF/LOC Update

Eric Ratzmann to: Eric Ratzmann 12/21/2011 10:58 AM

MACSSA Members,

Please see the update below on NF/LOC eligibility changes provided by Louise Starr from Dakota County.

From: Starr, Louise
Sent: Wednesday, December 14, 2011
Subject: NF/LOC update

Hello – It has been some time since I have had a report to share, but now that there is activity again with the NF/LOC eligibility changes, I want to be sure all counties are updated. In the last legislative session the legislature required DHS to submit a request for a waiver to the Maintenance of Effort clause in the Health Care Act that required maintenance of effort in HCBS program eligibility through 2014. The waiver would ask that the proposed nursing facility/Level of Care eligibility changes planned for 2011 go into effect instead on July 1, 2012. If this does not occur, the legislature has a built-in 1.67% decrease in provider rates for these programs that will take effect on that same date.

DHS has issued this request in the state register. **It is open for public comment through December 28, 2011.** I hope counties will review the document and provide input to DHS on the changes. I have included both the link to the proposal and the links to the DHS Waivers and NF/LOC websites for additional information. Of greatest assistance in interpreting these changes and their effects will be Appendixes I, IV and V. Thank you – Louise Starr, Dakota County

http://www.comm.media.state.mn.us/bookstore/stateregister/36_19.pdf

www.dhs.state.mn.us/Healthcare/Waivers

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147891

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Kooistra, Jan M (DHS)

From: christophergbell@comcast.net
Sent: Wednesday, December 28, 2011 3:54 PM
To: Kooistra, Jan M (DHS)
Subject: Comments by the American Council of the Blind of Minnesota Regarding Long-Term Care Realignment Section 1115 Medicaid Waiver Request
Attachments: ACBM NF LOC-CGB-12-28-2011.docx

Please see the attached comments of the American Council of the Blind of Minnesota. Thank you.
Chris Bell

WORKING TOWARD
JUSTICE FOR ALL

MINNESOTA DISABILITY LAW CENTER
Duluth Fertile Grand Rapids Mankato Minneapolis
Anne L. Henry ▪ (612) 746-3754 ▪ alhenry@midmnlegal.org

American Council of the Blind of Minnesota

MEMO

To: Jan Kooistra, Department of Human Services Federal Relations
jan.kooistra@state.mn.us

From: Christopher G. Bell, Esq., Vice President
American Council of the Blind of Minnesota
christophergbell@comcast.net

Re: Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver Request

Date: December 28, 2011

The American Council of the Blind of Minnesota (ACBM) is a non-profit membership organization of persons who are blind, deaf blind, or visually-impaired, which promotes equal access, equal opportunity, full participation, independent living and economic self-sufficiency for its members. ACBM is an affiliate of its parent organization, the American Council of the Blind, a national non-profit, consumer organization having the same goals. ACBM has no information regarding how many persons receiving MA have multiple disabilities including low-vision or blindness. However, we are of the opinion that notwithstanding this lack of data, some of the persons impacted by the proposed waiver, if granted, likely will have severe vision loss or

experience it in the future. We submit the following comments on your department's 1115 Medicaid Waiver Request regarding long-term care realignment.

1. **Agreement with comments previously submitted on behalf of the Minnesota Consortium for Citizens with Disabilities and by Anne Henry of the Minnesota Disability Law Center.**

ACBM agrees with the comments submitted by MN-CCD and by Anne Henry of the MDLC.

2. **Minnesota will again be in violation of Title II of the Americans with Disabilities Act if its 1115 waiver request is granted and implemented.**

The US Supreme Court's decision in *Olmstead v. L.C.*, 527 US 581 (1999) interpreted Title II of the ADA to prohibit the unjustified segregation of persons with disabilities in institutions and required that individuals with disabilities receive services and supports in the most integrated setting appropriate to their needs.

It is unfortunate that the State of Minnesota is intentionally choosing to violate the *Olmstead* mandate by seeking this waiver to raise the NF LOC requirements. Because the NF LOC currently also determines eligibility for the HCBW (including the Elderly Waiver, Community Alternatives for Disabled Individuals (CADI) and Traumatic Brain Injury (TBI) waiver) the granting of such a request by CMS and its implementation by DHS will result in an increased risk of institutionalization for persons made ineligible for the CADI waiver, as described more fully by Anne Henry in her MDLC comments of December 22, 2011. Courts have determined that the ADA's integration mandate not only applies to individuals who are currently institutionalized, but also to individuals who are at risk of unnecessary institutionalization because of a jurisdiction's administration of its Medicaid system. See M.R. v. Dreyfus, 2011 WL 6288173 (9th Cir. 2011) (finding risk of institutionalization when state reduced hours of in-home personal care); Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same); Pitts v. Greenstein, 2011 WL 2193398 *2 (M.D. La. 2011) ("The ADA's and Section 504's 'integration mandate' prohibits a state from increasing an individual's risk of institutionalization if reasonable accommodations are available"); Brantley v. Maxwell-Jolly, 656 F. Supp. 2d 1161, 1170 (N.D. Cal. 2009) (stating that the risk of institutionalization is sufficient for a violation of the ADA); M.A.C. v. Betit, 284 F. Supp. 2d 1289 (D. Utah 2003) (same).

Moreover, the State has not developed an *Olmstead* Plan. One way a state can meet its obligations under *Olmstead* is to develop and implement a comprehensive and effective plan to move individuals with disabilities into the community, with any list of individuals waiting for services moving at a reasonable pace. See *Olmstead*, 527 U.S. at 584; see also Frederick L. v. Dept. of Public Welfare, 422 F.3d 151 (3rd Cir. 2005) ("[A] comprehensive working plan is a necessary component of a successful 'fundamental alteration' defense."); Pa. Prot. and Advocacy, Inc. v. Dept. of Public Welfare, 402 F.3d 374, 381 (3rd Cir. 2005) ("[T]he only sensible reading of the integration mandate consistent with the Court's *Olmstead* opinion allows for a fundamental alteration defense only if the accused agency has developed and implemented a plan to come into compliance with the ADA.").

The recent Final Order in the METO litigation requires the establishment of an *Olmstead* planning committee and the issuance of an *Olmstead* Plan within 18 months of the court's approval of the settlement.

In addition to the State's failure to adopt an *Olmstead* Plan there are numerous other areas of potential *Olmstead* liability. These areas of legal vulnerability include but are not limited to inadequate planning and advocacy for wards of the State, the lengthy waiting list and slow pace of acceptance of persons eligible for the DD waiver, segregated employment and sub-minimum wages paid to persons with disabilities in Day Training and Habilitation Programs, to name just a few areas of potential ADA liability.

ACBM raises the State's lack of compliance with the ADA and the *Olmstead* decision generally as the larger context in which this waiver application should be viewed.

3. DHS should post all public comments it receives on its website and also should provide them to CMS as an appendix to its waiver application.

The critical importance of ensuring public transparency of state operations dictates that DHS should post on the agency website all public comments received regarding its waiver application. The public comments also should be shared with CMS because such comments are an important part of the process for refining this waiver application.

MINNESOTA DISABILITY LAW CENTER
Duluth Fertile Grand Rapids Mankato Minneapolis
Anne L. Henry ▪ (612) 746-3754 ▪ alhenry@midmnlegal.org

RECEIVED
DEC 27 2011
Medicaid Director's Office

MEMO

To: Jan Kooistra, Department of Human Services Federal Relations
jan.kooistra@state.mn.us

From: Anne L. Henry, Minnesota Disability Law Center
alhenry@midmnlegal.org

Re: Comments on Long-Term Care Realignment Section 1115 Medicaid Waiver Request

Date: December 22, 2011

The Minnesota Disability Law Center represents children and adults with a wide variety of health conditions which result in disabilities across our state. Many people contact us seeking assistance to obtain health and long-term support services to be able to live as independently as possible in their community. On behalf of our clients with disabilities, we submit the following comments on your department's 1115 Medicaid Waiver Request regarding long-term care realignment.

1. Loss of Medicaid Coverage

An unknown number of Minnesotans who now have coverage under our Medicaid program, Medical Assistance, will lose that coverage if this 1115 waiver proposal is approved.

The appendix entitled "Projected Fiscal Effects on Minnesota's Medicaid Program" shows that at least 137 persons are expected to lose Medical Assistance (MA) coverage entirely during the twelve months beginning July 1, 2012. Those numbers increase in succeeding years. This request should not be granted because it violates the Affordable Care Act which prohibits changes in standards, methodologies and procedures which result in a loss of Medicaid coverage for adults until 2014 and for children until 2019. The Affordable Care Act seeks to increase the number of people with health coverage and therefore requires states not to eliminate coverage for Medicaid recipients in anticipation of changes which become effective in 2014. Minnesota

should not be allowed to terminate Medicaid coverage for an unknown number of seniors and persons with disabilities.

Further, we question the DHS estimates of the number of persons who will actually lose Medicaid coverage due to the loss of the special income standard for seniors and other more favorable treatment of income and assets compared to the medically needy requirements for those with incomes over 100% FPL to spenddown to 75% FPL (explained in Appendix V of the 1115 waiver proposal.). Because the individuals affected by the change in nursing facility level care (NF LOC) are relatively low-income to begin with, meeting higher spenddown requirements (an average of $394/mo. for seniors being terminated from the Elderly Waiver (EW)) will put these people in a position of choosing between paying their rent and paying for health coverage. People need both a place to live and health coverage and therefore, we believe that DHS underestimates the actual number of seniors who will lose health coverage because they will not be able to pay their increased spenddown and still have enough to live on in their homes in the community. In addition, we disagree with the DHS contention that no persons under age 65 now eligible for the "Community Alternatives for Disabled Individuals" (CADI) home and community based waiver services (HCBW services) will lose MA coverage. Loss of Medicaid is especially likely for those whose families now benefit from the HCBW services treatment of spousal income and assets and the children who qualify under the TEFRA-MA option.

2. The Proposed NF LOC Changes are not Consistent with the 1115 Waiver Standards for a Demonstration to Further the Purposes of the Medicaid Program

Section 1115 demonstration waiver authority under the Social Security Act (42 U.S.C. 1315) was enacted to allow states to waive certain provisions of federal Medicaid law in order to create an "experimental, pilot, or demonstration project" if it is cost effective, efficient, and not inconsistent with the purposes of the Medicaid Act. Terminating health coverage and restricting access to important community services for low income seniors and persons with disabilities is contrary to and certainly does not further the purpose of the Medicaid Act.

3. Lack of Specific Data on Impact of the Changes Proposed

DHS should include as an appendix the data used to develop the NF LOC proposal and to design the Essential Community Support service. Detailed information about the incomes and assets of those who will be affected by the changes, including the family incomes of children eligible through the TEFRA option and the services used by those who will be terminated from eligibility for HCBW services is available and should be provided to the public. This data should also be part of the 1115 proposal submitted to CMS.

4. Alternative Services under the MA State Plan and Essential Community Supports (ECS) are not adequate to meet the needs of those terminated from eligibility for HCBW services because they no longer meet the NF LOC

For those under age 65, DHS estimates nearly 680 (3% of CADI enrollees, page 40 of the 1115 waiver proposal) individuals are projected to lose CADI HCBW services and will be left with inadequate alternatives under the MA state plan and are ineligible for Essential Community Supports. The listed MA state plan services are also inadequate for seniors and ESC services are

similarly unavailable to those seniors who remain eligible for MA state plan coverage, but not HCBW services.

a. MA State Plan Services are not a substitute for HCBW services to be terminated.

The 1115 waiver request asserts that personal care assistant (PCA) services and home health aide services are MA State Plan options which will meet the needs of those eliminated from HCBW services who remain eligible for MA. These two state plan services will not fill the gap left when EW and CADI HCBW services are terminated for the following reasons:

i. PCA services require meeting criteria even stricter than the proposed nursing facility level of care criteria. Many who do not qualify under the proposed NF LOC will not qualify for PCA services

The PCA program was substantially cut in 2009 by tightening the definition of dependency to remove prompting and cuing for those with cognitive limitations such as brain injury or intellectual or developmental disabilities. The definition of dependency now requires that a person need hands-on physical assistance or require constant cuing and supervision throughout the performance of the activity of daily living (ADL). Persons with cognitive limitations who need only prompting and cuing are not eligible for PCA assistance. In addition, the Level 1 behavior category for those who are a danger to themselves, to others or engage in property destruction have been cut to only 30 minutes per day for PCA assistance. This means individuals with behavioral issues and mental health conditions either get no assistance each day because it is difficult to impossible to arrange for a PCA to come to your home to work for half an hour given the low rate paid or the thirty minute segments are grouped into one 2½ hour period one day per week. This service is simply inadequate to meet the gap caused by the loss of CADI Waiver services, especially since those limited to 30 minutes of PCA can qualify for extended PCA under CADI.

ii. Home Health Aide under the MA State Plan

A Home Health Aide visit is not a substitute for all the EW and CADI services eliminated. The Home Health Aide visits (usually twice per week) include such tasks as setting up medication, assisting with foot care, assisting the person with bathing and checking for skin breakdown. These are a limited set of more medically oriented services which do not substitute for assistance with instrumental activities of daily living such as food preparation, shopping and chore service, accompanying the person to appointments or elsewhere outside the home. Providing limited services does not compensate for the loss of other supports such as equipment and supplies. In a sample of 500 persons who will lose CADI eligibility, DHS data reveals that most people used CADI services such as homemaker, extended equipment or supplies, transportation, home delivered meals which are not available through the MA State Plan.

b. Essential Community Supports (ECS) unavailable to most who would lose HCBW services

ECS services are not available at all to persons under age 65 or to anyone of any age eligible for MA state plan services. The types of services allowed under ECS are not covered in the MA state plan. Yet, these are the very services needed by most, if not all, persons who now receive HCBW services and will have that eligibility terminated under this 1115 waiver proposal. Because federal Medicaid match is sought for ECS, these services should be available for all MA recipients terminated from HCBW services, as well as those who lose MA coverage altogether. Also, home delivered meals should be listed as an ECS for all ages, since this service is used by many who will lose it if this 1115 waiver request is approved. The ECS services are provided under EW and CADI and thus could be added to the state plan under 1915i discussed below in #6 or through a 1115 waiver request.

5. NF LOC Criteria Does Not Adequately Cover Mental Health Conditions

The new NF LOC criteria should be revised to better cover mental health conditions. The criteria will be used to determine eligibility for the CADI waiver which is our state's only HCBW service available for those whose primary diagnosis is a mental health condition. DHS recently indicated that about 60% of those qualifying for CADI waiver services have a history of a mental health condition. There are significant terminology issues involving the need for staff assistance and clinical monitoring of symptoms not reflected in the criteria. For example, to what extent does the "need for clinical monitoring" criterion include symptom management for those with a mental illness; or does it refer primarily to medical monitoring such as blood pressure, medications, blood sugar? Similarly, the risk factors for 'vulnerability' include maltreatment, neglect, falls, or sensory impairment, but do not include vulnerability related to mental health symptoms such as hallucinations or paranoia that would represent risk factors to a person with a mental illness.

6. Reserve the Institutional Level of Care for Those with Higher Needs and Continue Current Eligibility Policy for Community Services under the HCBW Services through 1915i

We understand and support tightening the criteria for nursing facility services, but oppose continuing to tie eligibility for the HCBW services (EW, CADI, and Brain Injury) to the nursing facility level of care criteria. It is very clear that it makes sense from a fiscal and social policy perspective to provide services to a wider group to maintain people in the community and to avoid or at least delay institutional care.

Our state can separate the institutional level of care criteria used for nursing facility services from the criteria used for eligibility for HCBW services. We urge that our state pursue the 1915i option established by the Deficit Reduction Act of 2005 as amended by the ACA or similar approach to separate institutional level of care from eligibility for community support services. This option would allow Minnesota to proceed with tightened nursing facility level of care criteria while providing access to community support services as offered through the HCBW service programs at current levels through the medical assistance state plan. We believe this would be a wiser policy which would not result in denying needed community support services. Other requests or restructuring would be needed to assure that no persons lose MA coverage, even under the 1915i approach.

7. Due Process Notice and Appeal Rights Concerns

The time period for notice for those who lose eligibility for HCBW services is inadequate and must be provided at least 90 days before the loss of services. People who would lose EW and CADI services under this 1115 waiver request are vulnerable and relying on those services to maintain themselves in their homes or residential settings. If they are going to lose services and need to make other arrangements, a 90 day notice period is needed with a 30 day period allowed to request services pending appeal as was done with the PCA cuts adopted in 2009, § 256B.0659 subdivision 30 (2).

Thank you for the opportunity to provide comments on the Long-Term Care Realignment Section 1115 Waiver Proposal. We urge that DHS publicly respond to the comments made during this comment period and include specific data listed in comment #3 to CMS.

ALH:nlb

1111-0327571- 887726

S.K.

COURAGE CENTER

RECEIVED
DEC 27 2011
Medicaid Director's Office

MEMO

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

From: Courage Center

Re: Comments in regards to the State of Minnesota Long-Term Care Realignment Section 1115 Waiver Proposal

Date: December 22, 2011

Courage Center is a comprehensive rehabilitation and resource center for people with disabilities and complex medical issues. We serve those with lifelong and newly acquired conditions at every point in the life cycle. On behalf of our clients of all ages with disabilities, we submit the following comments on your department's 1115 Medicaid Waiver Request regarding long-term care realignment.

The proposed changes will result in at least 137 people losing MA coverage, but does not adequately account for the number of individuals who will lose coverage due to the special income standard for seniors who are on the Elderly Waiver. Many will drop MA coverage rather than pay the additional $394 in spenddown to qualify for MA because they need to choose between housing and health care coverage. It also does not adequately take into account the number of children who qualify for the TEFRA-MA program by eligibility for the CADI or Brain Injury waiver. In this regard the proposed changes to eligibility are in violation of the Affordable Care Act.

The State of Minnesota has a long history of providing a comprehensive mix of services to our most vulnerable citizens through Home and Community Based Services for individuals with a variety of disabilities and the elderly. The changes to the waiver programs that are proposed will undermine the good work that has been done thus far to keep people in the community and out of nursing homes. The remedies proposed for service provision for those who will have to leave the waiver are inadequate for persons with a disability who are under age 65. The changes proposed will have an unfair impact on those individuals who have substantial functional impairments due to a behavioral disorder, such as mental illness or brain injury. The time period proposed for notification of loss of eligibility is inadequate considering that many are receiving customized living (assisted living) and may have to find new housing.

A change in criteria for the Nursing Facility Level of Care which is described in this proposal will limit access to important services, force people off the waiver and lead to greater use of institutionalization and other negative consequences such as homelessness and increased hospitalization for psychiatric or behavioral reasons. The proposed changes are a very big

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Minneapolis, Minnesota 55422

p: 763 588 0811

CourageCenter.org

change compared to the current criteria and are worded in such a way that they could be interpreted in many different ways, especially in regards to the proposed operational criteria for "Clinical Monitoring" "Cognition or Behavior" and "Frailty or Vulnerability". "Clinical Monitoring" does not define which conditions could require monitoring: mental health symptoms or only physical health conditions like blood pressure and blood sugar. The new MNChoices assessment process described in this proposal has a more robust assessment of behavioral and cognitive concerns, but will not be operational and deployed state wide when this proposal is to go into effect, and the current long term care screening document does not adequately capture those behavioral and functional impairments experienced by people with mental illness and brain injury who are on the CADI waiver. While we support the inclusion of "Frailty and Vulnerability" as an eligibility criteria, that is also vague and not well defined. It does not designate whether someone is eligible who is at risk of maltreatment and neglect (including self-neglect) or only those who have actually had an incidence of maltreatment or neglect. The very purpose of Home and Community Based Services is to provide supports so that individuals do not deteriorate to such an extreme level.

In addition, no look back period is defined in the criteria. Often the provision of supports will improve functioning and reduce risks in the areas of behavioral concerns or vulnerability. Once those supports are removed the impairments and risks most often come back, causing a "revolving door" of eligibility. With almost every county in the state having a wait list for CADI services, there is no guarantee that services lost can be quickly reinstated, preventing loss of housing and/or return to institutionalization.

The Department of Human Services recognized the devastating effect of pulling service from so many who will no longer qualify for the Elderly Waiver by proposing a new state plan menu of Essential Community Support services (ECS). Yet, they made no such provision for those under age 65 who will lose eligibility for the CADI waiver, which is estimated to be 680 individuals. While the overall number and percent of individuals on the CADI waiver affected, the results will be no less devastating, placing them at undue risk. State plan services will not be adequate substitutes for the Home and Community Based services that will be terminated. The current criteria for PCA services are stricter than the proposed nursing facility level of care due to requiring "hands on assistance or constant cueing" to establish a dependency in ADL's. Those who only need prompting or cueing are not eligible. Because federal Medicaid match is sought for ECS, these services should be available for all MA recipients terminated from the waivers regardless of age, but tailored to the unique needs of the population served. For example Essential Community Supports for those under 65 should include home delivered meals (which is unavailable through Older Americans Act funding to those under 65) and Independent Living Services to foster skill development and community integration.

We support the tightening of criteria for nursing facility services, but oppose continuing to tie eligibility of the Home and Community Based Wavers (EW, CADI, and Brain Injury). We urge the state to take action to pursue the 1915i option to separate institutional level of care from eligibility for community support services. It makes good sense fiscally and on a social policy level to provide community services to a wider group to maintain people in the community and to avoid or at least delay institutional care.

In summary we believe the proposed changes are in violation of the Affordable Care Act and will place people with substantial functional impairments at risk for institutionalization or homelessness. The proposed services to remedy the devastating effects of this change in eligibility criteria are inadequate for those under age 65.

KANDIYOHI COUNTY FAMILY SERVICE DEPARTMENT

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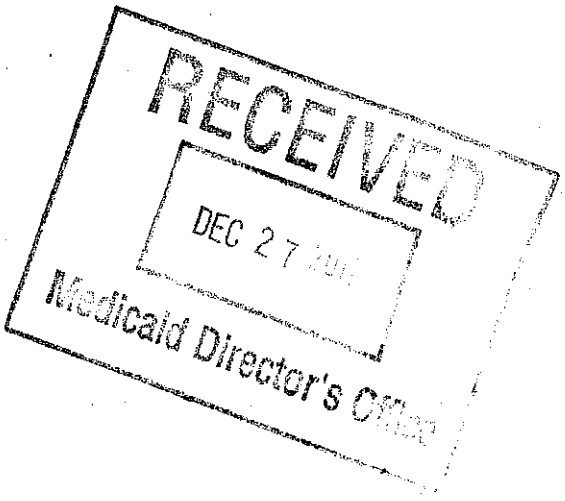
Jay Kieft
Director



December 22, 2012

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

Re: Long-term Care Realignment Section 1115 Medicaid Waiver

Ms. Kooistra,

I would appreciate your consideration of my comment:

Because implementation of the 2009 N/F LOC legislation and Section 1115 Federal application to implement a more restrictive nursing facility level of care standard could result in homelessness of nursing facility residents, that no longer meet the new N/F LOC, upon their discharge. I would like to recommend the waiver application include hardship waiver language that would allow a 90 day extension of discharge from a Nursing Facility if the discharge would result in homelessness. The nursing facility would have to apply for the extension of payment to the Department of Human Services and provide the Department a plan of care that would include active housing search assistance and application assistance to housing services such as Section 8.

Respectfully Submitted,

Tamraa Goldenstein
Social Service Supervisor

Cc.
Jay Kieft, Director

J.K.

MN **Leadership Council** on Aging

Members

AARP Minnesota

Aging Services of Minnesota

Alzheimer's Association Minnesota-North Dakota Chapter

Amherst H. Wilder Foundation

Care Providers of Minnesota

DARTS

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Living at Home Network

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Minnesota Association of Area Agencies on Aging

Minnesota Home Care Association

Minnesota Medical Directors Association

Minnesota Network of Hospice and Palliative Care

Senior Community Services

Volunteers of America of Minnesota

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Minnesota Leadership Council On Aging
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COMMENTS ON MODIFIED NURSING FACILITY LEVEL OF CARE

RECEIVED
DEC 21 2011
Medicaid Director's Office

December 22, 2011

Jan Kooistra
Minnesota Department of Human Service
P.O. Box 64983
St. Paul MN 55164-0983

The Minnesota Leadership Council on Aging (MNLCOA) coalesces the resources and power of consumer, advocacy, social and health service organizations to advocate boldly to positive systems change for older adults and their families in Minnesota. Sixteen leading nonprofit organizations form the Council. Together these organizations represent or serve more than 300,000 seniors and family caregivers. MN LCOA is pleased to offer the following comments on the Long Term Care Realignment Section 1115 Medicaid Waiver request.

We recognize the legislative mandate to reduce the numbers eligible for Medicaid, as part of overall budget management. Our comments below reflect our concerns that the proposed changes will have significant undesirable consequences, not just to those who are not eligible, but also to the systems that assess and serve those individuals. In general, our comments focus on the elderly, but some issues apply to the CADI waiver also.

I. Transitions

We are concerned about the implications of this change on the thousands of seniors currently receiving services through the nursing facility and/or waiver program. It appears that there has not been sufficient transition planning for those who would be impacted overnight by such a change, especially in situations where there is no family caregiver available and/or no "home" to return to once the senior is discharged from their current location. Is there a way to "grandfather" in current recipients of NF/EW/CADI services, who have already severed their "relationship" to alternative housing/services?

Can this be moved upstream so that individuals will know in advance how to plan for what services rather than at the point where the services are needed?

II. Data

It is concerning to us that there would be such a significant policy change made without a transparency regarding analysis of the data on who is affected by the change today, who will be affected in the future, and what unintended consequences this policy changes may have. Specifically, how will individuals be cared for if they are poor enough to be eligible for Medicaid by income and assets, assessed by professionals as needing assistance, but no longer eligible based upon proposed clinical criteria?

III. Health and Safety

The proposal assumes that individuals who are no longer eligible to receive nursing facility care, or services under the elderly waiver (EW) or community alternatives for disabled individuals (CADI) waiver will have adequate resources to live safely in the community. Given the lack of transparent data, we question that assumption. It is unclear what obligation current providers will have to ensure that their clients (who no longer qualify for reimbursement for their level of care) are discharged to a safe environment, which is required by regulation. There does not appear to be an exceptions process to take into account unique circumstances such as the consumer with limited funds, no community housing option, moderate dementia and no spouse for caregiving.

IV. Level of Care Criteria

It does not appear that the criteria identified reflect the needs and vulnerabilities of persons with Alzheimer's disease so we would request the following additions/changes to the criteria:

Functional Needs: Needs ongoing or periodic assistance with hands on care, supervision or cueing from another person in safely or appropriately performing four or more ADLS.

Cognitive or Behavior: The person has impaired cognition:

- Short term memory loss
- Disorientation of person, place, time or location
- Impaired decision-making ability

OR

Frequent history of the following behavior symptoms:

- Wandering
- Physical abuse of others
- Resistive to care
- Behavior problems requiring some supervision for safety of self or others
- Difficulty expressing self or understanding others

Vulnerability

Living alone and risk factors are present:

- Self neglect: The person has not or may not obtain goods or service necessary to ensure reasonable care, hygiene, nutrition and safety or to avoid physical or mental harm or disease

- Neglect, abuse or exploitation: the person's caregiver(s) or other persons cannot provide reasonable care to the person, or the person has been or may be physically and/or verbally abused, or the caregiver(s) or other persons have or may mismanage the person's funds and/or possessions.

V. Access to Services

In rural communities, where the choices in the spectrum of care are not as robust, this change to who is eligible for specific older adult services, is far more dramatic. If a consumer is no longer eligible for nursing facility stay, there are limited community-based services or supported housing for them in many rural communities. Their choices will then be to either move away from their family/friends in their home community, or wait for their conditions to deteriorate so they could become eligible once again.

Current clinical guidelines for eligibility for Medicaid nursing facility level of care have rarely led to conflict. In general, they are both clear and generous enough to permit eligibility whenever clinicians see a need for assistance in daily life. The proposed guidelines are, by intent, less generous, but also more subjective. For example, what are "high needs for assistance"? What is "need for clinical monitoring"? What is "significant difficulty"? Even "living alone" is subject to interpretation, in terms of consistency or competence of others in the home.

VI. Consumer rights

There are federal requirements relating to discharge notices and timeframes for notices and appeals that must be followed by nursing facilities. We are unsure if these requirements have been incorporated into this process. We are also uncertain about the appeal rights for individuals who will no longer or newly assessed as being ineligible for reimbursement for these specific Medicaid services—do patients appeal through the human services appeal process, the administrative process or both? Is there a role for the long term care ombudsman to represent these consumers? Who will have the right to appeal on behalf of the typical impaired applicant for Medicaid? If the people impacted by this level of care change are also enrolled in health plans, is there an appeal process through their health plan?

VII Process

The population currently eligible for nursing facility level of care often has changing conditions that require changes in service plans. Similarly, the criteria for eligibility must recognize varying levels of need over days and weeks. Criteria should both enable individuals deemed eligible to remain eligible for some time, even if their condition improves, until it is clear the condition will not likely decline again. Individuals deemed ineligible based on clinical criteria should have timely opportunity to be re-assessed if their condition worsens. The level of care changes need to have "real time" flexibility to allow recipients to move back into eligibility as their condition/needs change.

Some criteria, such as living alone, are not health related. It is unclear what process could be used to assess such a variable. If an adult child comes to stay with a frail parent, will there need to be a process to determine how long that person has stayed to cause loss of eligibility? Other criteria, such as difficulty with memory or using information, may be assessed by different types of professionals in different ways. Is that a judgement for a neuropsychologist (gold standard), an occupational therapist observing functional testing , or a nurse, social worker or physician using a cognitive screening tool? "Need for clinical monitoring" can be judged only by estimated risk of lack of monitoring or by evidence of benefits of monitoring (which is unlikely

known until monitoring is provided). What process could be used to make such a judgment about risk and benefit? What if there is a demonstrated need for daily monitoring, but the eligible individual refuses such monitoring (in a home setting)?

VIII. Intersecting Systems Changes

The level of care changes are but one systems change being proposed by the Department of Human Services. There are other changes underway relating to payment, assessment, benefits, and eligibility that will clearly intersect with the level of care change being proposed. There has been no public presentation of data in a comprehensive fashion regarding: who is impacted by various proposals; will reduced eligibility for coverage for home and community based services lead to physical declines causing subsequent need for nursing home care, will reduced eligibility for Medicaid increase costs to other types of state and local government services besides state health plans (e.g. vulnerable adult services, court systems, police and fire services). Will these changes cause measurable declines in quality of health care outcomes, such as re-hospitalization rates? Individuals enrolled in MSHO who are no longer MA eligible—do they have to be dis-enrolled?

IX. General Policy Considerations:

a. Is this good public policy? We would summarize our concerns as being critical of the proposed policy for its difficulty to successfully implement. We anticipate extraordinary challenges and costs for providers and others who must deal with those who become or are newly deemed ineligible despite clear need for assistance and lack of income or savings to purchase help. We also anticipate conflict between those assessed for eligibility and government agents, conflict between providers try to shift responsibility for such seniors and conflict between seniors and their family members. Conflict has costs not factored into the analysis of this policy.

b. Given the risks associated with the proposed policy and the, to our knowledge, lack of prior input by non-government employees (e.g. academic experts or professional societies) into the eligibility criteria, we ask that proposed criteria be thoroughly tested prior to acceptance as policy. This could be accomplished by adopting criteria from another state that has experience in their use or testing proposed criteria against current criteria concurrently. Without such evidence, we strongly object to implementation as a testing process.

c. If state health plans must reduce spending for elderly Medicaid eligible by about $25 million over the next three years, but cannot safely implement level of care change policies, alternative solutions besides provider rate reductions should be considered. One possibility would be raising the income threshold for those eligible for waiver services. In other words, some or the budgetary pain could be shared across a large number of seniors rather than applied to a few newly ineligible seniors or at the expense of providers, some disproportionately to the point of bankruptcy. Another

alternative that could be considered would be better targeted reductions in payments to providers, based upon ability to absorb such reductions (due to payer mix or non-patient fee revenue).

The Minnesota Leadership Council on Aging, as a consortium representing all perspectives from the community, would be pleased to collaborate with the Department of Human Services in the coming months to improve this policy. Feel free to contact either of us with questions and/or to schedule follow-up discussions.

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Kooistra, Jan M (DHS)

From: Sue Kvasager <sue.kvasager@mail.co.douglas.mn.us>
Sent: Friday, December 02, 2011 8:40 AM
To: Kooistra, Jan M (DHS)
Subject: Comments on proposed changes in nursing facility LOC

*I have been doing LTCC screenings for **18 yrs.** and have always felt that the LOC criteria for access to waiver/AC services and nursing home admission needed to be stricter/tightened up; as it reads now, anyone with an intermittent need for homemaking meets SNF LOC criteria. With that being the standard now, I feel it is too extreme to go from 0 ADL dependencies to requiring 4 ADL dependencies (along with several other options) to meet nursing facility level of care criteria.*
Also, I think that there should also be 2 levels of care criteria:
#1 LOC criteria to be eligible for waiver/AC services (needs can be safely met in the community)
#2 LOC criteria for admission to a skilled nursing facility

#1: the ADL criteria for waiver/AC LOC:

- ***2 dependencies** in one of the following areas: **dressing, grooming, bathing, eating, transferring**, or **bed mobility** (positioning) or need **medication administration**.*

OR

- ***1 dependency** in **bed mobility (positioning), transferring, ambulation** or **toileting** (critical ADL's that cannot be scheduled)*

#2: the ADL criteria for SNF admission should be:

- ***3 dependencies** in one of the following areas: **dressing, grooming, bathing, eating, transferring**, or **bed mobility** (positioning) AND need **medication administration***

OR

- ***2 dependencies** in **bed mobility (positioning), transferring, ambulation** or **toileting** (critical ADL's that cannot be scheduled)*

For #1, keep the other DHS LTCC LOC proposed criteria:

- *Clinical monitoring at least once per day*
- *Significant difficulty with memory.... , that require at least occassional staff intervention (should require **significant** staff intervention for #2 SNF Admission)*
- *Person currently lives alone AND meets one of the following:*

1) has fallen which resulted in a fracture
ELIMINATE #2 At risk of maltreatment, neglect, etc. AS ANYONE RECEIVING SERVICES OR IN A FACILITY IS CATEGORICALLY A VULNERABLE ADULT
3) sensory impairment that substantially impacts functional ability...
4) meets one of the above LOC criteria AND continues to meet at least one criteria at 90 days after admission to a SNF

Thanks for allowing our comments and input.

Sue Kvasager RN, PHN
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Waiver Program Coordinator
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Kooistra, Jan M (DHS)

From: LouAnne Olson <louanne.olson@co.polk.mn.us>
Sent: Tuesday, November 29, 2011 2:57 PM
To: Kooistra, Jan M (DHS)
Subject: Public comment on LOC revision

Dear Jan, If we are truly interested in the prolonged safety and health of our Seniors we would do well to strengthen the supportive and preventative nature of Alternative Care and Elderly Waiver including access to Medical Assistance as provided through SISEW. If we say we cannot afford such supportive and preventative care, how in the world can we afford countless ER visits, hospitalizations, premature nursing home stays and the like that lack of good home care and basic medical coverage would cause? I'll end there. Thanks much, and good luck. LouAnne Olson, LSW, Polk County Social Services, Crookston, Mn 11-29-11

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Appendix VI - DHS response to public comments

Appendix VI Responses to Public Comments

A request for public comment on this waiver request was published in the Minnesota State Register on November 28, 2011. This comment period provided an opportunity for public and stakeholder input on the proposed modifications to Minnesota's nursing facility level of care standard and process. We appreciate the thoughtful comments that were submitted. These comments have been discussed and analyzed, and we have made some adjustments to the demonstration project because of concerns that were raised. This appendix is intended to respond to the concerns raised through the public comment process, which we have categorized into major themes.

I. Public Policy Concerns

Some commenters agreed that modification to the nursing facility level of care criteria was appropriate, but thought that a requirement of four ADLs was too high.

Response: The revised nursing facility level of care criteria presented in this waiver request is set out at Minn. Stat. § 144.0274, subdivision 11, which was enacted by the 2009 legislature after extensive public debate. Further revision to the level of care criteria would require amendment to state law. Please note that the revised LOC criteria do not require deficits in four ADLs if the individual has need for daily clinical monitoring, or requires assistance with at least one critical ADL.

Several commenters expressed concerns that current state plan services are insufficient to maintain persons who would no longer qualify for the revised level of care in the community, and could lead to higher rates of institutionalization.

Response: To the extent that these comments are made in the context of concern for people who may not meet the criteria for personal care assistance or PCA services under the state plan, DHS acknowledges that some people who would not meet the proposed nursing facility level of care criteria will not meet the criteria for PCA.

To the extent these comments are made in the context of concern for people who may lose long term care services and will not be eligible for PCA or the Essential Community Supports (ECS) program as described in the draft waiver provided to the public on November 28, 2011, DHS has amended the earlier waiver draft to expand the eligibility for Essential Community Supports. DHS proposes that if federal matching funds are made available through this waiver request, the ECS program should be expanded as discussed in Section 3.3.3 of the waiver proposal to include all people who received Medicaid-funded long term care services prior to the implementation of

the demonstration and are no longer eligible under the revised nursing facility level of care criteria.

DHS also proposes to add a new service called "community living assistance" to the Essential Community Supports program. Community living assistance is a new service that would be developed for the first time under this demonstration to address needs identified by commenters, such as assistance and support for basic living and social skills, household management, medication education and assistance, monitoring of overall well-being and problem-solving DHS believes that the evaluation of the experience of these additional eligible people and the added service will be valuable as DHS works on the future reform initiatives outlined in Section 2.4.6 of the waiver proposal, including a potential expansion of state plan benefits under Section 1915(i) of the Social Security Act.

Some commenters urged the state to pursue the 1915(i) option to separate nursing facility level of care from eligibility for supportive services in the community, and to require a higher level of care to qualify for payment of nursing facility care than community care.

Response: DHS will take these comments into consideration as work continues on the reform efforts outlined in Section 2.4.6. DHS seeks to create a more dynamic home and community-based services system that removes the pressure to move into waivered services in order to receive lower-intensity supportive services. DHS seeks reform that will support people in accessing higher levels of service when needed to safely remain living in the community, but also allow people to stay at or return to lower levels of service when those are sufficient.

Several commenters were concerned that the revised level of care criteria would disproportionately affect persons with a mental illness who rely on the home and community-based waivers, in particular those individuals for whom current services have contributed to an improvement of their symptoms and therefore have less need for behavioral interventions.

Response:

1) First, the revised nursing facility level of care criteria are designed to recognize people with cognitive and behavioral needs, including those for whom behavioral needs are a symptom of mental illness. The criteria account for risk based on the potential for self-neglect, and also recognize a person's need for occasional intervention to address behavioral needs. Such interventions can include services to maintain reductions in behaviors attributed to a mental illness.

2) Next, an analysis of the data that was conducted in response to the comments did not support the contention that the change in the nursing facility level of care criteria will disproportionately affect people with mental illness.[1] An analysis found that the opposite was true; people with a past mental health diagnosis were significantly *underrepresented* in the sample group of those at risk of losing eligibility under the revised level of care criteria. Approximately 3% of the CADI case load, or about 500 CADI participants, have been identified as potentially at risk of not qualifying for the revised nursing facility level of care. If the revised level of care criteria disproportionately affects persons with a mental illness, one would expect that the proportion of the sample group reporting a mental health diagnosis would be much higher than 500 out of 16,000 recipients, given that 70% of the caseload reported a mental health diagnosis at some time in the past. Moreover, 40% of people in the sample group reported a mental health diagnosis in the past, compared to 70% in the overall CADI caseload. Additionally, an analysis of mental health claims for the sample group showed low rates of utilization of mental health services over the past year. For example, only 71 claims for medication management (procedure code 90862) were made in the past year by the 221 current CADI participants who have reported a past mental health diagnosis and who appear to be at risk of no longer qualifying for waiver services under the revised level of care criteria.

3) Finally, the proposed revision of the Essential Community Supports Program would ensure that individuals who lose nursing facility level of care due to the implementation of the revised criteria are assured of some transitional community support.

II. Nursing Facility Level of Care Criteria

Commenters expressed concern about the revised nursing facility level of care criteria, asserting that the criteria were more subjective than the current set of criteria and asserting that a number of the terms used needed to be more fully defined. Concerns were also raised that the revised criteria will not adequately measure the needs of people with Alzheimer's, mental illness, or behavioral needs.

Response: Many of these comments likely stemmed from the brevity of the description in the draft waiver proposal explaining how the proposed criteria would differ from the current criteria. DHS has amended the draft waiver proposal to add additional detail regarding the criteria and

[1] Currently there are over 16,000 CADI recipients; 70% of these people reported having a mental health diagnosis at some point in the past. This measure likely overstates the number of people for whom a mental health diagnosis is a current primary concern because the diagnosis could have been rendered at any time in the past.

would like to take this opportunity to clarify that the terms utilized in the proposed criteria have the same meaning as they have always had.

Clarification of proposed criteria: One of the improvements sought in the proposal is the creation and implementation of a *less* subjective set of criteria. The proposed criteria are based on assessment information gathered during the current assessment process, using the current tools and assessment items, and entered into MMIS. However, while the current level of care criteria is based on professional judgment and groups of needs described by DHS, the proposed criteria relies more on assessment items that have "forced choice" responses (i.e. coded data) and defined thresholds of need. At the same time, DHS also intentionally retained categories of level of care that continue to allow professional judgment to account for unique circumstances (i.e. determining the risk of self-neglect).

Focusing on any one of the multiple categories of level of care criteria and asserting that it fails to encompass a particular need or population ignores the broad array of needs that the proposed criteria continue to include. DHS provided additional detail in Section 3.2 of the waiver proposal to clarify that revision to the level of care criteria has not changed the meaning of the terms "clinical monitoring," "significant difficulty with memory." Additional clarification of the term "occasional staff intervention" with regard to behavioral needs is also included in Section 3.2.

The threshold for the revised level of care criteria related to behavioral needs is the need for "*occasional staff intervention.*" This can include intervention to maintain reductions in behaviors as well as interventions needed in response to behavioral events or mental health symptoms. "Occasional" is defined as occurring less than 4 times per week. Like clinical monitoring, however, this intervention needs to be based on appropriate assessment of the behavior(s), a plan for intervention developed by appropriate professionals, staff training in delivering and monitoring of the effectiveness of the intervention, and so on.

Commenters expressing concern about the potential impact on individuals with mental illness should be aware that behavioral and functional limitations resulting from mental illness will continue to be captured in the revised nursing facility level of care criteria. People who have less need for behavioral interventions because their current services have contributed to a reduction in those behaviors will continue to be evaluated for risk based on the need for occasional intervention to address behavioral needs, which can include supports delivered to maintain reductions in behaviors. The category "potential for self-neglect" encompasses, for example, individuals with no informal supports who can no longer maintain their household without assistance, or who are at risk of falling, in the absence of modifications to their environment. Professional judgment will also continue to be an important part of the determination of this basis of level of care. DHS is seeking to more fully incorporate this element into the assessment tool and level of care decision tools.

Diagnosis-specific criteria: *Some commenters requested that DHS adopt diagnosis-specific criteria, such as in the case of a person with Alzheimer's.*

Response: DHS does not believe that this approach would be the most fair or efficient method of determining level of care. The nursing facility level of care criteria are based on functional limitations, the need for restorative or rehabilitative care or treatment, cognitive or behavioral needs, or a professional assessment of frailty or vulnerability. Individuals who meet the standards for these kinds of needs, regardless of the underlying diagnosis, will meet the revised nursing facility level of care.

Single ADLs with significant risk: *Some comments urged DHS to allow a nursing home level of care determination for individuals who have high needs in only one ADL where there is significant risk associated with that one activity, such as eating with choking risk.*

Response: In previous analysis, it was found that individuals typically do not have high needs in only a single ADL. Rather, people with underlying health conditions that result in a high level of need in one activity of daily living will have functional limitations in several areas of life, and therefore would meet the revised criteria. This is true of ADLs affected by mobility limitations (toileting, positioning, transferring) as well as those affected by cognitive impairment. The revised nursing facility level of care criteria require only one dependency in one of three critical ADLS (toileting, positioning, and transferring) when there is a need for human assistance, in part because this type of need must be able to be met at any time.

Revised nursing facility level of care and case mix: Advocates and consumers may be familiar with the Minnesota case mix classification system, which is used to differentiate people who meet the nursing facility level of care by their intensity of need. Commenters may find it helpful to learn that all individuals who are currently classified as case mix B or higher will meet the revised nursing facility level of care criteria. This means that people who have already been assigned to the higher case mix classifications will the one level of care criteria using standardized items and scores.

Many people in the lowest two case mix classifications will also qualify under the revised nursing facility level of care criteria.[2] This is because the thresholds used for purposes of case mix classification items are *higher* than those used for purposes of establishing level of care. For example, clinical monitoring must occur at least once every eight hours to "count" for case mix, while the nursing facility level of care criteria requires clinical monitoring to be needed only once in 24 hours. This is also because the factors considered in assigning case mix are less comprehensive than the revised nursing facility level of care criteria. Case mix is built from only eight ADLS, a clinical monitoring and treatment item, and a single behavior item. Finally, case

[2] The lowest case mix classifications are "A" and "L." Case mix classification "L" is used to classify very low need seniors.

mix is built from "forced choice" items, while professional judgment will continue to be an important part of determining level of care in such areas as need for occasional staff intervention for behavioral needs or potential for self-neglect.

III. Legal Concerns

Commenters raising legal concerns primarily concentrated on due process rights of recipients during the implementation of the revised nursing facility level of care, the purpose of the Medicaid program, increased risk of institutionalization, and the maintenance of effort requirements in the Affordable Care Act.

Due Process: Several commenters questioned how individuals will receive notification about their potential loss of coverage for long term care services.

Response: Changes to the nursing facility level of care criteria that affect an individual's coverage or eligibility will result in the required notice of negative action and appeal rights. Notices related to denial or termination of long term care *services* will follow the state's requirements for all such service notifications, including provision of appeal information. Notices related to *financial eligibility* determinations or redeterminations for MA will follow the current requirements for all such eligibility notifications, including provision of appeal information. In addition to these standard notices, DHS will work to identify those who may be affected.

Maintenance of Effort requirement in the Affordable Care Act: Several commenters argued that the revised nursing facility level of care criteria violates the ACA MOE.

Response: DHS agrees that a waiver is required to implement the revised nursing facility level of care criteria, based on CMS' guidance regarding the Affordable Care Act. The proposed approach will best target long term care resources to those most in need and is preferable to a reduction in benefits and/or provider rates that would affect all long term care recipients, regardless of level of need.

Purpose of the Medicaid Program: Some commenters argue that the purpose of the waiver is merely to terminate health coverage and restrict access to services and therefore does not further the purpose of the Medicaid Act.

Response: To the extent that these comments are made in the context of concern for people who may lose long term care services and will not be eligible for the Essential Community Supports program as described in the draft waiver provided to the public on November 28, 2011, DHS has

amended the earlier waiver draft to expand the eligibility and services for the program and to evaluate the impacts of those efforts.

In addition, DHS challenges the assertion that restricting access to services cannot serve the purposes of Title XIX. It is important for states to efficiently administer their programs and use public funds wisely, particularly in this era of spiraling health care costs and expected demographic challenges. Thoughtful, incremental reform in the delivery of long term care services based on level of need promotes that purpose of the Medicaid program and is appropriate under section 1115 of the Social Security Act.

Increased Risk of Institutionalization: A few commenters argued that the proposed changes in the nursing facility level of care criteria would result in an increased risk of institutionalization for some people who would no longer be eligible for home and community-based waiver services and would therefore be in violation of the United States Supreme Court decision in Olmstead v. L.C., 527 U.S. 581 (1999).

To the extent that these comments were made in the context of concern for people who will not be eligible for the Essential Community Supports program as described in the draft waiver provided to the public on November 28, 2011, DHS has responded by amending the earlier waiver draft to expand the eligibility and services for the program and to evaluate the impacts of those efforts. DHS believes that the modest restriction in eligibility under the revised level of care standard will over time ensure that waivered services are available for those most at risk of institutionalization. In addition, by strengthening programs such as Alternative Care and Essential Community Supports, people with the lowest level of functional needs will be more appropriately served in community settings.

IV. Transition Planning for Individuals Who No Longer Meet Level of Care Standard

Commenters expressed concern that the needs of individuals who would no longer meet the nursing facility level of care could not be met by state plan services. In particular, commenters noted that number of ADL limitations required for receipt of personal care assistant services under the state plan is more restrictive than the current nursing facility level of care standards. Therefore, some people who would no longer be eligible for waivered services would not be eligible for personal care assistance under the state plan, or would receive an insufficient amount of PCA services.

Response: DHS has shared transition plans with stakeholders for people who will be transitioning out of Medicaid-funded long term care services, and has included some of this documentation at Appendix VII. DHS will continue to consult with stakeholder to develop

transition, referral and notification protocols. As noted above, all notice requirements will continue to apply during this transition period. While transition planning is an important feature of implementing a change to the state's level of care criteria, termination of home and community-based services due to an improvement in health or functioning has always occurred under the waiver programs. DHS considers the implementation of the revised nursing facility level of care criteria to be an opportunity to identify strategies for individuals who are terminated from the waivers due to any number of reasons, including improved health or functioning.

DHS acknowledges that some people who would not meet the proposed nursing facility level of care criteria will not meet the criteria for PCA. As noted above, DHS has amended the earlier waiver draft to expand the eligibility for Essential Community Supports (ECS) to provide supports to people who must transition out of a home and community-based services waiver. Most people residing in a nursing facility will be grandfathered in under the revised nursing facility level of care criteria. Supportive services, including ECS, are available to people who lose eligibility for nursing facility level of care.

Implementation of revised level of care in the community: First, with respect to the home and community-based waivers, the changes to the nursing facility level of care criteria will be applied to all new waiver applicants on or after an effective implementation date, and to current participants at the next reassessment occurring on or after the effective implementation date. Under current program rules, people receiving home and community-based waiver services can lose eligibility for these services following their annual reassessment or a reassessment performed due to changes in circumstances if they no longer meet the level of care criteria. Going forward, the same process will be used, but the new level of care criteria will be applied following the implementation date. As described earlier, all due process rights will be afforded.

Prior to implementation of the new criteria, DHS will work with tribes, health plans, and counties to identify current participants who may not meet the changed level of care criteria at their next reassessment in order to begin transition planning in advance of redeterminations.

Implementation of revised nursing facility level of care in nursing facilities: *Concerns about how current nursing facility residents will receive notification about their potential loss of service eligibility were raised by commenters and have been discussed during the comment period with stakeholders*

As described earlier, all due process rights will be afforded. In addition, the "qualifying nursing facility stay" element of the revised nursing facility level of care criteria is designed to ensure that the majority of people currently residing in nursing homes will continue to meet level of care. Efforts such as the "Return to Community" initiative to identify individuals who wish to return to the community and may need assistance to do so are in place now. Prior to and after implementation of the revised nursing facility level of care, nursing facility diversion efforts will

continue to be geared toward ensuring that people who are not likely to meet level of care will be informed of their status and helped with planning.

Advance notice will be provided to help ensure that appropriate transition planning takes place. Notices will be incorporated into the case mix classification notifications that result from the MDS assessment.[3]

Relocation assistance: DHS has implemented other "outreach" strategies intended to identify and assist individuals in nursing facilities and other institutions who want to return to the community. These relocation strategies are incorporated into the overall implementation strategy for level of care changes.

- Any individual under age 65 admitted to an NF receives a mandatory **face-to-face long term care consultation (LTCC) visit** within 40 days of admission to a facility; this strategy was implemented in 2002. This visit results in a community support plan for individuals who want to return to community life.

- The **"Return to Community"** initiative, implemented in April 2008, provides relocation assistance to all NF residents through a partnership with the Area Agencies on Aging (who serve privately paying NF residents) and lead agencies (who provide targeted relocation case management and care coordination to recipients). This strategy includes five years of follow along for private pay individuals who return to the community, with or without the assistance of the AAA community network specialist.

- **Relocation planning by providers**: Many providers have requirements to assist individuals with discharge planning, or transition planning if the provider gives notice to discontinue services. DHS will continue to work with providers, in particular providers who deliver services in settings in which landlord/tenant provisions apply, to integrate provider requirements with MA notification requirements and case manager transition planning responsibilities.

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[3] Nursing facility residents admitted less than 90 days before implementation must meet the revised nursing facility level of care criteria at the first quarterly MDS assessment, typically due at 90 days after admission to establish a "qualifying nursing facility stay." However, the information about level of care can be communicated on any and all MDS assessments that occur, including those conducted a short time after admission and at changes in conditions (e.g. readmission to an acute hospital). Nursing facilities and residents will receive timely notice of the need for a face-to-face LTCC if the MDS assessment performed at admission shows that the person falls into one of the lowest two rate classifications. For people in all other rate classifications, MDS assessment data will be sufficient evidence that the long term care criteria are met.

- **Essential Community Supports:** As discussed above, this program will provide supportive services to individuals who may lose eligibility under the level of care changes. Staff who determines eligibility for other home and community-based services and programs will determine eligibility for ECS as well.

- **Money Follows the Person:** Minnesota will receive an award of up to $187.4 million in federal funds over five years to improve community services and support people who wish to move out of institutions and back into the community. As this demonstration is more fully implemented, participation in this program will help DHS to provide more individualized care for some of Minnesota's most vulnerable residents and continue to rebalance its long-term care system away from dependence on institutional care. The goals of the MFP demonstration include:
    - Simplify and improve the effectiveness of transition services that help people return to their homes after hospitalization or nursing facility stays.
    - Advance promising practices to better serve individuals with complex needs in the community
    - Increase stability of individuals in the community by strengthening connections among health care, community support, employment and housing systems

V. Data Requests

Several commenters requested data supporting which service will be part of the Essential Community Supports package.

Response: DHS has included information at Appendix III describing the data analysis that was done to develop the benefits for Essential Community Supports.

Several commenters requested additional data supporting the analysis of the number of persons who would lose long term care services but remain on Medical Assistance.

Response: DHS has included information at Appendix XI that was previously presented to stakeholders at the HCBS Partners Panel. Because needs change as people age and because not all aspects of the revised nursing facility level of care criteria are accounted for in current data, however, the number of people who will no longer meet nursing facility level of care may be overstated.

Commenters expressed concern that DHS may have underestimated the number of people under age 65 who would lose Medicaid financial eligibility if they were subjected to spousal deeming requirements.

Response: DHS acknowledges that spousal income is not currently known for many people on the waivers, and DHS estimates are not intended to serve as actual numbers.

Commenters also questioned DHS estimates of the number of people over age 65 who would continue to meet Medicaid spend down requirements rather than forego any Medicaid coverage.

Response: DHS responds that the spend down assumptions were based on current data about the cost of services of the group that is at risk of losing Medicaid long term care eligibility under the revised nursing facility criteria and the rate at which current Medicaid participants over age 65 with spend down tend to utilize that basis of eligibility.

VI. Waiver Evaluation Plan

Commenters critiqued the proposed evaluation plan, arguing that it does not measure outcomes for people who lose eligibility for Medical Assistance and that there is a need to monitor how loss of home and community-based services will impact those who remain eligible for Medical Assistance.

Response: The revised waiver proposal document includes proposed modifications to the eligibility for the Essential Community Supports program and modifications to the waiver evaluation plan to help accomplish these goals, as well as to inform future reform efforts.

Appendix VII - External stakeholder work group materials

Updated 6-10-10

HCBS Expert Panel
Nursing Facility LOC and Essential Community Supports Workgroup

Workgroup Role Description

Scope

- Provide input regarding referral protocols and roles of lead agencies (counties, tribes and health plans), financial workers, Area Agencies on Aging and providers in the implementation of the NF LOC changes and Essential Community Supports program.

- Provide input regarding the development of resource information and training for lead agencies in order to maximize referral protocols and options for individuals who do not meet public program financial eligibility, level of care or other service eligibility criteria.

- Provide feedback on consumer and provider information materials related to the long-term care choices of private pay individuals and their families

Expectations

- Each workgroup member represents their organization, association or network, which is a member of the HCBS Expert Panel.

- Workgroup members will participate in 2-4 meetings and solicit input from their colleagues and will use this information to shape the feedback that they provide at workgroup meetings.

- Workgroup members will share information received at the workgroup meetings with their colleagues.

Stakeholder Meetings

- December 16, 2009 – in-person meeting
- February 2010 – in-person meeting on community-based referral protocols and scenarios
- March 2010 – conference calls for further feedback on referral protocols
- April 2010 – in person meeting (after legislative session ends): postponed to June 2010
- June 2010 – in-person meeting on legislative updates, work done to date, interaction with other initiatives, future work plan

Minnesota Department of **Human Services**

Modification of Nursing Facility Level of Care (NF LOC) Criteria

Objective:
To provide more consistent access to services and target services to persons in greatest need

Overview:
The NF LOC Initiative will change NF LOC criteria for public payment of long-term care. The changes will affect the most independent people who would receive nursing facility services or publicly-funded long-term care services in the community, including Elderly Waiver (EW), Alternative Care (AC) and Community Alternatives for Disabled Individuals (CADI) Waiver. The Essential Community Supports Program will provide alternatives for people 65 years or older whose eligibility for Medical Assistance or Alternative Care is affected by the changes to NF LOC criteria.

External Work Group:
The Aging and Adult Services Division and the Disability Services Division have convened an external stakeholder work group made up of lead agencies (health plans, counties and tribes), Area Agencies on Aging, Centers for Independent Living, providers and advocates to:

- Provide input regarding referral protocols and roles of lead agencies, financial workers, Area Agencies on Aging and providers in the implementation of the NF LOC changes and the Essential Community Supports program;
- Provide input regarding the development of resource information and training for lead agencies in order to maximize referral protocols and options for individuals who do not meet public program financial eligibility, level of care, or other service eligibility criteria; and
- Provide feedback on consumer and provider information materials related to the long-term care choices of private pay individuals and their families.

The external stakeholder work group will meet several times in CY 2010 to develop recommendations related to:

- Referral protocols and transitional communications related to implementation of the NF LOC changes and the Essential Community Supports program.
- Consumer notification requirements for individuals affected by these changes.
- Lead agency training and the overall evaluation plan for the initiative.
- Review of consumer notification and lead agency training materials.

Outcomes:
The expected outcomes of this initiative are:

- DHS will be better equipped to manage the growth of its public long-term care programs.
- Lead agencies will be better equipped to assess individuals, monitor programs, evaluate outcomes and assess the impact of public spending.
- Individuals 65 years or older who do not meet NF LOC will have access to critical services to support their community living.

Implementation:
Implementation of adopted changes to Minnesota's nursing facility level of care is affected by 2010 federal health care reform provisions. The Department of Human Services is working to clarify the scope of this effect. Based on current understanding, it is anticipated that the NF LOC changes and the Essential Community Supports program can take effect no sooner than July 1, 2011.

Nursing Facility LOC/Essential Community Supports Workgroup

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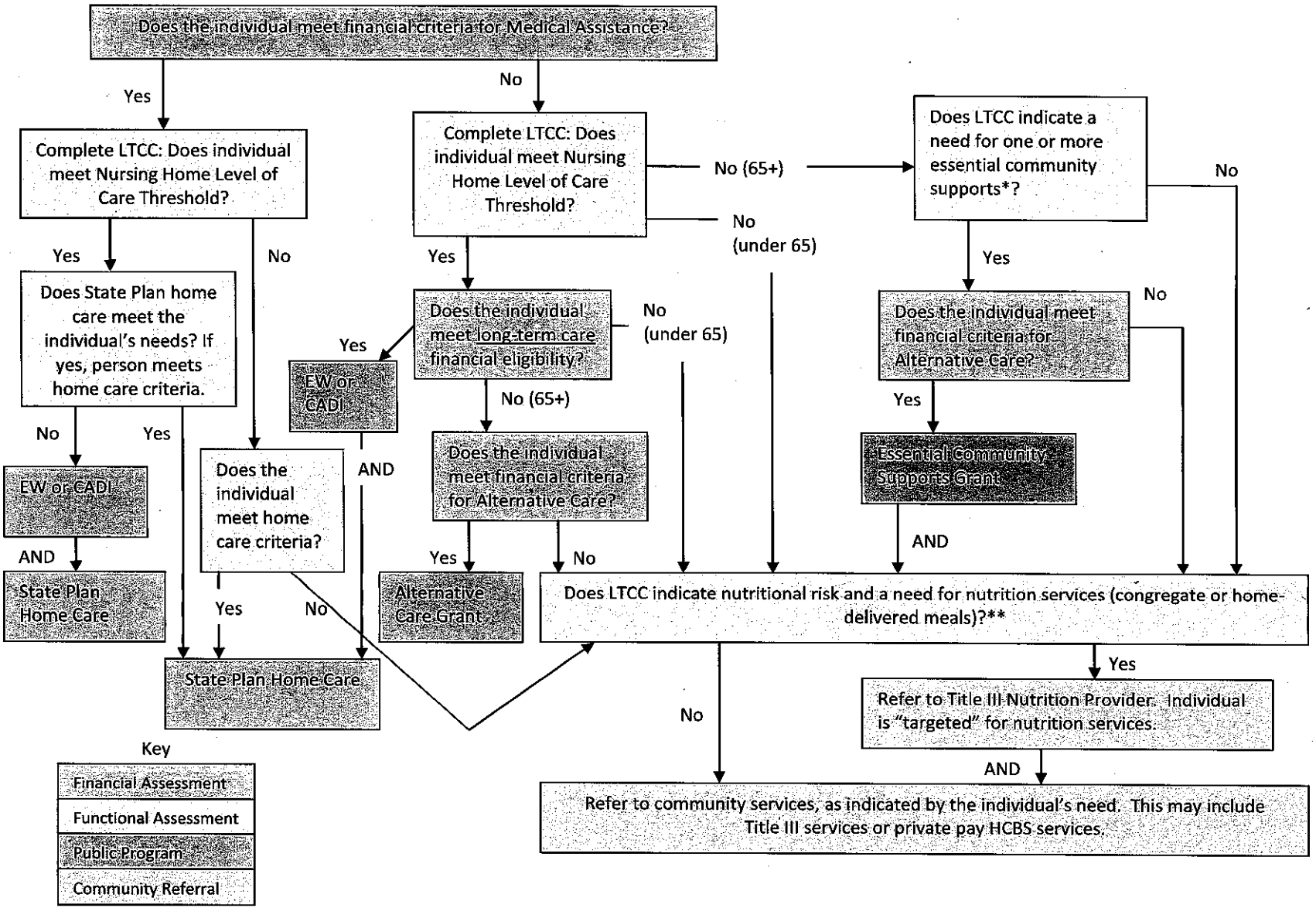
Home and Community Based Service Options
Public Program Criteria: Decision Tree – All Ages



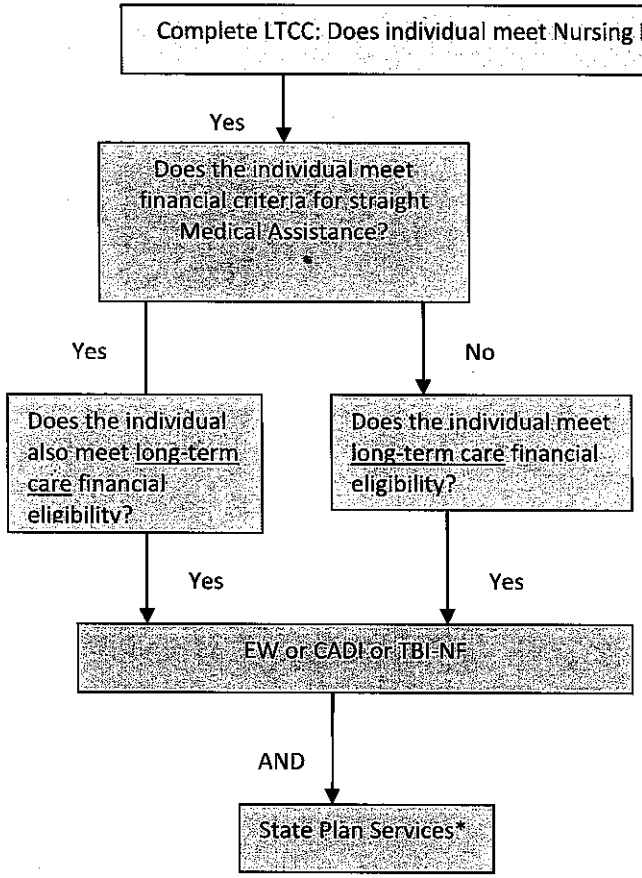
*Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system

**Individuals under 60 are not eligible for Title III Nutrition services. If under 60, move to "Refer to community services as indicated by the individual's need."

Home and Community Based Service Options
Public Program Criteria
Meets Both NF LOC AND MA Financial Eligibility

Key

- Financial Assessment
- Functional Assessment
- Public Program
- Community Referral

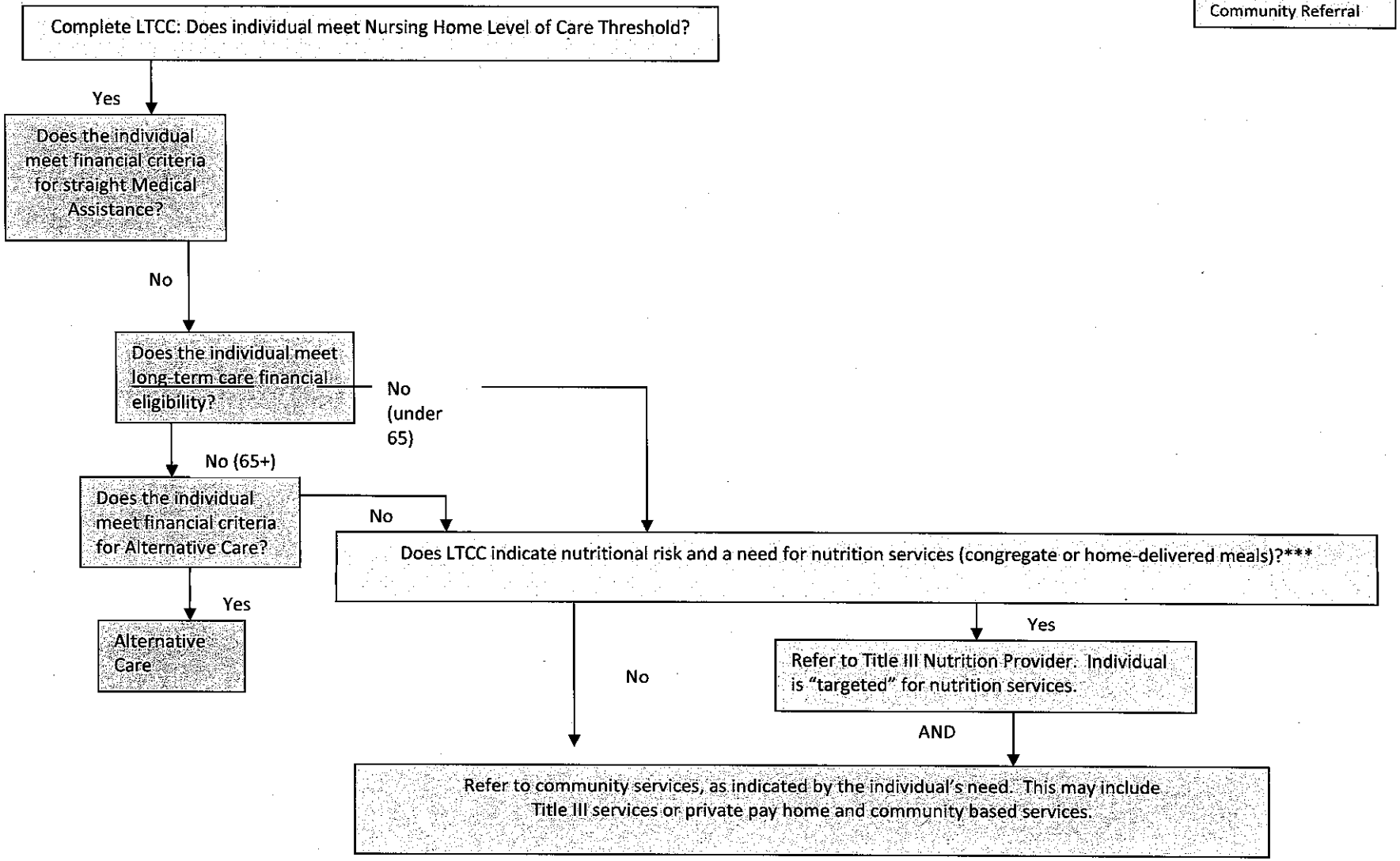


NOTES

*Individual may or may not qualify for State Plan Home Care, based on whether the individual meets criteria for that program.
**Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system
***Individuals under 60 are not eligible for Title III Nutrition services. If under 60, move to "Refer to community services as indicated by the individual's need."

Home and Community Based Service Options
Public Program Criteria
DOES Meet NF LOC and DOES NOT Meet MA Eligibility

Key
- Financial Assessment
- Functional Assessment
- Public Program
- Community Referral



*Individual may or may not qualify for State Plan Home Care, based on whether the individual meets criteria for that program.
**Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system
***Individuals under 60 are not eligible for Title III Nutrition services. If under 60, move to "Refer to community services as indicated by the individual's need."

DOES Meet NF LOC and DOES NOT Meet MA Eligibility

Things to Consider

- For individuals 65+ who do not meet AC financial criteria – should these individuals be referred to SLL for assessment for Title III nutrition and other services? Are there other community referrals that should be made?

- For individuals 60 to 64 – should these individuals be referred to SLL for assessment for Title III nutrition and other services? Are there other community referrals that should be made?

- For individuals under 60 – should these individuals be referred to DLL? Are there other community referrals that should be made?

- In all of these scenarios, is the LTCC screener the person responsible for making these referrals?

Key

- Financial Assessment
- Functional Assessment
- Public Program
- Community Referral

Home and Community Based Service Options
Public Program Criteria
Individual Does NOT Meet NF LOC AND DOES Meet MA Financial Eligibility Criteria

Complete LTCC: Does individual meet Nursing Home Level of Care Threshold?

No

Does the individual meet financial criteria for straight Medical Assistance?

Yes

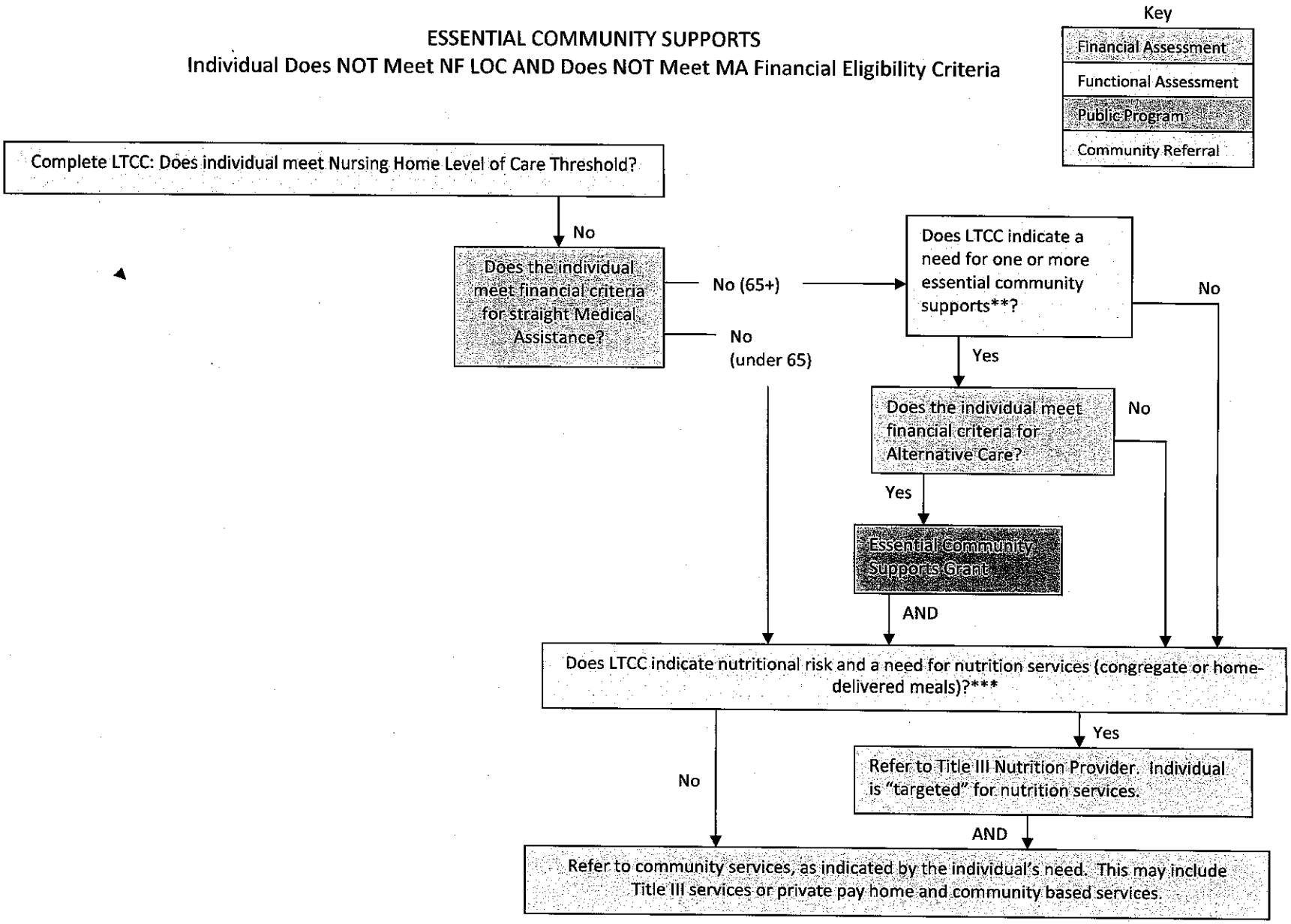
State Plan Services*

Things to Consider:

If a person has been on a waiver previously and a reassessment indicates that the person does not meet NF LOC, what is the process for getting the person assessed for eligibility for state plan services? Who is responsible for ensuring that the person is connected to these services?

*Individual may or may not qualify for State Plan Home Care, based on whether the individual meets criteria for that program.
**Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system
***Individuals under 60 are not eligible for Title III Nutrition services. If under 60, move to "Refer to community services as indicated by the individual's need."

ESSENTIAL COMMUNITY SUPPORTS
Individual Does NOT Meet NF LOC AND Does NOT Meet MA Financial Eligibility Criteria



*Individual may or may not qualify for State Plan Home Care, based on whether the individual meets criteria for that program.
**Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system
***Individuals under 60 are not eligible for Title III Nutrition services. If under 60, move to "Refer to community services as indicated by the individual's need."

Does Not Meet NF LOC AND Does NOT Meet Eligibility for MA

Things to Consider

This group of individuals may be eligible for Essential Community Supports (ECS), if:

- They are 65 or older
- They meet financial eligibility criteria for the Alternative Care program,
- They have been assessed to need one of the services available under ECS

For the person who IS eligible for Essential Community Supports, how is information shared between the LTCC staff, ongoing ECS case manager, and Title III provider?

For the person who IS NOT eligible for Essential Community Supports, what role does the SLL/AAA have in terms of follow-up and coordination with providers? How will information be shared with Title III providers so they do not perform the same "assessments"?

HCBS Expert Panel
Nursing Facility LOC and Essential Community Supports Workgroup

Referral Protocols

In the context of referrals, a protocol is a "blueprint" or guide for the "next steps" to be taken as part of the work processes.

For implementation of the NF LOC changes, DHS is seeking input from the External Workgroup on what should be in the blueprint or guide for professionals and/or providers, including:

- when a referral should be made (points in time and/or steps in a work flow or process)
- by whom
- to whom
- for what purpose

In addition to the information listed above, recommendations or suggestions about communication tools that can support this work are welcome.

Providing DHS to Feedback

Recommendations from the group

Existing Resources for People in the Community

In thinking about recommendations, keep in mind some of the existing requirements, resources, and other initiatives. For people living in the community, these include:

- Senior LinkAge Line® (SLL) and Disability Linkage Line (DLL)
  - Includes Long Term Care Options Counseling
- "Live Well at Home" Initiative (handout)
- LTCC for support planning and information about community resources
- Care coordination for people in managed care under MA
- State plan resources for people on MA
- Other Minnesota Health Care Programs like Minnesota Care

Existing Resources for People in Nursing Facilities

In thinking about recommendations, keep in mind some of the existing requirements, resources, and other initiatives. *For your consideration for the next meeting*:

For people in nursing facilities, these include:

- Mandatory LTCC face-to-face assessments for ALL individuals under 65 by the 40th day of admission to a NF.
- Relocation Services Coordination: a type of targeted case management available to all individuals on MA intended to assist the person to return to the community. The person does not need to be returning to the community with any particular services or programs in place.
- Return to Community Initiative targets individuals admitted to the NF. The intervention is provided by Long Term Care Options Counselors at the SLL. The SLL intervention is primarily targeted to private paying individuals. SLL staff are responsible under the model to connect people on MA to other resources like RSC or their managed care coordinator.
- Care coordination requirements under managed care models. A care coordinator is responsible to coordinate care across settings.
- Discharge planning requirements of the facility itself

NF LOC WORKGROUP
Nursing Facility Scenarios

I. Three scenarios
   i. Referral protocols
   ii. Communications between LTCC and FW
   iii. Changes to current forms
   iv. Training
   v. Ideas about program evaluation

II. Keep in mind Return to Community and any recommendations related to this strategy

III. External communications: web site, MSSA presentation (Power Point on web), RRS training, others?

IV. Consider the work group role in delivering recommendations:
   a. Provide input regarding referral protocols and roles of lead agencies (counties, tribes and health plans), financial workers, Area Agencies on Aging and providers in the implementation of the NF LOC changes and Essential Community Supports program.

   b. Provide input regarding the development of resource information and training for lead agencies in order to maximize referral protocols and options for individuals who do not meet public program financial eligibility, level of care or other service eligibility criteria.

   c. Provide feedback on consumer and provider information materials related to the long-term care choices of private pay individuals and their families

For each scenario, please provide feedback related to: a) referral protocols and lead agency roles, b) resource and training information needed, and c) consumer and provider materials related to choices.

Scenario 1: Admissions occurring before April 1, 2012

a.

b.

c.

Scenario 2: Admissions occurring on or after April 1, 2012: MA eligible

a.

b.

c.

Scenario 3: Admissions occurring on or after April 1, 2012: Private Pay

a.

b.

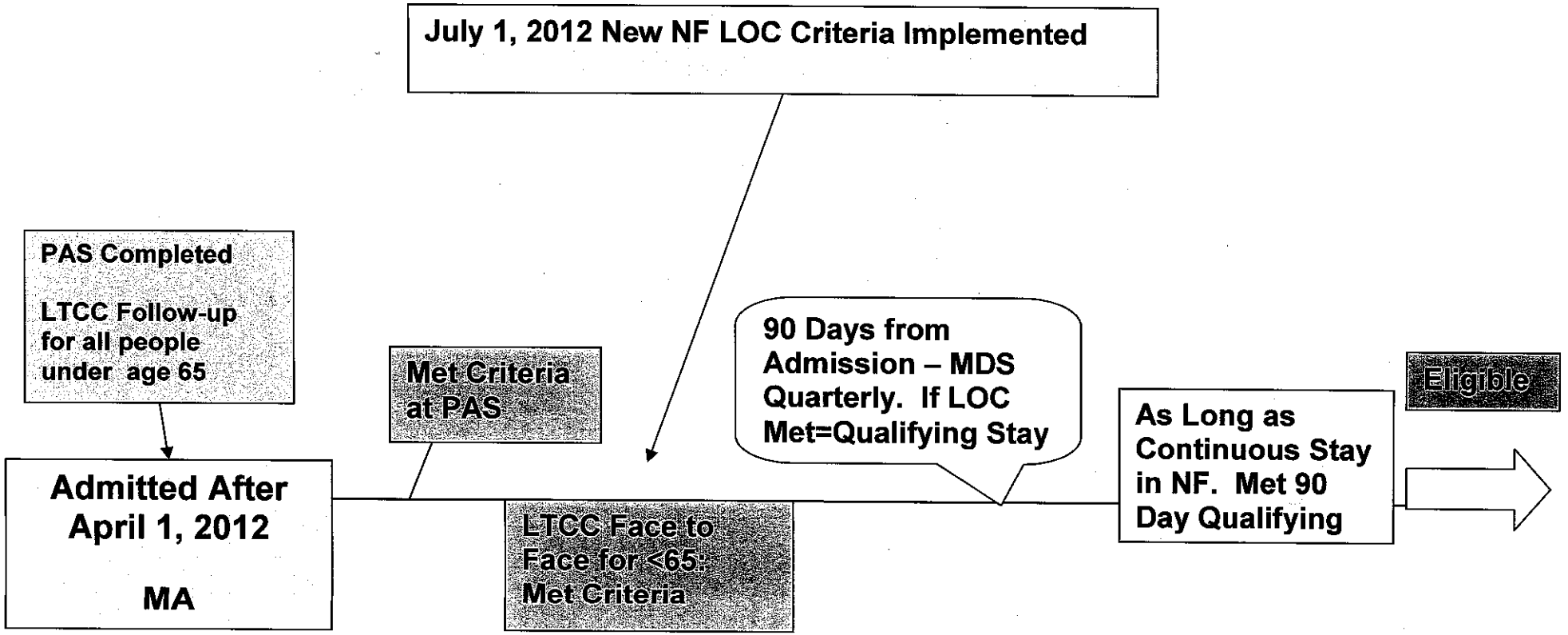
c.

Additional comments/concerns:

NF Level of Care Implementation

Timelines for NF Admissions

Potential July 1, 2012 Implementation

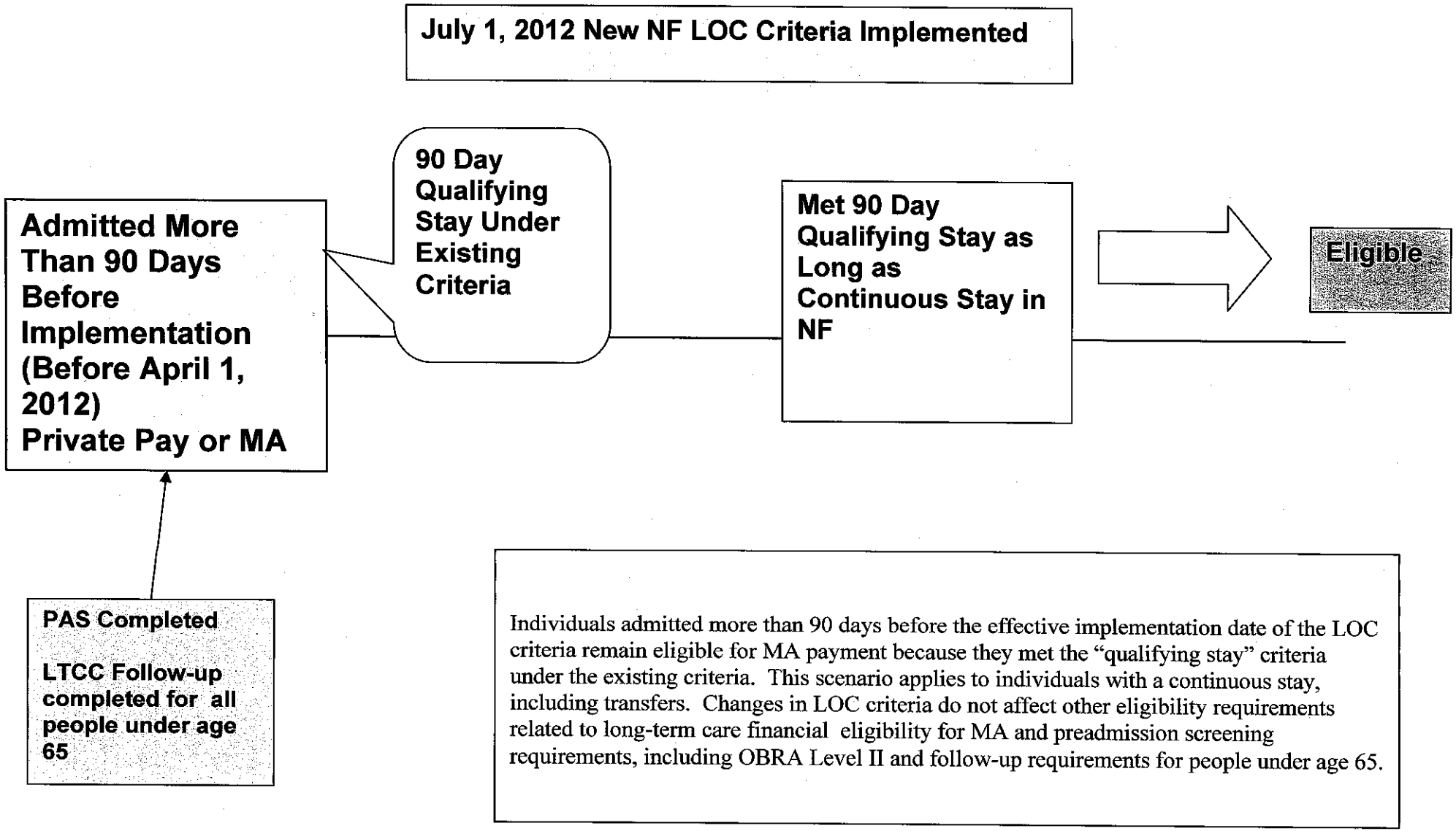


Individuals admitted on or after April 1, 2012 (for this scenario) must meet LOC under the changed criteria at admission and again at their next quarterly MDS assessment. When met at the MDS quarterly assessment, this establishes the "qualifying stay" . The individual remains eligible for MA payment during a continuous stay, including transfers. Changes in LOC criteria do not affect other eligibility requirements related to long-term care financial eligibility for MA and preadmission screening requirements, including OBRA Level II and follow-up requirements for people under age 65.

NF Level of Care Implementation

Timelines for NF Admissions

Potential July 1, 2012 Implementation

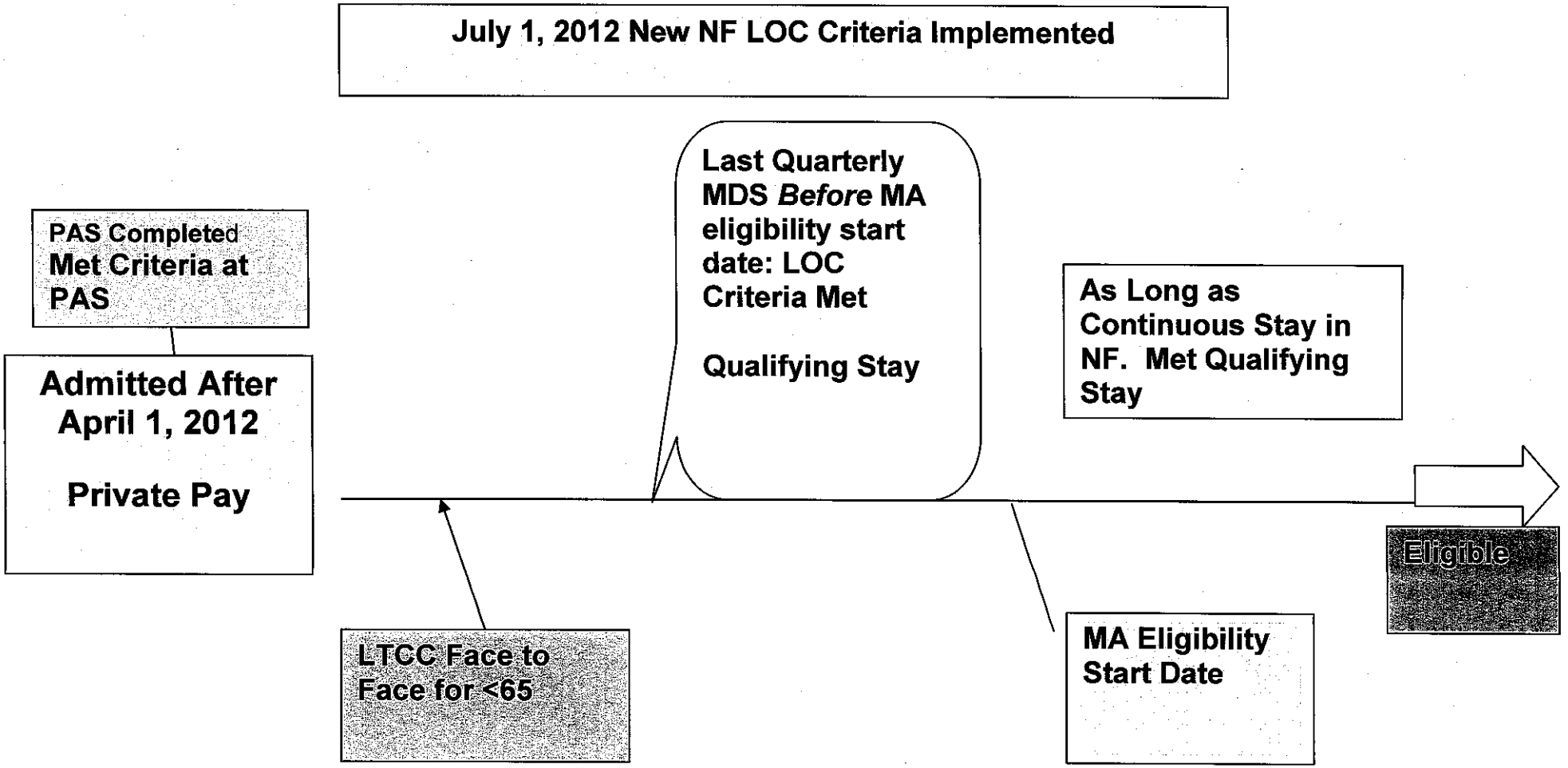


Individuals admitted more than 90 days before the effective implementation date of the LOC criteria remain eligible for MA payment because they met the "qualifying stay" criteria under the existing criteria. This scenario applies to individuals with a continuous stay, including transfers. Changes in LOC criteria do not affect other eligibility requirements related to long-term care financial eligibility for MA and preadmission screening requirements, including OBRA Level II and follow-up requirements for people under age 65.

NF Level of Care Implementation

Timelines for NF Admissions

Potential July 1, 2012 Implementation



For individuals admitted as private pay on or after April 1, 2012, the "qualifying stay" will be determined at the last quarterly MDS assessment completed *before* their MA eligibility start date. The individual remains eligible for MA payment during a continuous stay, including transfers. Changes in LOC criteria do not affect other eligibility requirements related to long-term care financial eligibility for MA and preadmission screening requirements, including OBRA Level II and follow-up requirements for people under age 65.

Appendix VIII - Tribal Consultation Policy

Minnesota Department of **Human Services**

Medicaid Tribal Consultation Process

May, 2010

DHS will designate a staff person in the Medicaid Director's office to act as a liaison to the Tribes regarding consultation. Tribes will be provided contact information for that person.

- The liaison will be informed about all contemplated state plan amendments and waiver requests, renewals, or amendments.
- The liaison will send a written notification to Tribal Chairs, Tribal Health Directors, and Tribal Social Services Directors of all state plan amendments and waiver requests, renewals, or amendments.
- Tribal staff will keep the liaison updated regarding any change in the Tribal Chair, Tribal Health Director, or Tribal Social Services Director, or their contact information.
- The notice will include a brief description of the proposal, its likely impact on Indian people or Tribes, and a process and timelines for comment. At the request of a Tribe, the liaison will send more information about any proposal.
- Whenever possible, the notice will be sent at least 60 days prior to the anticipated submission date. When a 60-day notice is not possible, the longest practicable notice will be provided.
- The liaison will arrange for appropriate DHS policy staff to attend the next Quarterly Tribal Health Directors meeting to receive input from Tribes and to answer questions.
- When waiting for the next Tribal Health Directors meeting is inappropriate, or at the request of a Tribe, the liaison will arrange for consultation via a separate meeting, a conference call, or other mechanism.
- The liaison will acknowledge all comments received from Tribes. Acknowledgement will be in the same format as the comment, e.g. email or regular mail.
- Liaison will forward all comments received from Tribes to appropriate State policy staff for their response.
- Liaison will be responsible for insuring that all comments receive responses from the State.
- When a Tribe has requested changes to a proposed state plan amendment or waiver request, renewal, or amendment, the liaison will report whether the change is included in the submission, or why it was not included.
- Liaison will inform Tribes when the State's waiver or state plan changes are approved or denied by CMS, and will include CMS' rationale for denials.

- For each state plan or waiver change, the liaison will maintain a record of the notification process; the consultation process, including written correspondence from Tribes and notes of meetings or other discussions with Tribes; and the outcome of the process.

Appendix IX – Budget Impact

Nursing Facility Level of Care Change
Effective July 1, 2012

Projected Fiscal Effects on Minnesota's Medicaid Program

	SFY 2012	SFY 2013	SFY 2014	SFY 2015
1 Proportion of recipient reduction				
NF		0.50%	1.51%	2.59%
EW	-	13.30%	13.30%	13.30%
CADI	-	2.95%	2.95%	2.95%
2 Recipient reduction phase-in factor for waivers (NF phase-in built in)	-	50%	100%	100%
3 Average monthly recipient change				
NF		(88)	(263)	(438)
EW		(1,563)	(3,260)	(3,396)
CADI		(260)	(541)	(554)
AC		(139)	(272)	(248)
Total		(2,050)	(4,336)	(4,636)
4 Average monthly service cost				
NF		$3,869	$3,915	$3,961
EW		$1,171	$1,252	$1,312
CADI		$2,707	$2,903	$3,156
5 Proportion of average cost applicable to recipients no longer eligible				
NF		84.90%	84.90%	84.90%
EW		59.80%	59.80%	59.80%
CADI		70.80%	70.80%	70.80%
6 Average monthly service cost for affected recipients				
NF		$3,285	$3,324	$3,363
EW		$700	$749	$785
CADI		$1,917	$2,055	$2,234
7 Total annual fiscal effect of recipient reduction				
NF		-$3,468,960	-$10,490,544	-$17,675,928
EW		-$13,129,200	-$29,300,880	-$31,990,320
CADI		-$5,981,040	-$13,341,060	-$14,851,632
8 Proportion of program savings shifting to other state plan services				
NF		7.50%	7.50%	7.50%
EW*		30.70%	30.70%	30.70%
CADI		33.00%	33.00%	33.00%
9 Offsetting costs for other state plan services				
NF		$260,172	$786,791	$1,325,695
EW		$4,030,664	$8,995,370	$9,821,028
CADI		$1,973,743	$4,402,550	$4,901,039

* 33% offset for the 93% assumed to retain MA eligibility.

Sum for CMS

10 Proportion of affected recipients with MA eligibility not affected				
	NF		52.00%	52.00%	52.00%
	EW		84.00%	84.00%	84.00%
	CADI		100.00%	100.00%	100.00%
11 Proportion of affected recipients with a new spenddown they are expected to meet				
	NF		16.00%	16.00%	16.00%
	EW		9.00%	9.00%	9.00%
	CADI		0.00%	0.00%	0.00%
12 Average monthly number of affected recipients with a new spenddown they are expected to meet				
	NF		14	42	70
	EW		141	293	306
	CADI		0	0	0
13 Average monthly value of spenddown expected to be met				
	NF		$519.00	$519.00	$519.00
	EW		$394.00	$394.00	$394.00
	CADI				
14 Annual value / fiscal effect of new spenddowns that are met				
	NF		-$87,192	-$261,576	-$435,960
	EW		-$666,648	-$1,385,304	-$1,446,768
	CADI		$0	$0	$0
15 Proportion of affected recipients with a new spenddown they are not expected to meet				
	NF		32.00%	32.00%	32.00%
	EW		7.00%	7.00%	7.00%
	CADI		0.00%	0.00%	0.00%
16 Average monthly number of affected recipients with a new spenddown they are NOT expected to meet				
	NF		28	84	140
	EW		109	228	238
	CADI		0	0	0
17 Average monthly value of spenddown NOT expected to be met				
	NF		$1,188.00	$1,188.00	$1,188.00
	EW		$684.00	$684.00	$684.00
	CADI				
18 Elderly basic care monthly cost		$725.00	$764.00	$828.00	$900.00
19 Annual value / fiscal effect of basic care not paid for those not expected to meet a spenddown				
	NF		-$256,704	-$834,624	-$1,512,000
	EW		-$999,312	-$2,265,408	-$2,570,400
	CADI		$0	$0	$0
20 Sum of fiscal effects in #7, #9, #14,#19				
	NF		-$3,208,788	-$9,703,753	-$16,350,233
	EW		-$9,442,432	-$21,401,710	-$24,117,252
	CADI		-$5,673,257	-$12,589,222	-$13,967,761
Total			-$18,324,476	-$43,694,685	-$54,435,247

Sum for CMS

Federal share @ 50%	-$9,162,238	-$21,847,343	-$27,217,623
Nonofederal share	-$9,162,238	-$21,847,343	-$27,217,623

State Programs for Which Federal Matching is Requested

	SFY 2012	SFY 2013	SFY 2014	SFY 2015
1 Alternative Care Program				
Avg. Monthly Recipients		3,008	2,894	2,915
Avg. Monthly Cost per Recipient		$809.54	$844.13	$910.18
Total Annual cost		$29,221,000	$29,315,000	$31,838,000
Federal share @ 50%		$14,610,500	$14,657,500	$15,919,000
Non-federal share		$14,610,500	$14,657,500	$15,919,000
2 Community Essential Grants				
Avg. Monthly Recipients		2,050	4,336	4,636
Avg. Monthly Cost per Recipient		$380.00	$380.00	$380.00
Total Annual cost		$9,347,984	$19,770,811	$21,142,189
Federal share @ 50%		$4,673,992	$9,885,406	$10,571,094
Non-federal share		$4,673,992	$9,885,406	$10,571,094
6 Claw Back Monthly Cost	$132.78	$136.42	$141.57	$146.84
13 Federal Financial Participation Rates				
Elderly Waiver	50%	50%	50%	50%
CADI Waiver	50%	50%	50%	50%
Nursing Facilities	50%	50%	50%	50%
Basic Care	50%	50%	50%	50%
Alternative Care	0%	0%	0%	0%
14 State Financial Participation Rates				
Elderly Waiver	50.0%	50.0%	50.0%	50.0%
CADI Waiver	50.0%	50.0%	50.0%	50.0%
Nursing Facilities	50.0%	50.0%	50.0%	50.0%
Basic Care	50.0%	50.0%	50.0%	50.0%
Alternative Care	100.0%	100.0%	100.0%	100.0%

Sum for CMS

Appendix X - Potential Impacts of Revised Nursing Facility Level of Care Criteria on Medicaid Eligibility in Minnesota

Appendix X: Potential Impacts of Revised Nursing Facility Level of Care Criteria on Medicaid Eligibility in Minnesota

The revised nursing facility level of care criteria may impact Medicaid eligibility for applicants and beneficiaries who may have met the original nursing facility level of care standards but do not meet the revised criteria and whose eligibility for Medical Assistance (MA) is dependent on the methods applied to persons who meet the Nursing Facility Level of Care.

Impact of Nursing Facility Level of Care Determination on Medical Assistance Eligibility for Seniors

The revised nursing facility level of care criteria may affect Medicaid eligibility for some seniors living in the community because Minnesota has taken up the option to apply the special income standard to persons aged 65 and older who seek home and community-based waiver services and would otherwise require the level of care furnished in a nursing facility. MA eligibility is also calculated differently for married individuals where one spouse qualifies for Medical Assistance payment of home and community-based services or nursing home care.

The Medical Assistance eligibility determination for seniors involves comparing a person's countable income and assets against the applicable standards and limits. Income and assets of a spouse are deemed available to the other spouse. A person residing alone in the community who does not meet the nursing facility level of care must have income at or below 100% of the Federal Poverty Guidelines (FPG), currently $908/month, and assets below $3,000. For a married person and spouse living in the community, Medicaid eligibility is based on the income and assets of the household. Couples are held to $1,227/month in income and assets of $6,000. Couples with income in excess of 100% FPG may be eligible under the medically needy category if they have sufficient medical expenses to spend down their income to 75% FPG.

The special income standard or SIS applies to the Medical Assistance eligibility determination for institutionalized seniors and seniors living in the community who receive services through the Elderly Waiver. The special income standard amount is equal to three times the maximum federal benefit rate for the Supplemental Security Income (SSI) program, which will be $2,094 effective January 1, 2012.

Married seniors who qualify for Elderly Waiver services and reside with a community spouse who does not receive long-term care services are subject to more generous anti-impoverishment rules that waive the deeming of the community spouse's income and use asset assessments to determine what amount of the couple's assets are evaluated in determining asset eligibility. A community spouse is allowed to keep half of the couple's assets subject to a minimum/maximum amount. The minimum and maximum amounts effective January 1, 2012 are $32,245 and $113,640. The community spouse may also, in some circumstances, be allocated a portion of

their spouse's income. Medical Assistance eligibility for a married person receiving home and community-based waiver services or nursing home care with a spouse who also receives HCBS or nursing home care is determined based solely on the person's own income and assets.

Impact of Nursing Facility Level of Care Determination on Medical Assistance Eligibility for Adults and Children

The special income standard does not apply to people below the age of 65. Therefore, the income standard for people who meet the requirements to receive services through the Community Alternatives for Disabled Individuals (CADI) waiver or Brain Injury (BI) waiver is the same for people who reside in the community. The income standard for people with disabilities is 100% FPG, which is currently $908/month. A person with income over the applicable monthly income standard falls into the medically needy group and must spend down to 75% FPG, which is currently $681/month.

Although the special income standard does not apply, people below age 65 who meet the nursing facility level of care are subject to more generous rules in two situations: 1) When married adults live together in the community, a spouse's income and assets are not deemed to a spouse who receives CADI or BI waiver services.[1] 2) Parental income is not deemed to a child under age 21 if the child meets the requirements to receive CADI or BI.

People who do not meet the nursing facility level of care and therefore do not qualify for the more generous deeming rules may be eligible under the medically needy category if they have sufficient medical expenses to spend down their income to 75% FPG. Alternatively, persons under age 21 may elect to use a child basis of eligibility rather than a disabled basis of eligibility and thereby be subject to the higher income standards for children. Children ages two to 18 are eligible for MA under the child basis if they have family incomes at 150% FPG or below. Children up to age 21 with family incomes at or below 275% FPG can qualify for MinnesotaCare, a premium-based waiver program that offers full state plan benefits. Adults under 65 with family incomes at or below 250% can also qualify for MinnesotaCare.

Minnesota also provides coverage for children under age 19 who meet the level of care for a nursing facility, hospital or intermediate care facility for developmentally disabled in the home and community-based waiver programs. Alternatively, children may receive state plan benefits through Minnesota's TEFRA (Tax Equity and Fiscal Responsibility Act) program. To qualify for TEFRA, a child must be under age 18, have a disability determination from the State Medical Review Team (SMRT), live with at least one parent, meet income limits (using the child's income only) and the cost for home care must not exceed what Medical Assistance would pay for

[1] Persons enrolled in the CADI or BI waivers may opt to remain on those waivers after age 65 and are not required to transition to the Elderly Waiver.

the child's care in a medical facility. Parents may be required to pay a fee based upon income. Analysis of the screening data for children currently enrolled under this program demonstrated that none of the children enrolled in TEFRA and using a nursing facility level of care have care needs that would fail to meet the revised nursing facility level of care criteria.

Appendix XI - Analysis of people at risk of losing eligibility for Medicaid payment of long term care services

Level of Care Analysis **July 2011 HCBS Population Sample** Sampled October 5, 2011

LOC Criteria- Group 1	EW	AC	CADI	BI-NH
	N=22,923	N=3,111	N=16,993	N=986
1. Clinically involved-Nursing	629	87	921	53
2. Highest ADL	1,010	55	977	73
3. Severe cognitive impairment	5,071	407	3,333	371
4. Moderate cognitive+ behavior	6,604	704	7,630	735
Individuals removed from next tests				
LOC Criteria- Group 2	**N=14,747**	**N=2,227**	**N=7,920**	**N=205**
5. Hi ADL (≥D)	3,375	314	1,560	18
Individuals removed from next tests				
LOC Criteria- Group 3	**N=11,372**	**N=1,913**	**N=6,360**	**N=187**
6. Clinically involved -monitoring	624	148	357	10
7. Behavior	3,248	682	4,601	187
8. Impaired cognitive functioning	1,868	473	1,243	18
9. Unscheduled need for staff	4,373	995	1,534	24
Individuals removed from next tests				

LOC Criteria – Group 4	EW	AC	CADI	BI-NH
	N=4,453	N=470	N=881	0
A. NF Qualifying Stay (eligible)	137	1	20	
B. Live Alone + Qualifying Risk (eligible)	1,267	201	360	

Summary:

EW:	Group 1: Highest need	35.5%	
	Group 2: High ADL	14.7%	
	Group 3: Moderate to high	30%	
	Group 4: Risk	6.1%	
	No LOC:	13.3%	99.6% (rounding)
AC:	Group 1: Highest need	28.4%	
	Group 2: High ADL	10%	
	Group 3: Moderate to high	46.4%	
	Group 4: Risk	6.5%	
	No LOC:	8.6%	99.9% (rounding)
CADI	Group 1: Highest need	53.2%	
	Group 2: High ADL	9.2%	
	Group 3: Moderate to high	32.3%	
	Group 4: Risk	2.2%	
	No LOC:	3%	99.9% (rounding)

BI:	Group 1: Highest need	79.2%	
	Group 2: High ADL	1.8%	
	Group 3: Moderate to high	19%	
	Group 4: Risk	0%	
	No LOC:	0%	100% (rounding)

Group 4: At risk Individuals grouped here either had a qualifying NF stay or lived alone and had an additional risk of self-neglect, neglect or maltreatment, or inability to remain independent because of sensory impairment. Establishing this group required 2-part tests:

1. NF Stay > 0 = Removed
2. Of those remaining, who was living alone?
3. Individuals who met one or the other criteria listed above were set aside. This left those who could not meet Group 4 criteria because they had *neither* a qualifying NF stay or *one* part of the risk test. This is the first count of ineligibles.

THEN

Of those with at least one NF stay indicated, how many did NOT meet the additional test for a *qualifying* stay? Some did NOT meet this part of the test.

THEN

Of the individuals who lived alone, how many did NOT also have an indication of additional risk?

The final count of ineligible individuals includes those who did not meet criteria in Groups 1-3, and who could not meet the criteria in Group 4 (either met no criteria or who did not meet part of the criteria).