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Centers for Medicare & Medicaid Services
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Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

November 30, 2012

Ms. Carol Backstrom
State Medicaid Director
Department of Human Services
540 Cedar Street PO Box 64983
St. Paul, MN55167-0983

Dear Ms. Backstrom:

Thank you for your recent section 1115 demonstration application entitled, "Reform 2020: Pathways to Independence." The Centers for Medicare & Medicaid Services (CMS) received your application on November 21, 2012. We have completed a preliminary review of the application, and have determined that the state's application has met the requirements for a complete application as specified under section 42 CFR 431.412(a).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's application. The 30-day federal comment period, as required under 42 CFR 431.416(b), begins on December 5, 2012 and ends on January 6, 2013. The state's application is available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

We look forward to working with you and your staff on the proposed application, and are available to provide technical assistance. If you have additional questions or concerns, please contact your project officer Ms. Heather Hostetler, Division of State Demonstrations and Waivers, at (410) 786-4515, or at Heather.Hostetler@cms.hhs.gov.

Sincerely,

/s/

Angela D. Garner
Deputy Director,
Division of State Demonstrations and Waivers

cc: Victoria Wachino, CMCS
Verlon Johnson, Associate Regional Administrator, CMS, Region V

State of Minnesota

Reform 2020: Pathways to Independence

Section 1115 Waiver Proposal

Resubmitted to CMS on November 21, 2012

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1 Section One – Executive Summary

1.1 Introduction

Minnesota’s Medicaid coverage levels for pregnant women, children and parents have historically been some of the highest in the nation. The state’s Medicaid program, known in Minnesota as Medical Assistance (MA), offers a broad array of home and community-based waiver services for low-income seniors and people with disabilities. Minnesota is also a recognized leader in reforming health care and long-term care and has long been in the forefront of the shift from institutionalization to community care.

Recent changes to federal law have allowed Minnesota to broaden Medical Assistance to include a new group with its own unique needs. In March of 2011, adults without children with incomes at or below 75% of the federal poverty level (FPL) were added under the state Medicaid plan. In August of 2011, adults without children with incomes up to 250% FPL were added to the state’s longstanding section 1115 expansion waiver. Many of these enrollees who are newly covered under Medicaid struggle with physical limitations, mental illness, chemical dependency, maintaining housing and employment, and health conditions that may result in disabilities. Their addition to Minnesota’s federally-funded health care programs underscores the importance of investing in models of accountable care and payment to support robust primary care, improving care coordination, and providing the necessary long-term services and supports (LTSS) to maintain independence, housing and employment. Investments in service delivery systems that integrate medical, behavioral and long-term care services in a patient-centered model of care, and modifications to LTSS that provide flexibility to match services with participants’ needs will profoundly impact the health of individuals, health care expenditures, and the fiscal sustainability of Medical Assistance into the future.

Bipartisan legislation enacted by the 2011 Minnesota Legislature seeks to reform the Medical Assistance Program for seniors, people with disabilities or other complex needs and medical assistance enrollees in general to:

- Achieve better health outcomes;
- Increase and support independence and recovery;
- Increase community integration;
- Reduce reliance on institutional care;
- Simplify the administration of the program and access to the program; and
- Create a program that is more fiscally sustainable.

The reform legislation did not require a reduction in spending, nor did it authorize additional state funds for reform activities. DHS has developed a number of reform initiatives utilizing current resources to better deliver the right services at the right time under Medical Assistance.

Many of the initiatives outlined in this waiver proposal are focused on improving the long-term services and supports (LTSS) system to better support people in having a meaningful life at all stages, according to their own goals, providing opportunities to make meaningful contributions, and building upon what's important to them. Such a system needs to be flexible, responsible, and accessible. Our goal is to provide individuals with the right services, in the right way and at the right time, that are functionally driven according to a person-centered plan in order to achieve better individual outcomes and that ensure the sustainability of the system through efficiencies achieved.

As the home and community-based system has evolved over several decades it has become increasingly complex and difficult to manage, sometimes resulting in barriers, gaps and redundancies that prevent people from accessing the most appropriate services. At the same time, the home and community-based system is pressured by demographic trends of increasing populations of elderly people and people with disabilities. To meet the rapidly growing demands for long term services and supports (LTSS), the system will need to efficiently and effectively support people's independence, recovery and community participation.

Two components of reform requiring federal waiver authority to realign the long-term care system and explore new opportunities to integrate Medicaid and Medicare coverage for seniors were submitted to the Centers for Medicare & Medicaid Services (CMS) in the spring of 2012 under separate cover. The Long Term Care Realignment Section 1115 Waiver proposal and the proposal for Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility are described in Section Two of this document.

Through this *Reform 2020* waiver proposal, DHS requests additional federal authority to implement demonstration activities that will further support the objectives of the 2011 legislation. Not all of the initiatives described in this proposal will require waiver authority under Section 1115 of the Social Security Act. However, they are included in this waiver proposal to provide context for the items for which the Section 1115 waiver requests are made.¹

Minnesota presents this waiver proposal to continue its history of on-going improvement to enhance its service delivery and home and community-based service systems. Minnesota has long been a national leader in developing innovative and effective Medicaid payment and care delivery models such as health care homes and integrated Medicare and Medicaid managed care programs. Alignment of health care payment system incentives promotes better outcomes and lower costs. The next step for Minnesota's service delivery system is expanded full and partial risk sharing at the provider level, using prospective, global or population-based payment

¹ DHS included descriptions of a number of related reform efforts to provide members of the public with a comprehensive picture of all of the related reform efforts underway and not just those that require section 1115 authority. This approach resulted in confusion for many commenters, however, about which initiatives require new federal authority that is being sought under this waiver. Please see Attachment J for a list of initiatives and whether federal authority for the initiative is sought under this waiver proposal. In addition, Section 13 lists the specific waiver authorities requested under this proposal for each demonstration.

structures that include the costs of providing traditional health care and other Medicaid covered services in addition to costs outside of the traditional health care system that impact a Medicaid enrollees' health and outcomes (e.g., social services and public health services). This will provide an incentive not to shift the cost of services on to other parts of the health care and long-term care system, as well as other county and social service systems, while also allowing providers flexibility in managing upfront resources and making needed infrastructure investments under a prospective payment.

Minnesota started its evolution toward contracting directly with integrated care provider organizations with younger populations including pregnant women, parents, children, adults without children and some disabled adults that are not dually eligible for Medicare. These populations have more predictable risk compared to dual populations and therefore are easier to include at the beginning of these demonstrations that are building the foundational components for more integrated organizations that can take on more diverse Medicaid populations in later years.

The next step for dual populations (older people and people with disabilities who have Medicare eligibility) is to move forward with contracting with provider entities for total cost of care to integrate care and financing of health care and long-term care services as well as other social and county services.

1.2 Demonstration Projects

Components of this waiver proposal include:

1.2.1 Accountable Care Demonstration

Minnesota will seek all necessary federal authorities to move forward with contracting with provider entities for the total cost of care. Minnesota expects that the shift to the new delivery system will be phased in by geographic area within the state as providers develop the necessary infrastructure to administer closed networks and contract for prospective risk-based global payments covering total cost of care. Minnesota expects that the new delivery system will allow for closed or semi-closed provider networks. This step is necessary to facilitate effective coordination of care for enrollees and to ensure provider systems will be best positioned to manage the total cost of care. Minnesota also seeks CMS guidance to ensure that the necessary authority is in place to facilitate data sharing between the state and providers and among the health care and social services systems. Payments will be calculated based on current spending and therefore will be budget-neutral. Minnesota is now meeting with providers, payers, employers, consumers and other health care system stakeholders to draft an application under the recently announced State Innovation Models Initiative administered by the Center for Medicare and Medicaid Innovation. No waivers are sought in this document but Minnesota will consult with CMS regarding whether additional federal authority may

be necessary to support the vision that will be outlined in the State Innovation Model application. This initiative is described more fully at Section 3.

1.2.2 Demonstration to Reform Personal Assistance Services

Minnesota will redesign its state plan Personal Care Assistance Services (PCA) benefit and expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after the Community First Choice Option. It will reduce pressure on the system as people use the service-option flexibility within CFSS instead of accessing the more expanded service menu of one of the state's five HCBS waivers to meet gaps in what they need.

The new CFSS service, with its focus on consumer direction, is designed to comply with the recently finalized regulations regarding section 1915(k) of the Social Security Act, allowing Minnesota (we believe) to apply the enhanced federal matching funds available under that option for people who meet an institutional level of care. To avoid a reduction in services for people currently using PCA services, Minnesota proposes to make CFSS available both to people who meet an institutional level of care and people who do not; appropriateness of CFSS services will be based on the CFSS functional eligibility criteria. This demonstration is described more fully at Section 4, and the new federal authorities sought under this *Reform 2020* waiver proposal are detailed at Section 13.

1.2.3 Demonstration of Innovative Approaches to Service Coordination (Children with CFSS)

Minnesota proposes a demonstration project to test models of service coordination for children age 3 through school graduation with complex involvement in the service system who meet eligibility criteria. Through this demonstration, Minnesota seeks to better coordinate services and supports across home, school and community. We hope to identify best practices and replicable models that utilize one service coordinator to locate, mobilize, identify needed revisions and connect all the services and supports needed by the child and family. The State plans to accept proposals from public or private organizations that describe a collaborative model, with invested leadership, that includes participation from a local education entity. Service coordination will be provided by a community based organization. We anticipate five or six demonstration sites serving up to 1,500 eligible children who receive CFSS and who have an Individualized Education Program (IEP). Because this is a demonstration, parents whose children are eligible will decide whether or not they wish to participate. This demonstration is a component of the Demonstration to Reform Personal Assistance Services and is described more fully at Section 4.2.3. The new federal authorities sought under this *Reform 2020* waiver proposal are detailed at Section 13.

1.2.4 Demonstration to Expand Access to Transition Services

Minnesota seeks to expand access to transition supports for people entering a nursing home or who are planning a move to assisted living, who are targeted as pre-eligible and at high risk of spend-down. These counseling, information, and other services are specifically designed to helping people remain in their homes, use less expensive services and to avoid risk of spend-down to expensive public programs. This demonstration is described at Section 5 and new federal authorities sought under this *Reform 2020* waiver proposal for this demonstration are detailed at Section 13.

1.2.5 Demonstration to Empower and Encourage Independence through Employment Supports

Minnesota requests federal authority to initiate a statewide demonstration program targeting distinct groups of people who are at a critical transition phase of life to help determine if telephonic navigation, benefits planning, and employment supports can help prevent destabilization and reduce application for disability benefits while providing a positive impact on the health and future of participants. The demonstration will:

- Offer strengths-based navigation and employment support services for people in a life transition phase.
- Ensure access to appropriate health care services at the right time, decrease duplication of services and delay progression of potentially disabling conditions.
- Stabilize employment and/or increase competitive employment, increase income, increase independence and decrease public program utilization.

This demonstration is described at Section 6.1 and new federal authorities sought under this *Reform 2020* waiver proposal for this demonstration are detailed at Section 13.

1.2.6 Project for Assistance in Transition from Homelessness (PATH) Critical Time Intervention Demonstration

Minnesota proposes a demonstration project for participants in the Project for Assistance in Transition from Homelessness (PATH) program. PATH is a federal McKinney–Vento Homeless Assistance Act program administered by the Substance Abuse and Mental Health Service Administration (SAMHSA). PATH provides services for people with serious mental illness, including co-occurring substance use disorders, who are homeless or at risk of homelessness. This demonstration seeks to leverage existing program infrastructure, knowledge and funding to provide evidence-based supportive services to homeless or at-risk individuals with a serious mental illness. Critical Time Intervention (CTI), an evidence-based practice, will be used to engage eligible participants and transition them to stable housing, services, and natural supports in the community. This

demonstration is described at Section 6.2 and new federal authorities sought under this *Reform 2020* waiver proposal for this demonstration are detailed at Section 13.

1.2.7 Housing Stability Services Demonstration

Minnesota proposes a demonstration project to:

- Increase access to necessary and appropriate levels of health and other community living supports for people on Medicaid who are homeless and have high medical costs;
- Improve housing stability for recipients of Housing Stabilization Services;
- Reduce costly emergency medical interventions, including inpatient hospitalizations, emergency room visits, ambulance transports, and psychiatric hospitalizations; and
- Improve consistency of care by helping to establish a relationship with a primary care provider.

This demonstration is described at Section 6.3. New federal authorities sought under this *Reform 2020* waiver proposal for this demonstration are detailed at Section 13.

1.2.8 Anoka Metro Regional Treatment Center Demonstration

The Anoka Metro Regional Treatment Center (AMRTC) is the state's remaining non-forensic institution that continues to serve discrete populations whose needs have not been met through the state's current service array. Minnesota seeks a Section 1115 waiver to allow Medical Assistance coverage and reimbursement while receiving treatment at AMRTC to assist the state in making additional strides forward in reducing lengths of stay, providing the cost-effective AMRTC setting only for the most acute needs and assisting timely and smooth transitions back to community-based supportive services. Medicaid coverage for AMRTC residents would facilitate continuity of care during transition from the community to the inpatient setting and back to the community. This waiver would also allow the state to invest in a new program to deliver supportive services to people with a serious mental illness and other co-morbidities who are experiencing difficulty returning to the community after completing their medical and behavioral treatment at AMRTC. This demonstration is described at Section 7 and new federal authorities sought under this *Reform 2020* waiver proposal for this demonstration are detailed at Section 13.

1.2.9 Eligibility for Adults without Children

As part of this request, DHS seeks waiver authority to impose an asset test of \$10,000 on adults without children enrolled in Medical Assistance with incomes at or below 75% of the federal poverty guidelines (FPG). DHS also seeks to reinstate the 180-day residency requirement for Adults without Children enrolled in MinnesotaCare with incomes above 75% FPG. This demonstration is described at Section 8 and new federal authorities sought under this *Reform 2020* waiver proposal for this demonstration are detailed at Section 13.

1.2.10 Additional Reforms

In addition to the requests for Section 1115 waiver authority outlined above, Section Nine outlines several other reform initiatives underway to provide additional information about the efforts undertaken to achieve the reforms outlined by the 2011 Legislature. New federal authorities are not sought under this *Reform 2020* waiver proposal for these initiatives. Some initiatives do not require additional federal authority, and some will require future action by DHS to request federal authority. For example, additional federal authority will be pursued in the future under state plan amendments under Section 1915(i) of the Social Security Act to coordinate and streamline the following services for groups with multiple and complex needs:

- A new program to deliver supportive services to people with a serious mental illness and other co-morbidities who are experiencing difficulty returning to the community after completing their medical and behavioral treatment at the Anoka Metro Regional Treatment Center. This program is interrelated with and would be greatly facilitated by approval of the Anoka Metro Regional Treatment Center Demonstration described above.
- A new program to provide more effective care and meet the unique needs of a small group of people with multiple disabling conditions including intellectual disability, cognitive impairment, serious mental illness and one or more sexual disorders that are currently receiving services under several different programs at the DHS.

Minnesota will consider the viability of a 1915(i) as well as other options in the design of services to support persons who have a diagnosis of Autism Spectrum Disorder (ASD). The primary goal of these services is to provide high quality, medically necessary, evidence informed therapeutic and behavior intervention treatments and associated services, such as respite, that are coordinated with other medical, educational and community services.

1.3 Conclusion

Minnesota seeks to move the service delivery system to a model that will better integrate medical, behavioral and long-term care services in patient-centered models of care, promote robust primary care, improve care coordination, and better align payment incentives to foster best practices. In addition, Minnesota proposes to modify existing long-term services and supports to provide additional flexibility to match the right services with participants' needs, at the right time by the right provider. These changes will profoundly impact the health of individuals, health care expenditures, and the fiscal sustainability of Medical Assistance into the future.

2 Related Reform Initiatives Pending Before CMS

2.1 Introduction

Two components of reform requiring federal waiver authority to realign long-term care services and supports and explore new opportunities to integrate Medicaid and Medicare coverage for seniors were submitted to the Centers for Medicare & Medicaid Services (CMS) in the spring of 2012 under separate cover and are described below. No additional requests for federal authority for the proposals summarized in this section are included in this waiver proposal. However, these proposals are described here because they are part of the overall reform effort of the 2011 Legislature.

2.2 Long-Term Care Realignment Section 1115 Waiver

The first phase of Minnesota's bipartisan Medicaid reform package was presented to CMS on February 13, 2012 under the Long-Term Care Realignment Section 1115 waiver. This proposal is currently under negotiation with CMS. A revised package was submitted in November, 2012. The Long-Term Care Realignment Waiver seeks federal authority to test reforms to move Minnesota's Medicaid program closer to a new equilibrium in which people with lower needs have their needs met with lower cost, lower intensity services. Minnesota seeks to 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. These reforms are designed to increase program stability by ensuring that higher intensity, higher cost services are used when necessary, and by relying on high impact, lower cost services for people with lower needs and fewer dependencies.

State law requires modification of the nursing facility level of care criteria for adults effective January 1, 2014 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 Supports will provide support to people who do not meet a nursing facility level of care and are transitioning off of a home and community-based waiver 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. The full proposal is available on the Department of Human Services' website at: <http://www.dhs.state.mn.us/Reform 2020>

In this *Reform 2020* waiver proposal, DHS is requesting additional federal authority to implement demonstration activities that will further support the goal of moving toward a new equilibrium in which people receive the right services at the right time to support their needs. The planned revision of the nursing facility level of care criteria was taken into consideration in constructing the proposals described in this waiver, with special attention to insuring that necessary services are not disrupted for consumers.

2.2.1 The Three Primary Components of the Long-Term Care Realignment Waiver

The Long-Term Care Realignment waiver is necessary in response to state law that requires a modification of the nursing facility level of care criteria for adults. Minnesota does not seek federal authority for that activity, but it is important to understand how the proposed demonstration components are designed to support Minnesotans with long term care needs during this transition:

Modify the Nursing Facility Level of Care Criteria

Minnesota is modifying its nursing facility level-of-care criteria (NF LOC) to require that a person 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 ADL. The new criteria raise the bar for entry to home and community-based waivers and Medicaid payment of nursing facility care. The new criteria also standardize the level-of-care decision and more precisely define the needs that must be present to meet the nursing facility level-of-care criteria.

Support Alternative Care Program

Minnesota seeks authority for federal matching funds for the Alternative Care (AC) program. AC is a state-funded program that provides home and community-based services to people 65 and older who meet the nursing facility level of care, who have income or assets above the Medical Assistance (MA) standards, but whose income and assets are insufficient to pay for 135 days of nursing facility care. Connecting these high needs seniors with modest income and assets to community services earlier will divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established.

Implement Essential Community Supports Program

Minnesota seeks authority for federal matching funds for the Essential Community Supports (ECS) program. 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 AC program, ECS enrollees must have income and assets that are insufficient to pay for 135 days of nursing facility care. The goal of this reform is to support this group of people 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 when full Medicaid eligibility is established. In the event that Minnesota is successful in obtaining federal matching funds for the AC and ECS programs, DHS will use at least a portion of the state savings that result to expand the benefits available under the ECS program.

The full proposal is available on the Department of Human Services' website at:

http://www.dhs.state.mn.us/dhs16_167144.pdf

2.3 Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility

Minnesota is actively engaged in working with the Center for Medicare and Medicaid Innovation and the Coordinated Health Care Office to improve care for people who are eligible for both Medicare and Medicaid. 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.

In April 2011, Minnesota was one of 15 states awarded a contract with the federal Centers for Medicare & Medicaid Services (CMS) to plan and design a new delivery and payment system model that integrates health care for dual eligibles. The 2011 Minnesota Legislature authorized DHS to seek authority to enter into a demonstration project with CMS to further the financial integration of the two programs, including the opportunity for Medicare to share potential savings with Medicaid.

On April 26, 2012, DHS submitted its final proposal to CMS for Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility. The federal comment period began on May 1, 2012 and has now concluded. DHS is working closely with the Center for Medicare & Medicaid Services on next steps for Minnesota's dual demonstration proposal. While the focus of the current proposal is on the re-design of Minnesota Senior Health Options, DHS will continue to explore with CMS ways in which Medicaid and Medicare can be better integrated for people under age 65 with disabilities, without pursuing a fully capitated model. DHS is focusing on integrated care system partnerships with providers using payment reform models with accountability and metrics for total costs of care.

Background

In Minnesota, people who are eligible for both Medicare and Medicaid represent 22 percent of the Medical Assistance population, but account for 40 percent of program spending. Their disproportionate share of the costs can be attributed in part to the high prevalence of chronic health conditions among this population. Nationally, 66 percent of people with dual eligibility have three or more chronic conditions, and 61 percent have a cognitive or mental impairment.² An additional and significant contributing factor to their incommensurate costs is that dually eligible people often find themselves in a highly fragmented system in which neither Medicare nor Medicaid is responsible for coordinating care and benefits. Because of this dynamic, dually eligible people encounter difficulty getting the care they need in the most appropriate setting, and often receive duplicative or unnecessary tests and treatments.

The Minnesota Department of Human Services (DHS) will build on current state initiatives to improve performance of primary care and care coordination models for people with dual eligibility served in integrated Medicare and Medicaid Special Needs Plans and fee-for-service delivery systems.

² Medicare Payment Advisory Committee Report to the Congress, *Aligning Incentives in Medicare*, Chapter 5: *Coordinating the Care of Dual-Eligible Beneficiaries*" (Washington: MedPAC: June 2010), available online at http://www.medpac.gov/documents/Jun10_EntireReport.pdf.

Existing initiatives include integrated Medicare and Medicaid through Special Needs Plan managed care programs such as Minnesota Senior Health Options (MSHO) and Special Needs BasicCare (SNBC), implementation of health care homes including the Medicare Advanced Primary Care Practice demonstration, and provider payment reform through the Health Care Delivery System demonstration. Minnesota has been a pioneer in establishing integrated programs for people with dual eligibility. In 1997, the state implemented the first state Medicare demonstration for dually eligible beneficiaries, the Minnesota Senior Health Options (MSHO) program. Currently, Minnesota serves over 70 percent of dually eligible seniors and 10 percent of dually eligible people with disabilities through contracts with Medicare Advantage Special Needs Plans (SNPS) under MSHO and Special Needs BasicCare (SNBC) programs. Proposed improvements include development of system-wide performance measures, risk adjustments, provider feedback systems and risk/gain sharing models specific to the dually eligible population.

The proposal and related documents can be viewed at the following web address:
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

Additional information is also available on the DHS website at www.dhs.state.mn.us/DualDemo

3 Accountable Care Demonstration

3.1 Statement of Proposal

Minnesota has long been a national leader in developing innovative and effective Medicaid payment and care delivery models such as health care homes and integrated Medicare and Medicaid managed care programs. These reforms have been premised on the idea that incentives in the health care payment system need to be adjusted and aligned to promote better outcomes and lower costs.

Minnesota is currently engaged in three efforts outlined in section 3.2 below that are based on the concepts supporting models of accountable care and payment incentives to support robust primary care, improve care coordination and test payment models that increase provider accountability for the quality and total cost of care provided to Medicaid enrollees.

In addition, Minnesota is working with stakeholders to prepare an application for the State Innovation Models Initiative to build on the current efforts outlined in section 3.2 and shift towards a delivery system based on partnerships with integrated care systems. Minnesota will develop a plan, articulated in the recommendations of the Care Integration and Payment Reform Work Group under the Governor's Health Reform Task Force, to advance total cost of care

arrangements in Minnesota. The goal will be to build on and enhance existing efforts around care delivery redesign and payment reform, with an emphasis on increasing levels of integration across the care and support continuum including, as appropriate, acute care delivery, public health, social services and long term care, both in care delivery and in funding streams. As part of this effort, Minnesota seeks to develop and pilot Accountable Health Communities, where community-based goals for improved population health, health care delivery quality, and total cost of health care would be set and measured.

Minnesota will seek all necessary federal authorities to support the application that will be submitted under the State Innovation Models Initiative, including any additional authority that may be necessary to contract with provider entities for the total cost of care. Minnesota seeks CMS guidance and technical assistance to determine whether Minnesota's existing waiver authorities are sufficient to support these efforts and what vehicle CMS would recommend. Minnesota expects that the shift to the new delivery system will be phased in by geographic area within the state as providers develop the necessary infrastructure to administer closed networks and contract for prospective risk-based global payments covering total cost of care. Closed or semi-closed networks will be necessary to facilitate effective coordination of care for enrollees and to ensure provider systems will be best positioned to manage the total cost of care. Minnesota is committed to ensuring that robust consumer protections are in place under the new system to ensure access to care, choice of providers and quality of care. Minnesota also seeks to work with CMS to identify any additional authorities required to facilitate data sharing between the state, providers, and among the health care and social services. Minnesota seeks to hold these discussions under the purview of this waiver, as well as in discussions with CMS regarding the proposal being developed for submission under the recently announced State Innovation Models Initiative administered by the Center for Medicare and Medicaid Innovation.

3.2 Current Initiatives

3.2.1 Health Care Delivery Systems Demonstration (HCDS)

The Minnesota Legislature authorized DHS to develop a Medicaid demonstration project to test alternative and innovative health care delivery systems, such as an accountable care organization, that would provide services to certain patient populations based on a total cost of care and risk/gain-sharing arrangements.

Through extensive negotiations with nine provider organizations, DHS has formulated the Health Care Delivery System (HCDS) demonstration. Three of these entities are also participants in the Medicare Pioneer Accountable Care Organization initiative with the CMS Innovation Center. Contracts are expected to be finalized in the summer of 2012 and implementation will begin by 2013. The demonstration will hold delivery systems accountable for the total cost of care delivered to the population they serve relative to a

pre-established spending target. Existing provider reimbursement methods will be used during the demonstration, with risk and gain-sharing payments made annually based on analysis of total-cost of care performance. Measurement for the payment model will span both the fee-for-service and managed care delivery systems.

Minnesota has recently secured the federal authority needed for this initiative under the state plan amendment process.

3.2.2 Hennepin Health

As of January 1, 2012, DHS and Hennepin County entered into a contract to establish Hennepin Health, an integrated health delivery network. This program focuses on a subset of the early expansion population of adults without children covered under Minnesota's state plan with incomes at or below 75 percent of the federal poverty level. Approximately 10,000 individuals per month will participate in the program. By integrating medical, behavioral health, and human services in a patient-centered model of care, the project seeks to improve health outcomes dramatically and lower the total cost of providing care and services to this population. This project will measure not only direct Medicaid costs, but also health care costs beyond the medical assistance benefit set, including uncompensated care, human services, and public health costs. The project also will quantify law enforcement, correctional, and court costs and savings, as well as the impact on community agency costs.

Additional federal authority was not necessary for the Medicaid component of the current program because it is operated under existing managed care authority, but it is included here to provide context for moving forward under new accountable care models described below. Hennepin Health brings together core county partners in Minnesota's most populous, urban county to improve outcomes for this population. The premise of the program is that treating medical problems without addressing underlying social, behavioral, and human services barriers and needs will produce costly, unsatisfactory results -- both for the patient and the programs providing and paying for care. Conversely, addressing all of these issues and incorporating them into a coordinated patient-centered, comprehensive care plan should end the cycle of costly crisis care.

3.2.3 Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility

As discussed above, while the focus of the current *Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility* proposal (also known as the Duals Demonstration) is on the re-design of Minnesota Senior Health Options, DHS is continuing to utilize this opportunity to explore with CMS ways in which Medicaid and Medicare can be better integrated for dually eligible people without

pursuing a fully capitated model. DHS is focusing on integrated care system partnerships with providers using payment reform models with accountability and metrics for total costs of care.

Minnesota will also implement a new purchasing and care delivery model for enrollees who are dually eligible for the Medicaid and Medicare programs. Under the umbrella of the Duals Demonstration, DHS will implement several service delivery and risk/gain sharing arrangements designed to align with statewide payment and delivery reforms, and to improve accountability for care outcomes across providers and service settings.

In particular, DHS will incorporate purchasing strategies similar to the HCDS models being implemented for other populations to stimulate new “integrated care system partnerships” (ICSPs) between health plans and providers. These partnerships will be designed to integrate primary care with long-term care and/or mental and chemical health, and will support payment and delivery reforms.

The State will create criteria for the ICSPs including requirements to utilize certified health care homes, primary care payment reforms, integrated care delivery and care coordination across Medicare and Medicaid services, accountability for total costs of care across a range of services including long term care and/or mental health, shared risk and gain, coordination between primary care and other providers and counties, incentives to provide services in all settings to minimize cost shifting, and enrollee choice of integrated care systems.

Enrollees would choose or be assigned (not attributed) to primary care arrangements within the ICSPs. Responsibility for individualized person-centered care coordination would be assigned from the point of enrollment, assuring tracking of costs and outcomes and alignment and accountability throughout the continuum of care as well as continuity of care for members.

The state will issue an RFP for these partnerships and will require that interested ICSP provider sponsors partner with a health plan to submit a joint response along with a proposed plan meeting RFP requirements for how they will work together under the demonstration. The RFP will specify parameters for standardized payment and risk/gain sharing arrangement options, including flexibility for graduated levels of risk/gain sharing across services and standardized risk adjusted outcome measures, and provider feedback mechanisms. The health plans will retain primary risk and thus will be part of the contract negotiations with ICSP providers in their networks.

3.3 New Accountable Models

3.3.1 Building on current efforts

The next step for the Health Care Delivery Systems and Hennepin Health projects is expanded full and partial risk sharing at the provider level, using prospective, global or population-based payments structures that include the costs of providing traditional health care and other Medicaid covered services in addition to costs outside of the traditional health care system that impact a Medicaid enrollees' health and outcomes such as social services and public health services. These models will hold providers accountable for the care (cost, quality and patient experience) they provide to their patients and for services provided outside of their systems to provide the incentive not to shift the cost of services on to other parts of the health care and long-term care system as well as other county and social service systems, but allow providers flexibility in managing upfront resources and making needed infrastructure investments under a prospective payment.

As part of the development process for the Health Care Delivery Systems effort, the state initiated a stakeholder process to seek input on the major design elements and policy decisions for the release of the model and RFP. In early April 2011, DHS released a Request for Information (RFI) and held a series of stakeholders meetings to present information and receive direct feedback from a variety of stakeholders. The RFI included questions on the amount of risk for which providers can and should be held accountable, patient assignment, quality and patient experience measures, consideration of other payment models, opportunities to increase value for Medicaid enrollees, and demonstration evaluation. DHS received approximately 40 responses from a variety of organizations including providers, safety net organizations, counties, health plans, foundations, and community and advocacy organizations. In addition to the RFI, DHS also provided for individual question and answer sessions for potential responders during the RFP process.

Due to the success of this process, DHS plans to use a similar process for stakeholder input for the next RFP. Given the magnitude of the changes being proposed, stakeholder meetings will be held over a longer period of time and will include direct meetings with a broader scope of organizations and groups.

The HCDS and Hennepin Health demonstrations included younger people including pregnant women, parents, children, adults without children and some disabled adults that are not dually eligible for Medicare. These populations have more predictable risk compared to dually eligible populations and therefore are easier to include at the beginning of these demonstrations. These demonstrations have provided valuable opportunities to build the foundational components for more integrated organizations that

can take on greater financial risk and more diverse Medicaid populations in later years. The next step is to move dually eligible populations (older people and people with disabilities who are also eligible for Medicare) into integrated care provider organizations that integrate care and financing of health care and long-term care services as well as social and county services. Minnesota will use the policy development and data work produced under the Duals Demonstration contract to further develop this model for these populations.

3.3.2 Vision for the future: Accountable Health Communities Partnering with Integrated Care Provider Organizations

Accountable Health Communities

Accountable Health Communities, to be developed under the Minnesota State Innovation plan, will engage citizens, health care and community organizations, businesses and payers to work toward measurable progress on the Triple Aim for the state and for communities. Accountable health communities will partner with accountable care organization boards and collaborate with accountable care organizations to ensure alignment between community goals and the goals and performance of the accountable care organizations. Accountable Health Communities will be accountable for a global community budget, with the scope of the funding streams and targets to be developed during the State Innovation Plan development process. Roles for citizens, employers, providers, health plans, government and communities will be established under Accountable Health Communities, which would set measurable and measured community-based goals for improved population health, health care and cost management, and lay out specific steps to achieve these goals. Providers and payers would work to align total cost of care measurement sets for transparency, accountability and payment. Specific funding and technical assistance will be available to assist rural communities, community clinics, and smaller providers and organizations to be part of the efforts. This will enable them to integrate with reform activities without being purchased by a larger system.

Integrated Care Provider Organizations

Organizations seeking to become accountable care organizations or integrated care provider organizations will not be limited to traditional provider systems, but can and will be encouraged to include counties, tribes, community organizations and providers, safety net providers such as federally qualified health centers, social service and public health agencies. Medicaid enrollees would directly enroll in these organizations to receive most or all of their Medicaid covered services and other non-Medicaid services. Providers under these integrated care umbrella organizations (health care and non-health care) will have the flexibility to develop payment arrangements among providers include shared

savings and risk models. These organizations will provide integrated and coordinated health care to enrollees, ensure coordination and receipt of critical non-health care services to help meet their basic needs, improve adherence to treatment, and improve outcomes. This can include coordination across the spectrum of services but also direct integration of services, e.g. co-location of primary care and mental health services.

These new integrated care provider organizations will need the capability to receive data from the state and share data among their members' providers (health care and non-health care) to better manage care for the populations they serve. This includes data analytic capabilities and storage capacity for reporting that potentially use a combination of health care claims, electronic medical records, and social service data to help providers better understand the care their populations are receiving and evaluate outcomes and care model strategies. Organizations must have the capabilities to stratify populations by need and develop appropriate models of care based on those needs.

A final critical element for these new organizations is the ability to maintain and improve quality of care and patient/client experience. These organizations must have the capability to report data on quality measures that currently exist under Minnesota's Statewide Quality Reporting and Measurement System and report on additional measures that can be validated and appropriate to the specific populations they serve and to Medicaid populations in general. Quality and patient experience measures will be integrated into the payment model so as these organizations are held more accountable for the total cost of an individual's care, the state can ensure that quality is maintained or improved, and that the right incentives are created to reduce inappropriate care and provide needed care.

4 Demonstration to Reform Personal Assistance Services

4.1 Proposal Statement

Minnesota is a national leader with a home and community-based service system that successfully supports a significant majority of older people and people with disabilities in their homes and communities. Minnesota presents this waiver proposal to continue its history of on-going improvement to enhance Minnesota's home and community-based service system to support inclusive community living. As the system has evolved over several decades it has become increasingly complex. The complexity sometimes results in barriers, gaps and redundancies that prevent people from accessing the most appropriate services for their individual circumstances when they need it, and is increasingly difficult to manage. At the same time, the system is pressured by state demographic trends of increasing populations of older people and people with disabilities over the next several decades. (For demographic data see

Attachment A.) In order to meet rapidly growing demands, the system must be efficient and effective in supporting people's independence, recovery and community participation.

Minnesota is seeking an 1115 waiver to redesign the Personal Care Assistance Services (PCA) benefit, as a key component in the State's plan to create a more coherent home and community-based service system that:

- better meets the need of each individual
- increases and supports individuals' independence and recovery
- supports individual stability
- prevents harm to self or others
- promotes the ability of individuals to direct and manage their own services
- reduces service barriers, gaps and duplication
- serves people earlier with less intensive service, in some cases delaying or avoiding the need for more intensive service
- is flexible and responsive enough to adjust quickly to changing circumstances without resorting to unnecessary use of high intensity services
- is administratively less complex
- promotes sustainability of the system

Minnesota will redesign its state plan personal care assistance services and expand self-directed options under a new service called Community First Services and Supports (CFSS). These changes will result in meeting more needs, more appropriately, of more people. A more flexible service may reduce pressure on the system as people use the flexibility within CFSS instead of accessing the more expanded service menu of one of the five HCBS waivers, or other available services in an effort to bridge the service gaps they currently encounter.

Additionally, Minnesota seeks to test innovative models of service coordination for children receiving CFSS, to coordinate services and supports across home, school and community. Minnesota proposes to contract with a small number of public or private entities working in a collaborative model that includes, at a minimum, a lead agency and a local education agency. Parents of up to 1,500 children who receive CFSS and who have an Individualized Education Program (IEP) can volunteer to participate if their child attends a school district in one of the demonstration sites.

The new CFSS service, with its focus on self direction, is designed to comply with the recently finalized regulations regarding section 1915(k) of the Social Security Act, and as such Minnesota believes that it is appropriate to apply the enhanced federal matching funds available under that option. Next, to avoid a reduction in services for people currently using PCA services,³

³ The criteria for PCA services do not align with the level of care criteria. Some people who do not meet level of care are eligible for PCA. Some people who meet level of care do not meet the PCA service criteria.

Minnesota proposes to make CFSS available both to people who meet an institutional level of care and people who do not, as long as they meet CFSS functional eligibility criteria.

A demonstration waiver is appropriate because CFSS is designed to be a viable and less costly option for people who today would only be able to receive sufficient care under a home and community-based services waiver. To make this option available to those people, we are requesting to extend the special Medical Assistance eligibility rules available under 42 CFR §435.217, currently applied to individuals receiving home and community-based waivers, to people who meet level of care and receive CFSS. Minnesota is not proposing to extend these same eligibility rules to people who receive CFSS but do not meet institutional level of care.

As an adjunct to the new CFSS service (not part of the 1115 waiver request), Minnesota will develop and test strategies to increase the capacity of existing case managers to effectively incorporate CFSS and other home care services into participants' plans. The plan is to expand the scope of existing case managers to include all forms of HCBS and home care into integrated plans across funding streams, in order to improve participants' outcomes, increase stability in the community and have a simpler, more efficient system. Eventually, Minnesota would like to offer home care targeted case management to those who could benefit from service coordination, and don't have access to other forms of case management, but this is not part of the list of initiatives to be implemented in the short term.

4.1.1 Brief Description of Current Home and Community-Based Services (HCBS) System

Minnesota has been reducing use of institutions through development of home and community-based long-term supports and services for over thirty years. Minnesota has rebalanced its system so that a large majority of the Medicaid-eligible seniors (61% in 2010) and people with disabilities (94% in 2010) who need long term care services are living in the community rather than in an institutional setting.

Minnesota covers the following long-term services and supports through the state plan: home health agency services, private duty nursing services, rehabilitative services (several individualized community mental health services that support recovery) and personal care assistant (PCA) services.

The PCA program has played a critical role in supporting people in their homes and avoiding institutional care, and has been one of the key vehicles supporting the rebalancing of the system. The service was designed in the late 1970's to support adults with physical disabilities to live independently in the community. Over time, the Legislature expanded PCA as a cost-effective option to support people of all ages with physical, cognitive and behavioral needs. PCA services are available to people based on functional need, without enrollment limits or waiting lists. PCA services help people who need assistance with activities of daily living (bathing, dressing, eating, transferring,

toileting, mobility, grooming, positioning) or independent activities of daily living (e.g. cooking, cleaning, laundry, shopping). The PCA program grew from 200 participants in 1986 to over 22,000 currently. In 2009, the legislature authorized changes to the PCA program to manage costs which resulted in changes in authorized levels of services for many people, both increases and reductions, and loss of access to one hundred and seventy people. At times, in an effort to get a specific service (such as special equipment or modifications to their home) or additional supports beyond traditional PCA services, those using PCA services have accessed one of the HCBS waivers (e.g. Developmental Disabilities or Elderly Waiver).

Minnesota has five home and community-based services waivers: Developmental Disability (DD)⁴, Community Alternatives for Disabled Individuals (CADI)⁵, Community Alternative Care (CAC)⁶, Brain Injury (BI)⁷ and Elderly Waiver (EW)⁸. Similar services to support individuals living in the community are offered under each waiver, but since each was developed over time, under different constraints and opportunities and for different populations, they differ from one another in areas such as eligibility criteria and annual spending.

There are many other components to the HCBS system, including, but not limited to: Aging Network services, Day Treatment and Habilitation, Semi-Independent Living Services, the Family Support Grant Program, mental health services, AIDS assistance programs, Group Residential Housing, independent living services, vocational rehabilitation services, extended employment, special education and early intervention.

Self-Directed Options

All services should be designed in a way that is person-centered, and involve the person throughout planning and service delivery. The term self-direction in this context refers to a service model with increased flexibility and responsibility for directing and managing services and supports, including hiring and managing direct care staff to meet needs and achieve outcomes. Currently each of the 1915(c) waivers offers Consumer Directed Community Services (CDCS)⁹. This service option gives individuals receiving waiver services an option to develop a plan for the delivery of their waiver services within an individual budget, and purchase them through a fiscal support entity who manages payroll, taxes, insurance, and other employer-related tasks as assigned by the individual. CDCS allows individuals to substitute individualized services for what is

⁴ 2011 unduplicated enrollment: 15,761

⁵ 2011 unduplicated enrollment: 18,927 (reflects high turnover rate)

⁶ 2011 unduplicated enrollment: 390

⁷ 2011 unduplicated enrollment: 1,513

⁸ 2011 unduplicated enrollment: 29,291 (managed care and FFS)

⁹ As of March 31, 2011 recipients using CDCS by waiver: BI – 53; CAC – 139; CADI – 1167; DD – 1689

otherwise available in the traditional menu of services in the waiver programs. Purchases fall into three categories: personal assistance, environmental modifications, and treatment and training.

In addition to CDCS, other current self-directed options include PCA Choice option within the state plan PCA program, the Consumer Support Grant and the Family Support Grant. In PCA Choice the participant works with an agency, but can select, train and terminate the person delivering the service. Direct staff wages are typically higher under PCA Choice. The Consumer Support Grant is a state-funded program that provides individuals otherwise eligible for home care services to receive and control a budget for buying the supports they need to remain in the community. Family Support Grant is a state-funded grant to families caring for a child with a disability.

Under the current system, CDCS has the greatest array and flexibility of services. The Consumer Support Grant and the Family Support Grant allow the greatest amount of participant autonomy and direction.

Case Management

The case management system in Minnesota is another component of the home and community-based long-term supports and services system or LTSS. Case management is a service under all of the waivers. Targeted case management is provided outside the waivers for certain groups and conditions: adult mental health, children's mental health, vulnerable adults and people with developmental disability, relocation service coordination and child welfare.

Alternative Care

Alternative Care is a state-funded program that provides a variety of services for people age 65 or older who are functionally eligible for nursing facility care but do not meet Medicaid financial criteria. The common services covered are case management, supplies and equipment, homemaker, home delivered meals, home health nursing, home health aide and personal care assistance.

4.1.2 What we want to change

(For concept graphic see Attachment B)

Despite the robust home and community-based services available, there still are people who are not receiving necessary services, are not achieving optimal outcomes for the services they do receive, or have extraordinarily high, potentially avoidable costs. The system evolved over a long period of time and now is quite complex and increasingly difficult to manage. Simplification would make it easier and more efficient for

participants and providers to navigate and for lead agencies and the state to administer. Aspects of the current system incent people to move to higher levels of service, or, certain services are not available until there is a critical need and thereby the opportunity to increase or prolong a person's ability to be more independent may be missed.

Right service at the right time, in the right way

While PCA services work well for many people, they are limited for others by only providing services that are doing “for” people in situations when individuals could learn to do more for themselves. In those cases PCA provides some support but less optimally than possible. The same is true in situations where technology or a home modification would enable a person to do more for her or himself, and may be able to substitute for a level of human assistance, but these services are only available today through the waivers.

Some people in these situations will go on a waiver in order to access technology, modifications or more flexible services, triggering an administrative process to enroll. Some people need these services, but cannot access the waiver when they need it, either because of not meeting the necessary institutional level of care (LOC) requirements¹⁰, or because there are waiting lists for waiver services due to limits set to manage growth.

In some cases, individual needs are not adequately addressed because the service is not delivered by the provider with the appropriate skills, or the service is treated as a stand-alone when it isn't the right service to address core needs. For example, while PCA services can provide redirection and assistance when a person has significant behaviors, such as physical aggression to self or others or destruction of property, they do not deal with the underlying issues nor are they intended to substitute for appropriate services to address the cause of the behavior. To be most effective in these instances, the PCA services need to be provided in coordination with mental and behavioral health, and/or educational plans. As a further example, there are children who need a consistent approach by home, service providers and school staff, which may not be possible given minimum provider standards and limits on what activities can be provided within the PCA service definition.

There are gaps and barriers between mental health services and long-term services and supports (LTSS). Many people who are served in the mental health system are never assessed for LTSS or there isn't adequate coordination of services. There have also been concerns with the adequacy of the functional assessment for LTSS in identifying and understanding functional needs resulting from a mental illness and the interaction of co-occurring conditions.

¹⁰ Minnesota has four types of LOC. Eligibility for home and community-based waivers is tied to one of these. See Attachment D.

Some people and providers have not pursued home and community-based services waivers because they don't feel they adequately respond to the needs of the individual with mental or behavioral health needs. There are people dually diagnosed for whom the service they receive is geared towards one condition but is not a good fit with co-occurring conditions.

A limitation of the current system is that home and community-based services waivers are organized as alternatives to institutional care and are tied to an assessed need for an institutional level of care. We know, however, that there are services which, if provided before a person reaches a certain level of care threshold, could change the trajectory of that person's ability to be independent, stay in the community and avoid or delay reliance on more intensive services.

Better coordination

There are people who are eligible but do not get connected with the appropriate service and others who are accessing many services across multiple system that are not well coordinated. Both of these situations can result in poor outcomes such as unstable housing, high medical costs, frequent crises, provider time spent in planning, re-planning and crisis management, and institutionalization.

Data analysis shows that approximately ten percent of people currently using PCA services utilize a variety of other systems and services that, when not well coordinated, result in fragmented, duplicative and/or inappropriate services, including use of more expensive services such as emergency departments and hospitalizations, and lead to poorer outcomes. Similarly, data shows that people who have high costs for avoidable services are often people who touch the system at many points or have multiple needs, but are not accessing useful services or coordinating them effectively.

As a result, some individuals receiving PCA services without access to case management may have services and supports that are not coordinated. They can have periods of instability during which they may not be in a position to make effective choices, but with better coordination would be able to regain stability in the community with appropriate supports.

Other individuals receiving PCA services may have access to one or more case managers, but within the existing case management structure each case management service provider may not have the expertise and authority to coordinate and manage all of the systems and services that the individual needs. As a result case managers may not be able to address the person's situation as a whole or provide what is needed to maintain the individual's stability in the community.

A simpler, sustainable system

The number of waivers, state plan and state-funded services and the differences between them make the system complicated, confusing and increasingly difficult to manage efficiently. When individuals cannot access the service they need through the state plan they often go on a waiver or a waiver waiting list, which is administratively burdensome and applies additional pressure to the waivers.

Every time any of the waivers and the state plan are out of alignment with each other, administrative challenges ripple through the system, from legislation, to policy development and implementation, quality management, county administration, health plan contracts, and program navigators such as case managers and service providers.

Minnesota has been working over the past several years to bring the waivers in alignment, and work continues to bring our vision for the future to reality.

One area of administrative complexity is the self-directed services financial support system. There are hundreds of PCA Choice providers and fifteen fiscal support entities for people using the Consumer Directed Community Supports waiver service under one of the five HCBS waivers. It is a complex system administratively, and difficult to monitor for quality assurance. Another component of Minnesota's overall reform agenda that works in conjunction with development of CFSS is a restructuring of Minnesota's financial support entity structure.

4.1.3 Brief description of how we want the system to be

Minnesota is working to build an LTSS system that supports people in having a meaningful life at all stages, according to their own goals, providing opportunities to make meaningful contributions, and building upon what's important to them. It is a system that is flexible, responsive and accessible by people who have an assessed need for LTSS. It is well managed to ensure its sustainability in order to be available to those who need it in the future.

Our goal is to provide the right service, in the right way, at the right time, functionally driven according to a person-centered plan, to individuals in order to achieve better individual outcomes and ensure the sustainability of the system through efficiencies achieved.¹¹

By transitioning away from the current PCA program and instituting the Community First Services and Supports (CFSS) program, individuals who have functional needs in areas of daily living will have access to a service that is designed to flexibly respond to their needs and provide the right service at the right time, in the right way.

¹¹ For concept graphic see Attachment C.

The added flexibility of CFSS to cover skills acquisition, assistive technology, environmental modifications, and transitions will lead to greater independence of people with functional needs, and further support recovery of eligible people with a mental illness. Making this service more accessible and flexible will facilitate transition out of institutional care and prevent or delay future admissions.

The CFSS will promote self-determination, and the ability for individuals to direct their support plan and service budgets to best meet their needs. There will be an option for individuals to directly employ and manage their own direct care workers, using a financial management entity under contract with the state. There will be provider agencies to deliver services for those who do not self-direct their services. Services will be delivered in accordance with a person-centered plan, regardless of whether or not the participant chooses to assume responsibility as the employer through the self-directed option.

In order for services to be effective they need to be delivered by providers with the appropriate qualifications. Minnesota would like to ensure that people are able to select providers with the skill set that best meets their needs. Self-direction gives people the option to hire, train and manage the staff they feel are qualified, and is already available. In setting provider standards for CFSS we will provide greater quality assurance that services will be provided by people who meet a minimum qualification level. We will also provide an option for providers to obtain certification documenting additional training and experience in areas of specialization. The state may choose to provide training itself, or contract with another entity, to develop the pool of qualified providers. There will be standards for agency-provided CFSS as a condition of enrollment. We will consider how to connect participants with qualified providers, such as maintaining a provider registry. A quality assurance plan will be established to monitor services and CFSS providers using strategies from our existing section 1915(c) home and community-based waivers. Minnesota will work with an Implementation Council to develop plans and protocols to help build the program we envision.

Minnesota is developing and rolling out a new comprehensive assessment and support planning application for LTSS, called MnCHOICES. It will be used with individuals of all ages, any disability and all incomes, and will replace four existing assessments for LTSS. A trained and certified assessor will identify a person's strengths, preferences, needs, and goals using a person-centered approach and develop a community support plan that will include referrals to other appropriate services as necessary, such as mental health therapeutic services.

MnCHOICES is designed to promote coordination and collaboration between other parts of the LTSS and health care system. For example, referrals may be made for a mental health diagnostic assessment when it is determined through the MnCHOICES assessment

and service planning process that a person would benefit from mental health therapeutic services. In addition to identifying referrals, MnCHOICES uses information from diagnostic and clinical assessments that have been done to help the assessor understand the underlying issues that result in the functional need, and community support planning incorporates this information into the most appropriate service plan.

Minnesota will use the launch of MnCHOICES in 2013 and the CFSS demonstration as an opportunity to learn how the additional information gained from the new assessment and support planning system can be used to better identify the need for services, to shape the best service plan, to coordinate services, and evaluate outcomes.

We believe that having a coordinated plan will contribute to better outcomes for the individual, including receiving coordinated, high quality primary care, mental and behavioral health treatment, and long-term supports and services appropriate to need and holistically integrated for each individual; the ability to recover or otherwise acquire skills; ability to live in the community and have more control over one's own life; improved quality of life, as defined by the individual and their family; smoother transitions, such as returning to the community from institutional stays; from primary to secondary school; at graduation; and fewer crisis episodes.

A simpler system will be easier to manage and more efficient to administer. This proposal fits in with many other efforts the state is making to simplify the system and achieve better outcomes. For example, the service coordination component of this proposal works in concert with larger-scale reform of case management services to assure first that there is access to needed service coordination, and second, that there is one service coordinator who is able to holistically plan and support the individual across all services, rather than multiple coordinators responsible for different services or program outcomes. Similarly, we have plans to restructure the fiscal support entity system currently in use with all self-directed services. The new system, which will carry over to support CFSS, will have fewer providers of financial management services, and greater capacity for quality assurance. By reducing administrative complexity within these services we will be able to redirect some resources into services.

As a result of a combination of reforms, Minnesota will have a more effective and efficient system. We anticipate that by providing more people with services that adequately meet their needs through the CFSS state plan option, pressure on the waivers will be reduced, and we will be able to target waiver services for those most in need of the expanded service menu waivers offer.

4.1.4 How we get there

Minnesota has been incrementally rebalancing its LTSS system for decades. In addition to the initiatives proposed in this document, there are other reform efforts either currently underway or in planning stages.

These include three projects to transform key elements of the system:

- Assessment and support planning (MnCHOICES)
- Payment rate methodologies (Disability Waiver Payment Rates System)
- Provider and quality standards (Waiver Provider Standards)

And there are other initiatives, studies, policy changes, and demonstrations, including:

- Services to support transition out of Anoka Metro Regional Treatment Center
- Therapeutic services for people, especially children, with autism
- Day treatment for adults with DD/serious cognitive impairment, serious mental illness and diagnosis of sexual disorder
- Inclusion of long-term care services and supports in Health Home demonstration (integration of mental and chemical health and physical health care)
- Alzheimer's Health Care Home Demonstration
- Evidence-based health promotion
- Universal Information and Assistance
- Implementing a HCBS report card
- Centralizing reporting for vulnerable adults
- Conducting gaps analysis, system needs determination and developing services
- New In-home supports service option
- Establishing access thresholds for certain residential services
- Redirecting nursing facility services to individuals with higher needs
- Creating an updated menu of waiver services and provider standards, including standards of positive practices, and prohibitions on restrictive procedures
- Revising Consumer Directed Community Services within the waivers
- Providing technical assistance to counties to divert commitments
- Money Follows the Person demonstration
- Redesign case management (service coordination), with interim steps that include:
 - Home Care Case Management: Currently, Medicaid recipients in Minnesota are able to access case management services if they are eligible for a Medicaid waiver or if they are eligible for certain targeted case management services. However, many people using home care services do not have access to case management or care coordination. As part of the reform of case management, Minnesota intends to implement a targeted case management service specifically for people receiving home care services (including CFSS), who do not otherwise have access to case management. The intent of the reform is to make case management services available as an option to people who

would choose case management services but do not have access to them now. The home care case manager would help the individual access services and supports to promote the person's stability in the community-based on that person's assessed needs. Case management will assist the individual to make the most effective use of the flexibility offered through CFSS including accessing assistive technology and environmental modifications, and increasing their ability to direct their own services. Case management will provide linkages with other appropriate services such as medical services, mental health services, financial counseling, occupational therapy, etc., and provide support to achieve outcomes.

- Consultation, training, and technical assistance for case management systems about CFSS: Also as part of future case management reform, for CFSS participants who are already receiving a case management service, approaches will be tested to assist existing case managers so that all services, including CFSS are coordinated in a single plan, the person is stabilized, avoidable service use is reduced, and outcomes are achieved. Training and technical assistance will include a focus on best practices for person-centered planning. Contracted technical assistance providers will develop strategies to achieve those outcomes and learn what practices must effectively support current case management/service coordination to incorporate CFSS into their planning and coordination activities to inform future improvements to case management. These technical assistance providers will consult with existing case managers about CFSS so that the case manager can most effectively use this service and achieve better outcomes. They will provide information about how CFSS can assist with the individual's overall community stability through support with activities of daily living, instrumental activities of daily living, skill acquisition, and access to assistive technology and environmental modifications or other features of CFSS, and assure that the services is effectively provided.

Because Minnesota has a mature system and much groundwork has already been done, the state is ready to tackle many problems through a deliberate plan, in an effort to truly reform the system. Services and systems are inter-related so it is necessary to make a number of these changes at the same time to avoid making the system even more unwieldy, creating policy conflicts and risking unintended outcomes.

Still, we need to manage these changes carefully to avoid putting individuals and providers at risk. We recognize that our lead agency partners, providers and participants cannot manage wholesale change of the system at one time. We also do not know exactly how each change will play out in terms of service utilization, provider capacity and cost,

nor exactly how the interaction of multiple changes will play out. Therefore we are pursuing a phased approach and are seeking authority to retain flexibility to quickly adjust programs, if necessary, as we learn.

We are interested in using authority under Sections 1915(k) and 1915(i) of the Social Security Act to reform personal care assistance services. However, there are many unknown factors, some directly related to this proposal and others coming from other system changes such as expanded Medicaid eligibility, emerging payment models, and the transformation projects we already have underway (such as the new assessment, provider standards and payment rate systems). To help manage the uncertainties, Minnesota is proposing putting together many initiatives to build the Community First Services and Supports program and demonstrate a coordination approach for children within a single 1115 demonstration waiver.

We would like to build services that align with CMS guidance concerning Sections 1915(i) and 1915(k) of the Social Security Act within this Section 1115 waiver to learn how we could effectively manage services under those options, while mitigating the initial risks by running them within a demonstration framework. We also would like to use the Section 1115 framework to allow us to work with CMS to develop a single set of assurances across the proposed CFSS, service coordination and other components of this submittal.

For those individuals and services that meet the conditions of the Section 1915(k) regulations we are requesting to receive the enhanced federal participation available under that section of the law. The funds that would be generated from this enable us to operationalize the entire plan.

We are using a Section 1115 demonstration framework to allow us to:

- Implement redesign with a limited group (those eligible for PCA services) that is large enough and crosses many types and levels of services to allow us to learn what works most effectively to assess and meet their needs in a more individualized, effective manner. The knowledge gained can then be applied more broadly.
- Adjust the individual service budget methodology used with CFSS when necessary to make the program financially viable and to stay within state cost parameters.
- Test innovative models for service coordination for children receiving CFSS, mental health, and special education health-related services. Minnesota wants to learn best practices for service coordination across home, school, and community.

- Provide participants in home and community-based service waivers with the option to receive the same services and supports available through CFSS as waiver services. For example, participants in home and community-based service waivers can access needed assistive technology, environmental modifications, and support services that would mirror those available through CFSS. However, to manage and evaluate the differences and outcomes of CFSS compared with our current PCA program, the demonstration will only include those receiving state plan CFSS, and not those receiving similar services through one of Minnesota’s five home and community-based services waivers.
- Extend the special Medical Assistance eligibility rules available under 42 CFR §435.217, currently applied to individuals receiving HCBS waivers, to people who meet level of care and receive CFSS. Minnesota is not proposing to extend these same eligibility rules to people who receive CFSS but do not meet institutional level of care.
- Limit settings where CFSS can be provided to match the restrictions of the current PCA program. Specifically, CFSS may not be provided for individuals in institutional settings or in a foster care setting licensed for more than four people or where the provider of service owns, leases, controls or otherwise has a financial interest in the housing and services. State law in Minnesota has defined community settings for home and community based services, which is similar to the proposed regulations issued by the Centers for Medicare and Medicaid for public comment.

4.2 Demonstration Details: Alternative to the Personal Care Assistance program

With the recent opportunities made available by changes at the federal level, Minnesota sees the potential of providing a better service that will more appropriately be the right service at the right time for people in need of assistance with personal care. We intend to end our current PCA program and replace it with a more flexible set of services, which we are calling Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, and allow individuals the opportunity to direct and manage their own services, will be modeled after the Community First Choice Option, or the “1915(k).” It will be available to those who meet the CFSS eligibility criteria¹², whether they meet an institutional level of care criteria or not. The administrative structures (1915(k) or (i) authority) to implement the program will be invisible to the participant, and are only the vehicles to serve those who may currently access PCA.

¹² To be eligible for CFSS, a person must meet the same criteria that are in place today for personal care assistance: an assessed need for assistance with at least one activity of daily living (ADL) or a level one behavior as defined in Minnesota law. Please see Attachment M for a comparison of CFSS to the current personal care assistance benefit.

4.2.1 CFSS for individuals who meet an institutional level of care [the “1915(k)” portion]

New service description

Community First Services and Supports (CFSS) provides assistance with and maintenance, enhancement or acquisition of skills to complete ADLs, IADLs, and health-related tasks and back -up systems to assure continuity of services and supports based on assessed functional needs for people who require support to live in the community. In addition, CFSS provides permissible services and supports linked to an assessed need or goal in the individual’s person-centered service plan, which may include, but are not limited to, transition costs from institutional services and supports that increase a person’s independence, including, but not limited to, assistive technology and home modifications.

The form that this assistance takes can vary widely and is driven by and tailored to the needs of the individual, based on a person-centered assessment and planning process. The participant receives a budget, based upon the assessed needs, and can use that budget to purchase CFSS. The individual has options for handling administrative functions, such as financial management of payroll, taxes and insurance, and would have the option to choose to arrange for services according to the support plan.

Implementation Council

Minnesota has consulted with and relied on the HCBS Partner Panel, the Consumer Directed Task Force, and numerous intensive workgroups to develop the Community First Services and Supports proposal included in this Section 1115 waiver proposal. We will expand participation in the next phase of development and form a separate Implementation Council during the summer of 2012 that will assist the Department of Human Services in the more detailed planning and protocols that will be necessary when preparing legislation for action by the 2013 Minnesota Legislature, and implementation plans to terminate the PCA program, and establish the Community First Service and Support in its place.

The Implementation Council will play an essential role in determining many of the details of CFSS including:

- The development of standards for CFSS providers and financial management entities
- The design of an effective quality assurance system
- Protocols, including incorporation of person centered planning and self direction into operational structures

- The selection of service models available through CFSS

Person-centered assessment and support planning

Person-centered assessments and community support plans will be completed by trained and certified staff within lead agencies (counties, health plans and tribes) using MnCHOICES, a new assessment application that will be implemented in 2013 for all long term services and supports funded through Medicaid and state dollars.

MnCHOICES includes an assessment of the individual's needs, strengths, preferences and goals, and supports decisions about services and program eligibility, including eligibility for and appropriateness of Community First Services and Supports.

As part of the assessment and service planning process, a community support plan will be developed and, for those eligible and choosing to receive CFSS, the individual will receive their individual service budget. At least annually, or more frequently if needs change, there will be an assessment, and determination of the next year's budget. A more detailed person-centered Coordinated Service and Support plan will be developed by the individual and people they choose to have involved that includes additional information to document agreements by all involved for the implementation of services, including the individual's goals and desired outcomes, a backup plan, risk factors and measures to minimize them, who will monitor the plan, and how services will meet the clinical and support needs identified through the assessment.

Service models

Individuals will have a choice of service models. The specific service models are to be developed in collaboration with the Implementation Council. The service models will differ in how many of the employer responsibilities the individual wishes to take on. Individuals may choose to purchase services through an agency-provider model which allows them to be actively involved in the selection and dismissal of their direct care workers while the agency is the employer. Or, individuals could choose a model in which they have complete control over whom they select and dismiss but where the financial management entity provides employer-related services such as processing timesheets and payroll, managing taxes and insurance, paying invoices, tracking budget funds and expenditures and providing reports to the person and the State. Or, the individual may choose to take on all of the employer responsibilities with the assistance of the financial management entity.

Based on recommendations from the Consumer Directed Advisory Task Force report, Minnesota will select financial management entities through an RFP process conducted by the state with participation by members of the Implementation Council. The final number of entities will be limited, although adequate in number to allow individuals a choice between at least two entities, regardless of where they live in the state. The

financial management entities will be under contract with DHS and will be reimbursed as an administrative function rather than a service.

Individual Service Budgets

Individuals using CFSS will be given an annual budget, which they can use to purchase services through an agency, or choose to direct their own services through a financial management entity. The notice of the individual service budget will include an average daily amount, the maximum total dollars that can be spent during the authorization period, and a conversion of the budget into the equivalent number of 15 minute service units. At the beginning of the demonstration, the budget will be established based on the current PCA home care ratings, with one exception. The lowest average daily amount will be the dollar equivalent of 90 minutes of PCA service, compared to the current 30 minutes (two units) available to people at the “LT” home care rating. This lowest average daily amount is based on a base home care rating of 75 minutes with additional time for identified behaviors and/or complex health-related needs. Services may be used flexibly to meet needs according to the person’s support plan. The plan must document projected use of service for the duration of the plan to assure that dollars are available over the course of the year when needed. Over the five years of the demonstration, the DHS and the Implementation Council will review data and trends from the assessments to determine what policy changes, if any, should be made to the MnCHOICES assessment, or service budget methodology based on additional assessment information, to create an individualized budget methodology for CFSS that reflects the needs of the people using CFSS.

Experience that Minnesota has gained from the use of flexible PCA services, where services may be provided at the time and intensity needed within a 6 month period, and the Consumer Directed Community Support service, which is a self-directed option under Minnesota’s five home and community-based waivers, and the work of the existing Minnesota Consumer Directed Task Force will inform the development of the Community First Services and Supports option, including budgets and related protocols. Over the next five years, during the demonstration period, analysis and evaluation information will inform future CFSS individual service budget methodology.

Provider Standards

Provider agencies providing CFSS will meet provider and outcomes standards as authorized by the 2013 legislature, with a goal of consistency where applicable with other HCBS standards. The staff providing CFSS, whether directly employed by the participant or by an agency, will meet certain standards, including background checks, certain core training prior to employment, and on-going training. There will be additional training and certification available for those who wish to specialize and have

more experience working with certain people (e.g.: people with a mental illness or complex health conditions). Accountability will be key to the success of this new model. Minnesota intends to build on the work we have done over the past few years, improving provider standards and basic direct care worker training. More work needs to be done and DHS will work with the Implementation Council to assure that checks and balances are in place.

Standards for financial management entities will build off what has been used for the certification of fiscal support entities that support self-direction in the HCBS waivers. The Consumer-Directed Task Force and the Implementation Council will assist in the final requirements that will be used in the RFP process to select agencies to provide this function.

Eligibility criteria

In order to qualify for this service an individual must meet all of the following criteria:

- Be on Medical Assistance
- Meet an institutional level of care for a nursing facility, intermediate care facility for persons with developmental disabilities, or hospital¹³
- Have an assessed need for assistance with at least one activity of daily living (ADL), or, be physically aggressive towards one's self or other or be destructive of property that requires the immediate intervention of another person ("Level One Behavior" per Minnesota Statute).

The special eligibility rules (application of Special Income Standard and exemptions from spousal or parental deeming) that apply today under Minnesota's home and community-based waivers will be extended to individuals who meet level of care and are receiving CFSS.

4.2.2 CFSS for people who don't meet an institutional level of care [the "1915(i)" portion]

Background

Based on available data, it appears that about 90 percent of individuals who currently use PCA services in Minnesota meet hospital, nursing facility, or ICF/DD level of care

¹³ For a description of each level of care, see Attachment D. For a comparison of the nursing facility level of care standards in place today to those that are expected to be in place at the time the demonstration is implemented, see Attachment E. It is anticipated that individuals meeting level of care criteria for Institutes of Mental Disease (IMDs) will also have met one of the other level of care criteria. This will be evaluated and IMD level of care may be included in the final 1915(k) submission.

criteria. It would be inconsistent with Minnesota’s overall policy direction, which is to provide services earlier in order to prevent or delay the demand for higher cost services, to limit the supports that enable people to live independently in their communities to those who meet an institutional level of care. Therefore, for those who do not meet a level of institutional care, we propose creating an option under 1915(i) to provide them the same benefits available under the CFSS 1915(k).

CFSS would be available both to people who meet an institutional level of care [via 1915(k)] and people who do not [via 1915(i)]. These two components of CFSS are designed to work together seamlessly to provide appropriate services to people who have a functional need. The service would be identical to what is provided under the 1915(k) component of the demonstration.

Eligibility criteria

- Eligible for Medical Assistance
- Does not meet institutional level of care (nursing facility, hospital, or ICF/DD level of care)
- Have an assessed need for assistance with at least one activity of daily living (ADL), or, be physically aggressive towards one’s self or other or be destructive of property that requires the immediate intervention of another person (“Level One Behavior” per Minnesota Statute).

4.2.3 Demonstration of Innovative Approaches to Service Coordination (Children with CFSS)

Demonstration description

Minnesota proposes a demonstration project to test models of service coordination for children, ages three through graduation, with complex involvement in the service system, to coordinate services and supports across home, school and community. Through the demonstration, we hope to identify best practices and replicable models that utilize one service coordinator or a designated service coordination team to locate, mobilize, identify needed revisions and connect all the services and supports needed by the child and family. We plan to accept proposals from public or private organizations that describe a collaborative model, with invested leadership, that includes participation from a local education entity. Service coordination will be provided by a community based organization. We anticipate five or six demonstration sites serving up to 1,500 eligible children who receive CFSS and who have an Individualized Education Program (IEP). Because this is a demonstration, parents of eligible children will decide whether or not their child will participate.

DHS will work with other state agencies, including the Departments of Education and Health, to develop and utilize a Request for Proposal (RFP) process to locate five or six willing entities

who are interested in supporting families of children with complex needs, improving outcomes for children and making the system more efficient. We hope to review innovative proposals that may link and utilize a variety of partners but that must include a local education agency. It is our belief that because schools are an important part of a child's life, they need to play a key role in this demonstration.

Through the demonstration, we intend to identify best practices for comprehensive, effective and simplified service coordination that addresses the "whole child." It is not our intent to add another "case manager" to the mix, but rather to have one "go-to-person" who can orchestrate the myriad of service providers, case managers, payers, etc. that are part of daily life for many families. Service coordination will assure that everyone connected to the child's plan, across home, school and community receives necessary communication and an opportunity to cooperatively plan in order to appropriately serve the child and his or her family. The service coordinator will work with the parent(s), flexibly, as needed.

During the RFP process the State will be looking for sites where there is an existing level of collaboration and leadership in place, along with a desire to improve outcomes for children with complex involvement in the service system.

In order to identify promising practices and those practices that are not as effective, the demonstration will include a thorough data collection process. DHS will engage a broad group of stakeholders for planning, development, implementation and evaluation, including parents, advocates, clinicians, providers, educators, lead agencies and other state agencies. Because eligibility for the service coordination demonstration is an adjunct to implementation of the Community First Services and Supports (CFSS) program, implementation is projected for 2014.

Families will be able to decide if they want to participate or not in this demonstration, and can discontinue participation at any time they choose. The demonstration can serve up to 1,500 children who are receiving services under CFSS and who have IEP-health related services on their Individualized Education Program (IEP) that are reimbursed by Medical Assistance.

The demonstration will only serve a portion of children who receive CFSS.

Eligibility criteria

- On Medical Assistance
- CFSS recipient (whether or not they meet level of care)
- At least 3 years of age and under 21 and still in school
- Have an IEP/IFSP that includes health-related services billed to Medicaid, and
- Have more than 2 complex health-related needs (e.g. gastrojejunostomy tube; total parenteral nutrition; multiple wounds) or;
- Receive mental health services or;

- Demonstrate physical aggression towards oneself or others or destruction of property that requires the immediate intervention of another person (Level 1 behavior)

4.3 Fiscal Analysis of the Demonstration to Reform Personal Assistance Services

The fiscal analysis is included at Attachment O. The analysis assumes that Minnesota receives the enhanced match available under the Section 1915(k) option for those people who also meet nursing facility level of care, that Minnesota is allowed to cap enrollment in the Demonstration of Innovative Approaches to Service Coordination (Children with CFSS), and that Essential Community Supports is funded for certain people eligible for Medicaid. Minnesota requested federal funding for Essential Community Supports in the Long Term Care Realignment waiver proposal to support persons who are transitioning off of a home and community-based waiver due to the change in the nursing facility level of care.

5 Demonstration to Expand Access to Transition Supports

5.1 The challenge

Through this demonstration, Minnesota seeks federal support to build on current state-funded initiatives with proven track records of success. Hospitalization and nursing home stays are expensive and can lead to a drop in income and assets that require people to apply for Medicaid to help meet their medical needs. Many seniors with complex care needs would prefer to remain living at home or in the least restrictive setting and avoid using public assistance, but do not know how to navigate the system to meet these goals. Consumers who have complex care needs and are moving home or into different settings after a hospital or nursing home stay are vulnerable to serious problems that often result in readmission or institutionalization. These individuals are also at high risk for spend-down to Medicaid and are referred to as “pre eligible.” A number of different evidence-based initiatives have demonstrated that education and support is effective in assisting consumers to return home after a hospitalization and/or nursing home stay and stay at home longer. Prevention-focused transition supports, together with a modest amount of intervention and follow-up, help people remain in their homes, use less expensive services and avoid risk of spend-down to expensive public programs.¹⁴

¹⁴ Naylor, M.D., Aiken, L.H., Kurtzman, E.T., Olds, D.M., Hirschman, K.B. (2011). THE CARE SPAN--The Importance of Transitional Care in Achieving Health Reform. *Health Affairs*, 30(4), 746-754; Arling G, Kane RL, Cooke V, et al. Targeting Residents for Transitions from Nursing Home to Community. *Health Serv Res Early On-*

Assistance with medication education by Minnesota long-term care options counselors has also been shown to reduce the risk of rehospitalization, another indicator of risk of nursing home placement and thereby spend-down.

Current state-funded initiatives make long-term care options counseling available to provide transition support to a wide range of pre-eligibles. With federal support, Minnesota could support community reentry for more consumers in nursing homes and other settings. The goal of this expansion is to help consumers access more appropriate options earlier through prevention models so that they can avoid spend-down to Medicaid, use less costly services, and stay at home longer.

5.2 Existing efforts – Return to Community Transition Support for People in Nursing Homes

In this demonstration, Minnesota seeks to utilize an opportunity to leverage existing work. The Senior LinkAge Line®, which services older adults in Minnesota’s Aging and Disability Resource Center initiative (The Minnesotahelp Network™) provides long-term care options counseling and transition support through a number of existing initiatives. These efforts have several overarching values:

- Replace the commonly held belief that nursing home placement is the only option available to meet supportive long-term care needs with knowledge that there are resources available throughout Minnesota to help people remain independent in their own homes and in their communities.
- Help high risk individuals who are pre-eligible avoid or delay spend down to Medical Assistance through the utilization of less costly, informal supports. The safety net is sustained for those individuals most in need.
- Plan for and anticipate the need to prepare for financing one’s own long-term care as a normal part of the adult financial planning process.
- It becomes common knowledge that Medicare is not available, long-term, to cover most services and that Medical Assistance is the safety net for the most vulnerable, low income Minnesotans.

The first major effort focused on transitions support undertaken by Minnesota’s Aging and Disability Resource Center (ADRC) was launched in 2010 by DHS and the other ADRC partners through a comprehensive long-term care rebalancing initiative, known as Return to Community. Its objective was to enable nursing facility residents to transition back to the community, with the support of home- and community-based services. Services provided under the initiative facilitate a temporary nursing home stay and a successful community transition in partnership with the

Line; and Chalmers, S. A., & Coleman, E. A. (2006). Transitional Care in Later Life: Improving the Move. *Generations*, 86-89; Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease, Mittleman, et al, *Neurology* November 14, 2006 67:1592-1599.

nursing home discharge planner, while respecting individual preferences for living and caregiving, using resources efficiently and promoting good health and quality of life.¹⁵

The effort targets nursing home residents who meet the following qualifications, based on research by the University of Minnesota Center on Aging and the Indiana University Center for Aging Research:

- Are early in their nursing home stay (admitted over 60 days but not more than 90);
- Have expressed a desire to return to the community;
- Fit a discharge profile that indicates a high probability of community discharge;
- Would otherwise become long stay residents based on the status of their peers;
- Are Minnesota residents;
- Are not yet eligible for Medicaid or Money Follows the Person benefit;
- Could benefit from discharge planning assistance based on the Community Living Mini Assessment developed by Dr. Greg Arling; and
- After an inquiry by a long-term care options counselor, request that a Community Living Specialist begin the process of helping them return home; or
- Have stayed longer than 90 days and then are referred to the Senior LinkAge Line® (the local contact agency) by nursing home staff after responding affirmatively that they wish to return to a community setting in response to Section Q of the MDS.

This service acts as the Local Contact Agency as required by the new MDS 3.0 Section Q guidance from the Center for Medicare and Medicaid Services. Qualified candidates then receive the following transition support:

- An initial interview that includes the Community Living Mini Assessment developed in partnership with Dr. Greg Arling at the Center for Aging in Indiana University.
- Care planning and service coordination.
- Transition planning by nursing home staff in partnership with Senior LinkAge Line® long-term care Options Counselors known as Community Living Specialists (CLS).
- Ongoing monitoring in the community through a rigorous follow up protocol by Senior LinkAge Line® Long-Term Care Options Counselors from the Minnesota

¹⁵ The service design was based on variables that came from admission, quarterly (90, 180 and 270 days), significant change or annual Medicare Data Set (MDS) 2.0 assessments. They included age, gender, marital status, and living alone prior to admission as well as diagnoses and problem conditions such as Alzheimer's or dementia, psychiatric disorder (schizophrenia or anxiety disorder), depression, diabetes, hip fracture, cancer, end stage disease, and bowel or bladder continence. The MDS was also used to group residents into major Rate Utilization Grouping (RUG-III) categories of Extensive Services, Rehabilitation, Special Care, and Clinically Complex, which served as general indicators of health conditions or service use.

HelpNetwork™ for up to five years.

Once the individual has returned to the community, the Community Living Specialist provides an in-person visit 3 days after nursing home discharge and continues with phone-based follow-up at 14, 30 and 60 days. Designated Senior LinkAge Line® options counselors then check in quarterly for up to five years. Over time, the Senior LinkAge Line® evaluates needs, coordinates services, and provides caregiver education and support. Any needed services are coordinated through the Minnesota's Aging and Disabilities Resource Center (ADRC) known as the MinnesotaHelp Network™ which includes the Senior LinkAge Line®, Disability Linkage Line®, Veterans Linkage Line™ and MinnesotaHelp.info®.

For those nursing home residents who are not directly assisted by the Community Living Specialist to return to the community but appeared on the profile list, the Senior LinkAge Line® provides quarterly follow-up for up to five years with consumer permission. The Senior LinkAge Line® is currently following up with 900 consumers in the community.

This reform initiative results in savings to the Medicaid program. The savings were projected by DHS using an analysis using actual claims of a sample of targeted residents comparing the claims to payment projections and assuming a reduced level of nursing home utilization. The data was compared to nursing home payments over a period of five years. The difference in nursing home days and payments between scenarios was substantial. The final fiscal analysis projected compounded savings over a period of five years. Dr. Greg Arling is currently evaluating the service and will be issuing a report that will document the availability of projected savings to the Medicaid program.

Evaluation of the program and impact will be studied by using an interrupted time series design to examine trends in long-term and acute care utilization and expenditures in MN before and after the implementation of the Return to Community Initiative; and conducting a longitudinal cohort analysis of the subset of residents transitioned from nursing home to community through the Return to Community Initiative that contrasts successful and unsuccessful cases. The latter analysis will describe experiences of the transitioned cohort, their use of services and costs, and factors that affect the individuals' capacity to remain in the community. The 5-year project period will allow us to assess long-term program outcomes and follow the transitioned resident cohort for a period of time sufficient to draw inference about long-term outcomes of the RCP program in avoiding or delaying nursing home use and Medicaid conversion. Secondary data sources, such as MDS, Medicaid and Medicare claims, as well as using longitudinal assessment data on transitioned individuals and caregivers will be used to aid in analysis. This work has been preliminarily selected for a grant from the Agency for HealthCare Research and Quality (AHRQ) and negotiations for the final grant are in process.

5.3 Existing efforts – Long-Term Care Options Counseling about Community-Based Housing Options

A second major transition support effort that Minnesota seeks to leverage through this demonstration was launched in October of 2011. Long-Term Care Consultation Expansion made changes to the Long-Term Care Consultation (LTCC) statutes during the Legislative Special Session in July 2011. The initiative was an expansion of LTCC and Long-Term Care Options Counseling (LTCOC) and is available to people of all ages who want to move into a registered housing with services setting – primarily focusing on assisted living.

The service originally was available to consumers on a voluntary basis since 2008. However, while very few people were calling for assistance, DHS was realizing a rise in the numbers spending down to Medicaid in assisted living. Of those that did call, close to 50% in any given quarter told the Community Living Specialist at the ten day follow up that they had changed their mind and would not move. Data reviewed from a six-month period in 2008 showed that 66% of Elderly Waiver (EW) enrollees who were newly eligible on Medicaid - at the same time had a Customized Living service authorization in the first month. This meant that the majority of people applying for EW were applying after having moved to assisted living and had spent down in that setting. DHS then conducted a study based on consumer preference and choice and learned from this citizen input that, while there is a good deal of information available about different long-term care options, few consumers or their families sought it out. Others complained that when they did seek out information from a variety of sources it was often difficult to use. Consumers and family members expressed concern that they were not aware of the cost of long-term care services and housing options. The report also concluded that there was a lack of health care financial literacy in general, and long-term care financial literacy in particular. It became apparent that the way in which to reach out to the populace moving to assisted living, and therefore influence spend-down, was to implement an option that was more direct and offered at the time of a contemplated move, thereby promoting more awareness of choice prior to individuals signing a lease.

After legislation was passed supporting this change in approach, the implementation plan was developed in consultation with representatives from the industry and designed in such a way as to facilitate easy access for older adults who are considering a move. The service is now available by phone to people of all ages and income levels and is focused on helping people learn about their options before they make a decision to move to avoid costly spend down to Medicaid.

The qualifications for this service and the protocol are fairly straightforward. Registered Housing with Services providers are asked to provide information to all prospective residents and inform that resident that they should contact the Senior LinkAge Line® for options counseling. Qualifications include:

- Is intending to move to an Registered Housing with Services Setting as either recommend by their family or because they need services or have safety concerns;
- Are of any age;
- Is a Minnesota resident or is an individual that is planning a move to the state;
- Is not yet enrolled in a Medicaid waiver (falls into the pre-eligible high risk of spend down category);
- Are not seeking a lease-only arrangement in a subsidized housing setting (exempts people who are not using services);
- Is not receiving or being evaluated for hospice services;

- Does not have a long-term care plan that covers planning for incapacitation with sufficient assets covering 60 months housing and services costs; or
- Has been referred by a hospital discharge planner because the hospital determined, using the Community Living Mini Assessment that the individual was:
 - In need of home modifications;
 - At risk of falls;
 - In need of medication management;
 - In need of access to transportation or support to get to primary care physician follow up appointments;
 - In need of access to caregiver support;
 - Have caregiver stress;
 - In need of chronic disease management follow up and education; or
 - In need of service coordination to manage activities of daily living.

The caller receives a validated risk screen that determines risk of permanent entry to assisted living and/or nursing home placement and spend-down to Medical Assistance that was developed by the Minnesota Board on Aging with assistance from the Area Agencies and Dr. Joseph Gaugler, PhD, University of Minnesota School of Nursing. The screen supports a conversation between the Long-Term Care Options Counselor and the caller about:

- Ability to manage activities of daily living.
- Access to caregivers.
- Injurious falls.
- Memory loss concerns.
- Caregiver stress.

The screening results in a determination that the individuals is at no, low, medium or high risk of nursing home placement. The current metrics are: 57% are at high risk of nursing home placement at screening, 26% are at moderate risk, and 12% are at low risk.

High risk callers are immediately offered a triage into a county based long-term care consultation and encouraged to get a face-to-face in-home assessment. Other callers, or those who don't want

a referral for an in home assessment, are provided with phone-based long-term care options counseling that focuses on a review of personal strategies to remain in one's home through modifications, services and resources, understanding benefits and other consumer-directed supports. The counselor also works with caregiver concerns and reviews options for support - including referrals to caregiver consulting services that can assist with supporting the caregivers directly.

After receiving the consultation assistance, individuals decide whether or not they wish to pursue moving into a housing with services setting or perhaps choose another option; that decision is reviewed at a 10-day follow up. Callers that choose not to move also get a six-month follow up. Callers who don't want options counseling may easily decline long-term care options counseling. All callers receive verification of the counseling and are offered a packet entitled *Before You Move* which has helpful information about options for remaining at home, reviewing settings, and comparing costs should they choose to move and finding resources.

This initiative results in savings to the Medicaid program. The initial assumption around fiscal savings was projected based on people making more appropriate decisions around purchase of services in a setting and around the setting they choose. Savings were not predicted based on delay of spend-down. An evaluation is being conducted. It is notable that 163 or about six percent of the callers made the decision not to move and another 159 remained undecided as of the 10 day follow up.

During the 2012 Legislative session, the law was revised to require the ADRC to work more closely with hospitals and health care homes and facilitate referrals of older adults who are at risk of nursing home placement to the Senior LinkAge® Line for the risk screen and long-term care options counseling. These changes are effective Oct 1, 2012. Business process modeling was done with representatives of health care partners including representatives of ICSI's RARE campaign and other health care and long-term care provider associations. The protocols will be implemented by October of 2012. The representatives assisted in an implemented service strategy that compliments the various initiatives coming from the federal and state level that support more effective transitions. The ADRC will have a role of ongoing follow up and transition support and will not duplicate care transitions work or the work of a clinic transition coordinator or navigator. This revision to the service was also projected to realize savings to the Medicaid program.

5.4 What we want to change

Minnesota seeks to expand access to transition supports for two targeted groups of pre-eligibles that are high risk of spend-down to Medicaid. The initiative will focus on people entering a nursing home or who are planning a move to assisted living, who are targeted as pre-eligible and at high risk of spend-down. The target group will be screened out by Senior LinkAge Line® long-term care options counselors or by a nursing home, hospital or health care home discharge

planner or social worker, using a new Community Living Mini Assessment that is in development in partnership with Dr. Greg Arling at the Center for Aging Research at the University of Indiana utilizing the transition tools cited above. The characteristics of this group are:

- Has dependencies in two activities of daily living;
- Has had one or more institutional stays and is at risk of a future stay because the person had one or more readmissions within one calendar year of the initial admit and fall into a target “Rate Utilization Group (RUG)” category;
- Is at risk due to:
 - Need for home modifications;
 - At risk of falls;
 - In need of medication management;
 - In need of access to transportation or support to get to primary care physician follow up appointments;
 - In need of access to caregiver;
 - Have caregiver stress;
 - In need of chronic disease management follow up and education; or
 - In need of service coordination to manage activities of daily living.
- Is age 70 or older but they may be younger based on risks;
- Is a Minnesota resident or is an individual that is planning a move to the state; and
- Has not been determined eligible for Medicaid due to availability of assets but is at high risk of spend-down of assets with 24 months.

Minnesota seeks federal matching funds on the state funds used for existing Return to Community efforts that are currently targeted to a narrow profile of people who remain in a nursing home for 90 days, as well as new state spending that will be used to expand access to the Community Living Specialists for individuals who meet the target characteristics outlined above.

The target group was selected based on data analysis conducted reviewing 2011 MN Nursing Home admissions using MDS 3.0 RUG III categories. In reviewing the data, most people are admitted into a nursing home for a short stay such rehabilitation and then leave. Approximately 21% (projected to be 10,214 people of an estimated 47,740 admits in any given year) of those admitted have another admission or more ranging from two to eight admissions throughout the year.

Of those people readmitted, there are three RUG IV (effective January 1, 2012) groups that will be targeted for the reasons cited below using the data analysis from RUG III. The Community Living Mini Assessment will target these groups:

- Clinically Complex-include those who need frequent physician visits and follow ups due to multiple medical conditions, i.e. pneumonia, oxygen therapy while a resident, surgical wounds or open lesions.

- Reduced Physical Functioning- include those who have decreased ADL capacities and could benefit from restorative therapy.
- Special Care-Low- including those who need assistance with ADLs, may be receiving dialysis treatment for 2 or more wounds, or on a tube feeding that provides at least 51% of total daily calories and can be monitored and treated with ongoing follow-up and supervision.

These individuals tend to need support through the use of evidence-based tools. Through Minnesota’s award-winning validated intervention and other comparable studies, it has been demonstrated that, with some modest assistance, individuals can use their own resources effectively for their care and avoid institutionalization.¹⁶ Most want to and can continue to remain in their home.

The Community Living Specialists function offered through Return to Community Minnesotahelp Network™ - ADRC have demonstrated that, with a modest amount of the right services (transition support and phone based follow-up) delivered at the right time (prior to a move or before they move and sell their home), consumers can effectively transition from a hospital to home, avoid readmissions, remain in their home and then further, avoid a nursing home stay and successfully manage their own care over time.

Through this proposal, DHS is seeking to maximize and access federal financial participation to enable expansion of these two currently state-funded initiatives in order to provide more assistance and support to pre-eligibles in order to assist more people to avoiding risk of spend down to Medicaid. The effort will result in:

- Expanded access to Community Living Specialists that provide long-term care options counseling using the Return to Community protocol by seeking 50% FFP on the state funds for this function.
- Maximized access by generating 50% federal match on the Registered Housing with Services Long-Term Care Options Counseling on the state funds portion of the long-term care consultation allocation.
- Realized additional savings to the Medicaid program, thereby making this proposal a budget neutral initiative.

To summarize, additional counselors will be provided at earlier critical pathways to long-term care (hospital, clinic, discharge follow up). They will focus on expanding access to a prevention approach using evidence-based screens for risk that have been developed over the last several years by the Senior LinkAge Line®. The initiative will offer the Return to Community follow-up

¹⁶ Ibid.

protocol to people who decide not to move to registered housing with services settings, and to people entering a nursing home who screen at risk of a future nursing home stay. This approach will be reviewed for applicability to people with disabilities (younger adults) and the age threshold to which this intervention would be applied. A final decision around expansion will be made by June 30, 2013.

5.5 Fiscal Analysis

DHS evaluated the experience of current state-funded efforts to predict the savings that will result from the Demonstration to Expand Access to Transition Supports will save more money in Medicaid than it will cost. The fiscal analysis is set out at Attachment O.

6 Empower and Encourage Housing, Work, Recovery and Independence

6.1 Demonstration to Empower and Encourage Independence through Employment Supports

Helping individuals maintain employment has been shown to delay or prevent the need to qualify for disability services, which can result in lower state and federal expenditures. Mental health recovery models cite employment as a factor that contributes to recovery by contributing to people's independence, self-esteem and feelings of self-worth, as well as by providing the kinds of social connections that result from working. Paid employment also contributes to economic stability and potentially interacts with people's ability to access and maintain housing.

Investment in employment supports has the potential to contribute in a positive way to Medical Assistance (MA) reform. These concepts were supported by Minnesota's Demonstration to Maintain Independence and Employment, Stay Well, Stay Working, also known as DMIE.

<http://staywellstayworking.com>

Building upon the experience gained through the Demonstration to Maintain Independence and Employment, Minnesota proposes to provide navigation, employment supports and benefits planning to help people:

- Maintain or increase stability and employment;
- Increase access to and utilization of appropriate services across systems;
- Reduce use of inappropriate services;
- Improve physical/mental health status;
- Increase earnings; and
- Achieve personal goals.

Minnesota has learned from several projects aimed at decreasing barriers to employment and improving employment outcomes of people with disabilities. These include:

- **Pathways to Employment**, which provided policy and program support to the Medical Assistance for Employed People with Disabilities (MA-EPD) program, developed policies that focused on employment within community integration and consumer-directed initiatives, and worked within DHS and with partner agencies to generate ongoing support of employment of people with disabilities. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVE&RevisionSelectionMethod=LatestReleased&dDocName=id_017355
- **The Demonstration to Maintain Independence and Employment (DMIE)**, which was a research project completed in 2010 that studied the effects of providing a comprehensive set of health, behavioral health care services and employment-related supports to employed persons with serious mental illness. Compared to the control group, DMIE participants were less likely to pursue a disability determination, experienced improvements in functioning and greater job stability, earned higher wages, and were less likely to delay or skip needed care due to cost. <http://staywellstayworking.com/>
- **Individual Placement Support (IPS)**, which was a program funded by a Johnson and Johnson/Dartmouth demonstration grant, tested supported employment, or IPS/supported employment in six pilot sites. Principles of the IPS model have been integrated into ongoing efforts within DHS, including motivational interviewing training for mental health and addictions treatment staff and Evidence Based Practice Fidelity scale reviews for mental health agencies. <http://www.dartmouth.edu/~ips/page3/page10/page10.html>

DHS currently provides employment support services through the home and community-based waiver programs, mental health services, and the Minnesota Family Investment Program.

6.1.1 First Phase

This demonstration seeks to target a group of people who are at a critical transition phase of life to help determine if telephonic navigation, benefits planning, and employment supports can help prevent destabilization and reduce application for disability benefits while providing a positive impact on the health and future of participants. DHS requests federal authority to initiate a statewide demonstration program focused on following distinct groups who are eligible for a federally funded health care program:

1. Medical Assistance Expansion recipients age 18-26 with a potentially disabling serious mental illness as identified used ICD-9 diagnostic codes (290-301 and 308-319) and health care claims associated with these diagnoses within the past 12 months. Preliminary numbers indicate 3,950 potentially eligible.
2. Medical Assistance for Employed Persons with Disabilities recipients age 18-26. Preliminary numbers indicate 141 potentially eligible participants.
3. MFIP parents who have turned to cash assistance as minor parents or because of the demands of caring for a seriously ill family member. Preliminary numbers indicated 114 potentially eligible participants.
4. Medical Assistance recipients identified as in transition from the Department of Corrections. Services will be offered to approximately 300 Medical Assistance recipients in a yet to be determined region.
5. Medical Assistance recipients ages 18-26 who have exited foster care. Preliminary numbers indicate 2,500 potentially eligible participants.

Based on the number of potentially eligible participants who enrolled in DMIE, we anticipate between 10% and 25% of those eligible for services will participate with a low estimated number of 420 participants. Enrollment will be capped at 800 participants at any given time. Participants will be eligible for services for six months at which time a follow-up assessment will be given to determine level of stabilization or need for service continuation. Those determined to have stabilized will receive periodic follow-up. Services will be offered as necessary to those who meet eligibility requirements for the life of the project. DHS will continue to outreach to new participants as people move out of the project. It is estimated that 7,600 participants could enroll during a 5 year demonstration.

6.1.2 Outreach

Potential enrollees will learn about this project through strategies previously used by the DMIE project:

Informational letters - Staff will send informational letters to individuals identified as potentially eligible for the project.

Telephonic outreach calls - Informational letters will be accompanied by staff follow-up calls.

6.1.3 Services

Coordinated services will be offered as a wrap-around to Medical Assistance, Medical Assistance Expansion and Medical Assistance for Employed Persons with Disabilities (MA-EPD). Participants will access services by contacting navigators who will be contracted through community organizations. Navigators will be located in the organizations' office sites. Navigators will have access to the administrative and technical systems of the Disability Linkage Line®. The Disability Linkage Line® (DLL) is a free, statewide information and referral resource that provides Minnesotans with disabilities and chronic illnesses a single access point for all disability related questions. Within the DLL is an interactive online tool called Disability Benefits 101 (DB101). DB101 helps people with disabilities learn how income and benefits interact so that they can make informed choices about their work, manage their benefits and maximize their potential.¹⁷ This network will provide navigators with a referral system to services which best help participants pursue their self-identified employment, health and personal goals.

Navigators will provide:

- Guidance in accessing needed medical, mental health, employment support and housing support services;
- Phone assistance focused on person-centered employment and life planning;
- Support to strengthen current employment;
- Support and referrals to find competitive employment;
- Health care benefits eligibility access, orientation and education– assist with benefits access, ensure access to right service at right time, encourage preventative care and act as liaison between participants and managed care organizations when necessary;
- Options counseling to recognize available support;
- Referral to appropriate outside entities that provide individualized services which navigators may be unable to provide;
- Follow up to ensure people's needs are met and address new needs as they arise; and
- Problem solving assistance to reduce barriers.

6.1.4 Provider Qualifications

For an organization to be considered for participation in the project as a navigation site, it must satisfy the following qualifications:

- The organization must have a demonstrated history of providing employment assistance services to workers who are coping with physical and or mental health issues.

¹⁷ Disability Benefits 101 can be found at the following website: <http://mn.db101.org/>

- The organization must have knowledge of and experience working with these populations.
- The organization's staff must have an adequate number of mental health professionals to serve demonstration enrollees.

Additionally, candidates for navigator positions with a Master's degree in Rehabilitation Counseling, Psychology, Social Work or similar social or human services field with two years' experience working with persons with complex physical or mental health issues will be sought. Minimum qualifications are a Bachelor's degree in one of the above noted areas.

To encourage similarities between this demonstration and the DMIE research demonstration, vendors will be limited and chosen through an RFP process and many procedures used in DMIE will be used. We anticipate this approach will promote similar project goals, produce similar participant outcomes and strengthen project evaluation.

6.1.5 Evaluation

Progress toward the following demonstration goals will be tested:

- To offer strengths-based navigation and employment support services for people in life transition phase.
- To ensure access to appropriate health care services at the right time, decrease duplication of services and decrease progression of potentially disabling conditions.
- To stabilize employment and/or increase income, increase independence and decrease public program utilization.

The evaluation will also study:

- Job stability;
- Job satisfaction;
- Income;
- Frequency and severity of symptoms of physical health conditions;
- Frequency and severity of symptoms of mental health conditions;
- Quality of life;
- Health care and navigation service utilization;
- Navigation service rates;
- Rates of application to SSA benefits; and
- Movement between Medicaid programs and health insurance exchanges.

The demonstration evaluation will focus on measuring the effectiveness of the provided resources at promoting employment and decreasing reliance on social services. Eventually this may inform policy decisions regarding people as they move in and out of health insurance exchanges.

Data Collection

Evaluation data will be gathered from Minnesota's integrated data warehouse: a central data library which includes MAXIS (state and county worker information mainframe), the Medicaid Management Information System, and billing and premium payment systems.

Additional data will be available through the Disability Linkage Line®. DLL system technology includes robust tracking services. Utilization of this system will include access to customizable tracking software to help facilitate seamless communication across different systems. Features of the tracking software can be used to:

- Ensure referral to appropriate providers;
- Ensure timely client follow-up;
- Track application for Social Security Benefits;
- Identify common client problems and needs;
- Track participant demographics including income;
- Track service utilization;
- Support reporting, monitoring and quality assurance activities; and
- Integrate planning and screening tools to build service delivery consistency.

Funding

Minnesota would also like technical assistance from CMS to determine if a portion of benefits planning services could be paid for through Affordable Care Act funding to assist people as they move between exchanges and public programs post 2014.

6.1.6 Next Steps

Minnesota envisions that analyses of these services may inform ways that employment, navigation and benefits planning services may be expanded in the future.

Services will be designed to benefit a wide range of people identified as having a potentially disabling condition and people with a certified disability. We are designing supports that may serve multiple different populations according to their needs.

Preliminary discussions have identified several groups as having characteristics consistent with those of participants in past projects who had the best outcomes with similar supports. These include:

- MinnesotaCare or Medical Assistance recipients with multiple chronic conditions;
- MFIP Family Stabilization Services recipients families with parents with serious, chronic and often multiple health problems and their children;
- Health homes participants;
- Youth ages 14-26 who have been certified as having a disability;
- Adults certified as having a disability who receive Home and Community-based Services;
- Adults certified as having a disability who receive State Plan Services; and
- People transitioning from Medicaid to exchanges and vice versa.

This demonstration is intended to inform design of a service which could, potentially, function in the future health insurance exchanges. Employment and navigation support services may help prevent exchange eligible individuals from experiencing income fluctuations above and below the MA income standard of 138% of FPG. People whose income is close to the standard are at risk of losing program eligibility and are at risk of gaps in coverage.

Future Services

For people with potentially disabling conditions, there is a continuum of ability levels and readiness to enter the workforce. For this reason, job match and support strategies must be individualized for each worker. For those individuals who are already working, there is a continuum of work effort ranging from periodic to steady employment, from part-time to full-time hours, from entry-level to professional positions, and from starting one's own business to managing an enterprise that employs others. Potential employment, benefits planning and navigation services may include Adult Rehabilitative Mental Health Services, Individual Placement and Support and the Discovery model of Supported Employment.

Considerations

This proposal intersects directly with all other DHS initiatives and reform elements as individuals served in every program may need to be connected with employment supports.

DHS will leverage existing relationships with the departments of Employment and Economic Development (DEED), Education (MDE), and Corrections and engage representatives from these agencies for collaboration.

Employment supports should be included as a component of holistic care models. We will engage stakeholders from the medical provider community to research collaboration opportunities, as well as continuing to engage community stakeholders.

Continued fiscal analysis will be necessary to make decisions regarding potential expansion of the service to other populations. DHS will also conduct further analysis of how these services and supports may interact with services and supports offered by other state agencies.

6.1.7 Fiscal Analysis

The analysis of the budget impacts of this demonstration includes a projection of cost savings based on the delay of disability onset for 10% of demonstration participants. Delay of progression to disability status will result in savings as participants remain on less costly Medicaid programs. This projection is based on Minnesota's experience under the DMIE program. Program participants were less likely to apply for Social Security benefits than their control group counterparts. Significantly fewer intervention group members (4%) applied for social security disability benefits during their first 12 months compared to the control group (14%). People who are eligible for SSDI or SSI benefits are more likely to stop working and no longer pay federal and state income tax.

In addition, Minnesota would like to evaluate whether there will be additional cost savings to the state and federal governments with the relatively low cost benefit set laid out in this demonstration. Two additional areas have been identified as having potential to provide cost savings over the course of five years.

- **Medical Service Savings**

A reduction in Social Security Disability applications will provide a corresponding reduction in eligibility for the more costly Medicaid services, i.e. Medical Assistance Disabled, and Medical Assistance for Employed Persons with Disabilities. SSDI recipients qualify for Medicare coverage after two years – a reduction in disability applications would decrease this cost as well.

- **Increased Tax Revenue**

Increased earnings will provide increased tax revenue. DMIE participants had a significant increase in earnings over the control group. Intervention group participant's income increased 6% over control group participants after 24 months in the program. Increased earnings will promote movement from Medicaid programs to health insurance exchanges resulting in lower costs at the state and federal level.

The Demonstration to Empower and Encourage Independence through Employment Supports is expected to result in overall savings due to the expected projected effect of delaying onset of disability-based eligibility. See Attachment O.

6.2 Project for Assistance in Transition from Homelessness and Critical Time Intervention Pilot

Many of the people who have been added to Minnesota's Medicaid program under the eligibility expansion to adults without children group struggle with physical limitations, mental illness, chemical dependency, establishing and maintaining housing and employment, and health conditions that may result in disabilities. These conditions can also significantly interfere with the ability to connect with the social service system to gain support to meet basic needs such as housing and health care. This demonstration seeks to leverage existing knowledge and funding to reach out to homeless or at-risk individuals with a serious mental illness, including persons with co-occurring chemical substance use disorder.

6.2.1 Background

The Project for Assistance in Transition from Homelessness (PATH) is a Federal McKinney–Vento Homeless Assistance Act program administered by the Substance Abuse and Mental Health Service Administration (SAMHSA). PATH provides services for people with serious mental illness, including co-occurring substance use disorders, who are homeless or at risk of homelessness. PATH services provide community outreach, and a set of defined service activities, to engage with persons and link them to housing and mainstream resources and services.

The PATH program is effective. In 2011 eleven Minnesota PATH providers (ten counties) contacted 3,820 individuals through outreach and in-reach. Eighty percent or 3,074 people were able to enroll in services with provider assistance.

Need exceeds current program capacity and outcomes could be improved by incorporating tested support services. The need for PATH services has consistently exceeded the capacity of the program. The Wilder Research Statewide Homeless Survey has shown that the percentage and number of individuals that are homeless and have a mental illness has consistently increased since the survey started identifying self-reporting individuals with mental illness in 1991.

Minnesota's ongoing financial commitment to the Project for Assistance in Transition from Homelessness is in excess of the required non-federal match for the program by that name which is authorized under the McKinney–Vento Homeless Assistance Act program

administered by the Substance Abuse and Mental Health Service Administration (SAMHSA). Through this waiver proposal, Minnesota seeks to extend this valuable program through Medicaid matching funds for specific support services provided to PATH participants.

The services Minnesota seeks to provide under Medicaid for PATH participants are known by the umbrella term Critical Time Intervention or CTI. CTI is an empirically supported, emerging evidence-based practice, supported by SAMHSA. CTI is a time-limited case management model designed to prevent homelessness for people with mental illness following discharge from institutions by focusing services during a transition period to help the individual establish themselves in stable housing, recovery oriented services, and natural supports. CTI functions by providing emotional and practical support during critical transitions and through strengthening linkages to services and natural supports.

By leveraging the effective and time-tested PATH program and the emerging promise of the Critical Time Intervention services, Minnesota and CMS will be making a high-impact and limited investment of Medicaid funds. Funding is to be sought first under the SAMSHA program and the Title XIX contribution will be capped at an agreed-upon amount, which will result in service availability on a first contacted by outreach or in-reach, first enrolled in PATH basis. Flexibility to use local government funds on a voluntary basis as the state match is also sought under this waiver request. Virtually all of the demonstration participants are eligible for Medicaid, but a majority of participants are also completely disconnected from the social service system. Efforts like PATH are critical in establishing contact and ultimately determining eligibility for Medicaid and other social services.

6.2.2 Intervention

Individuals with a serious mental illness, including co-occurring chemical substance use disorder, who are contacted through outreach and in-reach by PATH programs, will be enrolled in PATH services. Through the use of the CTI emerging evidence-based practice PATH providers will engage PATH eligible participants and transition individuals to stable housing, services, and natural supports in the community.

6.2.3 Population

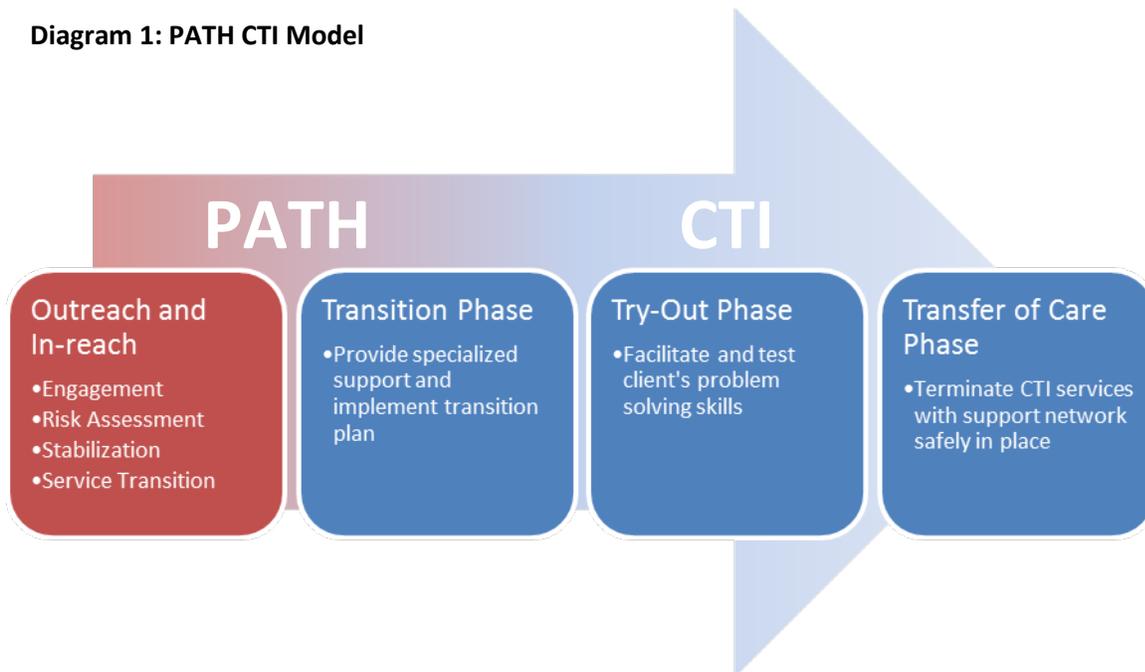
PATH eligible individuals are adults with a serious mental illness, or a serious mental illness and substance abuse, who are homeless or at imminent risk of becoming homeless and being served by a Minnesota PATH program. Eligible individuals include persons contacted via PATH outreach and in-reach services and persons that become enrolled in PATH services. The PATH target population is consistent with the population for which CTI has been demonstrated to be effective. The blending of PATH and CTI creates an

opportunity to deliver an emerging evidence-based practice with clear fidelity standards and demonstrable outcomes that will assure effective services for a very high needs population.

6.2.4 PATH CTI Pilot Model

The PATH CTI model (Diagram 1) combines the outreach, in-reach, and other defined PATH services with the CTI evidence-based practice framework for service delivery. PATH outreach and in-reach provides the initial service for engaging identified individuals, conducting a risk assessment of immediate and basic needs, facilitating eligibility determination and stabilization of the needs, and by providing service transition to assure linkage to needed mainstream services. Upon completion of PATH outreach or in-reach the individual transitions to the PATH CTI time-limited case management model. Utilizing the three phases of CTI, transition, try-out, and transfer of care, through PATH eligible services individuals are transitioned into housing, assisted with developing the skills for and resources for stabilizing in housing, and transitioned to ongoing service and natural support systems.

Diagram 1: PATH CTI Model



The PATH CTI model addresses the five primary areas of CTI intervention listed in Table 1: 1) psychiatric treatment and medication management; 2) money management; 3) substance abuse treatment; 4) housing crisis management and prevention; and 5) family

interventions. PATH eligible services align effectively with the CTI primary areas of intervention (Table 1).

In Minnesota the primary services provided by PATH are outreach, including in-reach, and case management. Outreach and in-reach are a pre-CTI intervention that engages a person to link PATH and CTI-eligible individuals. A potentially time intensive process, outreach and in-reach is a unique PATH service that is funded through the PATH grant process. PATH intensive case management service aligns with the CTI case management model of service provision for the identification and implementation of CTI interventions. The remaining eligible PATH services can be linked to the primary and secondary areas of CTI intervention as identified in Table 1. PATH training is utilized to assure that staff has the skills and tools needed to provide effective services. Training is built into the service expectation for CTI since staff needs to be trained in the effective provision of the evidence-based practice.

Table 1: PATH Service and CTI Intervention Alignment

PATH Eligible Services	Five Primary Areas of CTI Intervention
<ul style="list-style-type: none"> • Outreach • Case management 	
<ul style="list-style-type: none"> • Screening and diagnostic treatment • Community mental health 	<ul style="list-style-type: none"> • Psychiatric treatment and medication management
<ul style="list-style-type: none"> • Habilitation and rehabilitation 	<ul style="list-style-type: none"> • Money management • Family interventions
<ul style="list-style-type: none"> • Alcohol or drug treatment 	<ul style="list-style-type: none"> • Substance abuse treatment
<ul style="list-style-type: none"> • Housing services for stabilization • Supportive and supervisory services in residential settings 	<ul style="list-style-type: none"> • Housing crisis management and prevention
	Secondary Areas of CTI Intervention
<ul style="list-style-type: none"> • Referrals for primary health services, job training, education services, and relevant housing services 	<ul style="list-style-type: none"> • Life skills training • Vocational training • Education
<ul style="list-style-type: none"> • Staff training 	

6.2.5 Policy Direction

Persons with serious mental illness or with co-occurring chemical dependency, who are homeless or are at significant risk of homelessness, have many complex issues that negatively impact their ability to stabilize their mental or chemical health and have positive health and recovery outcomes. PATH is a unique and vital program that outreaches to and engages the population in order to help stabilize their lives and link

them to mainstream services. CTI as an emerging evidence-based practice provides a model framework for effective service provision with the PATH population. The time limited CTI process provides clear direction for service provision that is targeted to individual client need, optimizes the use of valuable staff resources, and assures that PATH CTI clients are able to transition to sustainable services. As a unique resource, PATH services are frequently overburdened due to the high number of individuals with serious mental illness (SMI) that are homeless, lack other dedicated outreach programs, have intensive level of client needs, and has limited resources to mainstream clients. The PATH CTI Model is a clear service design with demonstrable outcomes that will serve clients effectively, guide providers, and deliver services and data that can inform local and state mental health authorities.

6.2.6 Implementation

PATH providers will need time to be trained in the use of CTI and will need technical assistance for incorporating the PATH CTI model into existing services and local mental health system. The training and technical assistance process is estimated to take one year and will be a focus of the 2013 PATH training. The integration of PATH and CTI will require technical assistance from SAMHSA to assure that the model is accurately integrated with PATH services. This process includes informing SAMHSA about the PATH CTI model and proposed changes to PATH services in Minnesota in the SAMHSA FFY 2013 PATH Request for Application, obtaining approval to implement the model, and seeking SAMHSA PATH technical assistance during the course of FFY 2013. PATH CTI Model services are projected to be fully implemented in FFY 2014.

Eligible providers for the PATH CTI Pilot will be a county PATH grant recipient, or contracted non-profit, agency staff that meets the following qualifications:

- Successfully completed a DHS recognized course of training on the use of Critical Time Intervention;
- Be skilled in the provision of outreach and in-reach services for adults who have a serious mental illness, or serious mental illness with a co-occurring substance use disorder, who are homeless or imminent at-risk of homelessness;
- Be skilled in the process of identifying, assessing, and addressing a wide range of client strengths and needs;
- Be knowledgeable about local service, housing, and community resources, and how to use those resources to benefit the client; and
- Is a mental health professional, or are supervised by a mental health professional.

6.2.7 Evaluation

This demonstration will use PATH providers to outreach and engage in services adults with serious mental illness, or with a co-occurring substance use disorder, who are homeless or at risk of becoming homeless. Through the use of the CTI emerging evidence-based practice PATH providers will engage participants in services and transition individuals to stable housing, services, and natural supports in the community. The PATH CTI Model will incorporate PATH data elements that identify the number of persons served, demographic data, services provided, diagnosis and chemical dependency status, veteran and housing status, and homeless status. PATH providers in Minnesota also collect PATH Voluntary Outcome Measures (VOM) on referral and attainment of housing, benefits income, earned income, medical insurance, and access to primary medical care.

Below are the 2011 Voluntary Outcome Measures (VOM) for PATH. These are voluntary measures that are not federally mandated data elements. All Minnesota PATH providers report on the VOMs. In 2011 PATH providers enrolled and served 3,074 eligible adults. This data has some limitations because it includes clients that were assisted in the previous year, clients who declined service, and clients who were already enrolled in Medical Assistance. Despite these limitations, the figures are encouraging. Of the 1,096 PATH clients without insurance that were assisted in 2011, 94% or 1,031 applied for and attained access to medical insurance. Also of note is VOM 5 primary medical which indicates that 89% of clients needed and obtained primary medical care.

Table 2: PATH 2011 Voluntary Outcome Measures

Voluntary Outcome Measures	Clients Assisted	Clients Attained	% Attained
<i>VOM 1 Housing</i>	1,715	909	53%
<i>VOM 2 Benefits Income</i>	1,438	808	56%
<i>VOM 3 Earned Income</i>	895	270	30%
<i>VOM 4 Medical Insurance</i>	1,096	1,031	94%
<i>VOM 5 Primary Medical</i>	1,330	1,178	89%

The CTI emerging evidence-based practice has demonstrated impact across a range of outcomes including homeless status and retention of housing¹⁸. Additional CTI outcomes and performance measures will be designed to assess the impact of the five primary areas of CTI intervention, psychiatric treatment and medication management, money management, family interventions, substance abuse treatment, and housing crisis management and prevention.

The PATH CTI Model will provide an opportunity to integrate an emerging evidence-based practice with demonstrated outcomes for reducing homelessness. PATH data and Medicaid claims will be utilized to evaluate the demonstration. PATH program-eligible participants in pilot counties will be compared with PATH program eligible non-participants in pilot counties. The major program processes to be evaluated include:

- Identification and engagement of eligible individuals through outreach and in-reach;
- Individualized risk assessment of immediate and basic needs;
- Stabilization of immediate and basic needs through linkage to housing and services; and
- Provide case management that incorporates habilitative and rehabilitative services to teach and develop participant skills for independent living.

The primary outcomes to be evaluated include:

- Reduced homelessness and risk of homelessness;
- Increased housing access and stability;
- Increased benefits income;

¹⁸ Jarrett, M., Thornicroft, G., Forrester, A., Harty, M., Senior, J., King, C., Huckle, S., Parrott, J., Dunn, G., and Shaw, J. (2012) of care for recently released prisoners with mental illness: a pilot randomised controlled trial testing the feasibility of a Critical Time Intervention. *Epidemiology and Psychiatric Sciences*, 21:187-193.

Chen, FP (2012) Exploring how service setting factors influence practice of critical time intervention. *Journal of Society for Social Work and Research*. 3, 51-64. Herman, D., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., Susser, E. (2011). A randomized trial of critical time intervention in persons with severe mental illness following institutional discharge. *Psychiatric Services*. Jul;62(7):713-9.

Herman, D., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., Susser, E. (2011). A randomized trial of critical time intervention in persons with severe mental illness following institutional discharge. *Psychiatric Services*. Jul;62(7):713-9. New York Presbyterian Hospital and Columbia University. The Critical Time Intervention Training Manual. Substance Abuse & Mental Health Services Administration. <http://ctiplatform.nl/Pres-tools/CTImanual.pdf>

- Increased earned income;
- Increased access to medical insurance;
- Increased access to primary medical care;
- Increased and consistent access to community mental health treatment; and
- Decreased use of emergency services (hospitalizations, ED, ambulance).

6.2.8 Definitions

Outreach and In-reach

- Outreach is to locate, contact, and engage individuals who are living in locations not meant for human habitation or who are unstably housed. In-reach is to individuals who are in settings, such as shelters, corrections, hospitals, treatment centers, and health care centers, and who do not have access to housing. Components of outreach and in-reach services include:
 - Engagement: identification of individuals in need, establishing relationship and development of rapport to engage the person in service.
 - Risk assessment: screening for immediate and basic needs (food, clothing, shelter, income, and health care), and early identification of service needs.
 - Stabilization: eligibility determination, assisted referral and linkage to resources and services for meeting immediate and basic needs.
 - Service transition: completion of outreach and in-reach by transitioning to resources and services that address ongoing basic needs.

CTI Transition Phase

- Provide specialized support and implement transition plan: CTI worker makes home visits. Accompanies clients to community providers. Meets with caregivers. Substitutes for caregivers when necessary. Gives support and advice to client caregivers. Mediates conflicts between client and caregivers.

CTI Try-Out Phase

- Facilitate and test client's problem solving skills: CTI worker observes operation of support network. Helps to modify network as necessary.

CTI Transfer of Care Phase

- Terminate CTI services with support network safely in place: CTI worker reaffirms roles of support network members. Develops and begins to set in motion plan for long-term goals. Holds a recognition event or meetings to symbolize transfer of care.

Minnesota Medical Service Coordination

- Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department as an eligible procedure under a state healthcare program for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

6.2.9 Fiscal Analysis

The fiscal analysis of this demonstration is set out at Attachment O. The analysis assumes medical savings related to the housing support interventions consistent with the research summarized at section 6.3.6 below.

6.3 Housing Stability Services Demonstration

6.3.1 Statement of Proposal

In Minnesota, the recent expansion of Medicaid eligibility to a broader group of adults without children has created an opportunity to serve those individuals who traditionally have “fallen through the cracks” of our existing system. Our demonstration proposal aims to better serve adults with chronic medical conditions, frequent use of high cost medical services and identified housing instability with a new benefit called Housing Stabilization Services.

National research shows that stable housing can improve stability of employment, save health care dollars and contribute to personal and family stability. Improved housing access and stability is a necessary platform that when combined with coordinated necessary health care, has been shown to reduce health care costs by reducing costly institutional, crisis, and treatment services.

Prior to Minnesota’s 2011 Medicaid expansion, many single adults without children were not eligible for health and community living supports through Medicaid. Many of those with a lack of stable housing combined with high levels of poverty and chronic health conditions faced barriers to gainful employment resulting in severed ties to personal support systems and decreased independence.

With this demonstration, we aim to craft eligibility for the Medicaid service delivery system to be informed by risk factors indicating functional need rather than solely on certified diagnosis. We believe this is one way to eliminate unnecessary barriers, resulting in fewer systems gaps and fewer people left without needed services.

We propose that a new set of Housing Stabilization Services become available, comprised of service coordination plus one or more of the following services most needed to maintain stability and independence in the community:

- Service Coordination
- Outreach/In-Reach
- Tenancy Support Services
- Community Living Assistance

These services will be individualized through person-centered service plan development to help access, establish, and retain housing, as well as access necessary healthcare and economic resources, and other supports. Housing Stabilization Services may be short-term or on-going and vary in intensity depending on the needs of the individual.

Housing Stabilization Services will incorporate elements of the Housing First model of supportive services, as recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based best practice to end homelessness. The Housing First model is designed to help people move quickly into housing, regardless of other identified service needs that may need to be addressed longer-term, and remain as necessary to stabilize an individual in housing.

The goals of this demonstration are to:

1. Increase access to necessary and appropriate levels of health and other community living supports for people on Medicaid.
2. Improve housing stability for recipients of Housing Stabilization Services.
3. Reduce costly emergency medical interventions, including inpatient medical and psychiatric hospitalizations, emergency room visits, and ambulance transports.
4. Improve consistency of care by helping to establish a relationship with a primary care provider.
5. Increase opportunities for independent community living.

While a demonstration of Housing Stabilization Services is proposed here to request waiver authority under Section 1115 of the Social Security Act, we are interested in using authority under Section 1915(i) for this project and we would like to work with the Centers for Medicare and Medicaid Services (CMS) to determine the best approach.

6.3.2 Proposed health care delivery system

We will establish and consult with a housing stabilization implementation council which will inform the process of identifying provider qualifications as well as create a screening tool to determine potential eligibility.

6.3.3 Eligibility Requirements

There are two target groups for Housing Stabilization Services which both include adults with chronic medical conditions, frequent use of high cost medical services and identified housing instability.

Target Group One

- Medicaid recipient
- Eligible for General Assistance with one of the following bases of eligibility according to MN Statute 256D.05:
 - Permanent Illness or Incapacity;
 - Temporary Illness or Incapacity;
 - SSI/RSDI Pending;
 - Appealing SSI/RSDI Denial; or
 - Advanced Age.
- Homeless: Lacks a fixed, regular and adequate nighttime residence, meaning the individual has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less, and who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

Target Group Two

- Medicaid recipient
- Eligible for Group Residential Housing, which requires a basis of eligibility for General Assistance according to MN Statute 256D.05, or identified as aged, blind or disabled as determined by eligibility criteria by the Social Security Administration for Supplemental Security Income, and living in one of the following settings:
 - A housing with services establishment as described by MN Statute 256I.04, Subd. 2a; or
 - The supportive housing demonstration for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome according to MN Statute 256I.04, Subd. 3 (4).

The table below demonstrates that the prevalence of certain chronic medical conditions and costly service utilization among the combined target population are significantly higher than the overall Medicaid adults without children expansion population. However, Target Group Two has a lower medical service utilization than Target Group One. We attribute this difference to the impact of community-based housing for members of Target Group Two.

Characteristics of Target Population		
Prevalence in Target Groups Compared to Overall Medicaid Adults without Children Early Expansion Population		
MEDICAL DIAGNOSIS	Target Group One (General Assistance)	Target Group Two (Group Residential Housing)
Chemical Dependency and Abuse	135% more	106% more
Mental Illness	138% more	114% more
Diabetes	127% more	58% more
Heart Disease	135% more	100% more
Hypertension	132% more	105% more
Asthma	142% more	173% more
Chronic Liver Disease	146% more	189% more
Chronic Kidney Disease	140% more	92% more
MEDICAL SERVICE UTILIZATION (Fee-for-Service)	Target Group One (General Assistance)	Target Group Two (Group Residential Housing)
Number of Inpatient Admissions	127% more	10% more
Number of Emergency Room Visits	146% more	11% more
Number of Ambulance Transports	265% more	76% more

6.3.4 Benefits for individuals who will be covered under the demonstration

Housing Stabilization Services will include Service Coordination plus one or more of the following services most needed to maintain stability and independence: Outreach/In-Reach, Tenancy Support Services, Community Living Assistance.

Service Coordination: Services that are designed to coordinate an individual’s stabilization of health and well-being across multiple systems (i.e., medical, mental

health, chemical health, employment, legal). Activities can vary in intensity, duration, focus, staffing and location(s). Service coordination includes:

- Assessment – Identify with a person their strengths, resources, barriers and need in the context of their local environment.
- Service Plan Development – Develop an individualized person-centered service plan with specific outcomes based on the assessment.
- Connection – Obtain for the person the necessary services, benefits, treatments and supports.
- Coordination – Bring together all of the service providers in order to integrate services and assure consistency of service plans.
- Monitoring – Evaluate with the person their progress and needs and adjust the plan as needed.
- Personal advocacy – Intercede on behalf of the person or group to ensure access to timely and appropriate services.
- Transportation – Provide transportation and accompaniment as necessary to appointments.
- Assistance with application for benefits.

Outreach and In-reach: Outreach is to locate, contact, and engage individuals who are living in locations not meant for human habitation or who are unstably housed. In-reach is to individuals who are in settings, such as shelters, corrections, hospitals, treatment centers, and health care centers, and who do not have access to housing. Components of Outreach and In-reach services include:

- Engagement: Identification of individuals in need, establishing relationship and development of rapport to engage the person in service;
- Risk assessment: Screening for immediate and basic needs (food, clothing, shelter, income, and health care), and early identification of service needs;
- Stabilization: Eligibility determination, assisted referral and linkage to resources and services for meeting immediate and basic needs; and
- Service transition: Completion of outreach and in-reach by transitioning to resources and services that address ongoing basic needs.

Tenancy Supports: Services that are designed to identify individual housing needs and preferences; assess barriers and develop a person-centered plan to resolve barriers to accessing, establishing, and retaining housing. The provision of these services helps people find affordable units, access housing subsidies, and negotiate leases. Individuals may require assistance to overcome barriers, such as poor tenant history, credit history and discrimination based on ethnicity, gender, family make-up and income source. Service providers may develop a roster of landlords willing to work with the program and engage in strategies to incent participation. Tenancy supports may include:

- Assistance with finding housing;
- Assistance with application for housing;
- Assistance with landlord negotiation;
- Assistance with securing furniture and household supplies;
- Assistance with understanding and maintaining tenant responsibilities of lease;
- Assistance negotiating conflict with landlord or neighbors; and
- Budgeting and financial education.

Community Living Assistance: 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 \$600 per person, per month and would be exclusionary of home and community-based waiver services as well as the proposed Community First Services and Supports (CFSS).

We will consult with a housing stabilization implementation council which will inform the creation of an assessment tool to determine the need for ongoing services.

6.3.5 Enrollment and Budget

Please see Attachment O for the budget analysis.

6.3.6 Research hypothesis and evaluation design related to the demonstration proposal

The following hypotheses relate to a population of adults with chronic medical conditions, frequent use of high cost medical services and identified housing instability:

1. Housing Stabilization Services will increase access to necessary and appropriate levels of health and other community living supports, as evidenced by an assessment of service utilization at enrollment, annually, and at termination;
2. Housing Stabilization Services will result in improved housing stability, as evidenced by an assessment of housing stability at enrollment, annually, and at termination;
3. Housing Stabilization Services will result in a reduction in costly emergency medical interventions, as evidenced by fewer inpatient hospitalizations, emergency room visits, ambulance transports, and psychiatric hospitalizations; and
4. Housing Stabilization Services will result in improved consistency of care by helping to establish a relationship with a primary care provider.

6.3.7 Supporting Research

The medical savings estimates are supported by research involving similar target populations and service interventions across the United States.

Significant reduction in emergency room utilization. A study of the Chicago Housing for Health Partnership program found that an intervention for 200 homeless individuals who were provided housing and case management services resulted in 24% fewer emergency room visits than a similar sized, randomized control group over an 18-month period.

Sadowski, L.S., Kee, R.A., VanderWeele, T.J., Buchanan, D. (2009). “Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Homeless Individuals,” *Journal of the American Medical Association* 301(17): 1771-1778.

Significant decrease in inpatient admissions and hospital days. The same Chicago study saw 29% fewer hospital admissions and hospital days for the intervention group compared to the control group.

(Sadowski et. al., 2009).

Reductions in psychiatric inpatient admissions. Studies of supportive housing programs report decreases in psychiatric admissions.

Larimer, M.E., Malone, D.K., Garner, M.D., Atkins, D.C., Burlingham, B., Lonczak, H.S., Tanzer, K., Ginzler, J., Clifasefi, S., Hobson, W.G., and Marlatt, G.A. (2009). “Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems,” *Journal of the American Medical Association* 301(13): 1349-1357.

A significant reduction in Medicaid costs. A study of the Seattle East Lake project reported 41% lower Medicaid costs for residents after one year of supportive housing

(Larimer et. al., 2009).

Related Research. Martinez, T.E. and Burt, M.R. (2006). “Impact of Permanent Supportive Housing on the Use of Acute Health Care Services by Homeless Adults,” *Psychiatric Services* 57: 992-999. Raven, M.C., Billings, J.C., Goldfrank L.R., Manheimer, E.D., Gourevitch, M.N. (2009). “Medicaid Patients at High Risk for Frequent Hospital Admission: Real Time Identification and Remediable Risks,” *Journal of Urban Health* 86(2): 230-241.

7 Anoka Metro Regional Treatment Center Demonstration

7.1 Statement of Proposal

Minnesota has been an advocate for and a national model of deinstitutionalization for decades, starting with individuals with developmental disabilities, then older people and people with physical disabilities, and most recently, people with a mental illness. Anoka Metro Regional Treatment Center (AMRTC) is Minnesota's last remaining non-forensic "institution." AMRTC has continued to downsize as a more robust array of community services and community-based providers has arisen: AMRTC's capacity has shrunk from 250 beds a decade ago to 110 specialized acute care hospital beds today.

All of Minnesota's other large regional treatment centers have been closed in the last decade and replaced by smaller, non-IMD community hospitals or specialty care centers. At the same time, Minnesota has made great strides in providing community-based care. AMRTC now serves primarily as a short-term intensive specialized hospital setting. AMRTC continues to play a critical role in the state's mental health care system because it provides care for people at a time when they have needs that cannot be met as safely in any other setting. Although AMRTC provides the most intensive level of care, the cost per day is lower per diem than other hospital settings in the state.

In short, Minnesota has successfully transitioned away from restrictive care settings for people with mental illness, and AMRTC plays a very different role in the state's mental health system than in the past. Unfortunately, however, people lose Medicaid eligibility when they are admitted to AMRTC. As Minnesota has increased the number and variety of community-based mental health services, it has become increasingly apparent that the loss of Medicaid eligibility for people entering AMRTC has become a significant impediment to returning to the community after treatment. When Medicaid eligibility is lost, key linkages to community mental health teams, supportive housing, and case managers can be significantly disrupted. By preventing this disruption, more people could leave AMRTC in a timely manner. Facilitating easier transition back to the community would make sense not just for the people finding it difficult to return to the community, but for the entire mental system in the state. Moving people out of AMRTC on a timely basis would allow people who need intensive treatment to get into AMRTC more quickly, lessening the stress on community mental health providers trying to care for people experiencing a crisis who need a higher level of care than can be provided in the community.

Therefore, Minnesota seeks a Section 1115 waiver to redesign the relationship of the AMRTC to the rest of the Medicaid program. Virtually all people receiving treatment services at AMRTC are Medicaid-eligible at admission or would be Medicaid-eligible if the services were available

in the community, and a majority are also Medicare recipients.¹⁹ A waiver of the federal law prohibiting Medicaid coverage for persons “residing in institutions for mental diseases” (the IMD exclusion) for people receiving services at AMRTC is critical to allow for continuity of care during a person’s transition from the community to an inpatient setting and back to the community. Granting the State a waiver of the IMD exclusion and allowing MA coverage and reimbursement while receiving treatment at AMRTC will allow Minnesota to make additional strides forward in reducing lengths of stay, reserving the AMRTC setting only for the most acute needs and assisting timely and smooth transitions back to community-based supportive services.

7.1.1 Description of current system

Minnesota has continued to downsize the Anoka Metro Regional Treatment Center (AMRTC) as a more robust array of community services and community-based providers has arisen: AMRTC’s capacity has shrunk from 250 beds a decade ago to 110 specialized acute care hospital beds today. AMRTC no longer functions as a long-term residential institution for people with a serious mental illness. However, it continues to serve discrete populations whose needs have not been met through the current service array in the community.²⁰ Almost every person admitted to AMRTC is under a civil commitment, having been found by a court to be a threat to themselves or others and in need of judicial intervention and state supervised treatment.

AMRTC also plays an important safety net role for rural Minnesota. AMRTC admitted 450 patients in CY 2011; of this number, almost 33% (140) were from non-metro counties. In addition, the patients who receive short-term treatment at AMRTC are some of the most complex individuals, with 61% of the non-metro patients being admitted to AMRTC’s Intensive Behavioral unit for people at risk of aggressive or other high-risk behaviors. With so few cases per year from smaller, and often rural, communities, it is difficult for these non-metro counties to maintain the local services necessary to support this population.

7.1.2 Problems in the current system that we want to change

Despite the development of more community-based services, communities especially those in non-metro Minnesota – still face a serious gap in the state’s mental health continuum of care: access to psychiatric beds for adults who have serious mental illnesses

¹⁹ In the final six months of CY 2011, of the 400 patients served (some repeated times) at Anoka, 379 (almost 95%) had a Medicaid number when they were admitted, and approximately two-thirds were dually eligible for Medicare and Medicaid.

²⁰ Today the AMRTC is made up of small specialized units. The Med/Psych (20-bed unit) serving people with a mental illness who also have complex, chronic medical conditions; Complex Co-Occurring (a 22-bed and a 20-bed unit) serving people with multiple disabilities in addition to their mental illness such as addictions, traumatic brain injury, intellectual disabilities and medical conditions; Mental Illness and Intellectual Disabilities (12 beds) serving people with those two diagnoses (an increasing number also have aggressive behavioral issues); and Intensive Behavioral (a 20-bed unit and a 16-bed unit) serving those people with a mental illness, often with addiction as a secondary diagnosis and a history of aggression and violence in less acute community settings

and who are aggressive or violent. When an appropriate in-patient psychiatric bed for this population is not readily available in the community, it can result in turmoil for hospital emergency departments or psychiatric units, unsafe conditions for patients and staff, and patients ending up in jail instead of receiving the mental health services they need. Congress has begun to recognize this very problem in the context of private IMDs by authorizing and funding the Medicaid Emergency Psychiatric Demonstration under Section 2707 of the Affordable Care Act. The federal demonstration provides States with federal Medicaid matching funds to reimburse private psychiatric hospitals for emergency inpatient psychiatric care provided to Medicaid recipients aged 21 to 64 who are experiencing a psychiatric emergency.

Minnesota's State Operated Service system has undergone a significant transformation. All of Minnesota's remaining large regional treatment centers were closed in the last decade and replaced by smaller, non-IMD community hospitals or specialty care centers. Thus, the original policy concerns underpinning the IMD exclusion in Medicaid have been greatly reduced in Minnesota. At the same time, it has become increasingly clear that lifting the IMD exclusion would play a significant positive role in continuing Minnesota's transition to providing care for seriously mentally individuals in the least restrictive setting. Therefore, Minnesota seeks to lift the IMD exclusion for this facility to complete the transition for AMRTC to a short-term, intensive hospital setting.

In addition, lifting the IMD exclusion under the AMRTC demonstration would enhance the continuum of care for individuals with the most serious psychiatric disabilities who require short-term treatment that would otherwise be covered by Medicaid if delivered in the community. By allowing Medicaid coverage to continue while at AMRTC, the demonstration would also allow people leaving AMRTC to qualify for participation in the Money Follows the Person initiative that Minnesota is preparing to implement. This would engage some of the patients with the most complex needs being discharged to participate in, and help inform, the next phase of redesigning Minnesota's community supports and services.

7.1.3 Goals for the revised system

Those with serious mental illness and aggressive tendencies are especially challenging for smaller, more rural community providers to provide services for; as a result, many of these people are served by AMRTC. In most cases, the people served at Anoka have been or would be Medicaid-eligible for services if those services were available in the community. The availability of in-patient psychiatric beds for this population is dependent upon the flow of patients through the system, the transitions that patients make between levels of care and the range of housing and support services available in the patients' local communities. Making sure that patients' transitions back to the community are smooth and coordinated across Medicaid funded services and other social services

systems requires the development of complex relationships among the levels of care, with “front door” and “back door” challenges that can only be solved if the problem is approached at multiple levels simultaneously.

7.1.4 How we want to get there, including other current reform elements already underway

The average length of stay at AMRTC is approximately 90 days; however, many people return to the community within 45-60 days. Minnesota seeks to provide comprehensive continuity of care and active participation in the person’s discharge planning across all necessary Medicaid eligible services while at AMRTC to assist in the transition back to community living. If a patient enters AMRTC and MA eligibility is NOT suspended, community medical and behavioral health providers can be appropriately engaged in treatment and discharge planning, allowing AMRTC staff to minimize the risk for disruptions in a patient’s ongoing transition services. In addition, realizing that it is the people with complex behavioral health conditions and physical conditions who have the greatest difficulty leaving AMRTC after treatment has concluded and they no longer need hospital level of care, Minnesota intends to address this by creating a 1915(i) State Plan option for those who have the greatest trouble leaving AMRTC when they no longer need a hospital level of care. Such a model aligns well with other integrated care models being developed in Minnesota, many of which are described elsewhere in this *Reform 2020* document.

7.2 Demonstration details

Minnesota seeks a waiver of the federal law prohibiting Medicaid coverage for persons “residing in institutions for mental diseases” (the IMD exclusion) for people receiving services at Anoka Metro Regional Treatment Center (AMRTC), to allow for continuity of care during a person’s transition from the community to an inpatient setting and back to the community. Granting the State a waiver of the IMD exclusion and allowing MA coverage and reimbursement while receiving treatment at AMRTC will allow Minnesota to limit use of the AMRTC setting only for the most acute needs and assist in timely and smooth transitions back to community-based supportive services. This waiver would allow the State to coordinate existing services with AMRTC in a more cost-effective and less disruptive manner while investing in further community mental health services infrastructure development as outlined in the proposed Section 1915(i) proposal at Section 9.1.4 of this document to support individuals with mental illness who are at risk for institutionalization without access to an integrated community-based system of care.

7.2.1 Evaluation

Questions to be addressed as part of this demonstration project include:

- What is the impact on the average length of stays in AMRTC due to the increased service options created by the waiver? Does the waiver decrease stays and reduce readmissions to IMDs to help meet compliance with the Olmstead Act?
- What is the MA service profile of AMRTC recipients during the year prior to entering AMRTC and the year after leaving AMRTC? How do these MA service profiles and costs compare to pre and post profiles for recipients receiving MA contract bed services as an alternative to admission to AMRTC? What are the cost comparisons for services provided during stays at AMRTC pre-waiver vs. post-waiver?
- Does the wait time for admission to AMRTC decrease to reflect more timely access to more appropriate services?
- Do the recipients discharged from AMRTC end up in more appropriate treatment settings based on the level of care needs compared to recipients discharged prior to the waiver services? Are recipients more likely to live in more independent living situations more quickly than before the waiver?

Data Collection

Evaluation of cost data will be based on information from the MMIS billing system that will provide MA claims and payment information on recipients who previously were in AMRTC prior to the waiver as well as those receiving AMRTC services after the waiver. MMIS will also provide similar cost comparisons from recipients of MA extended stay beds in the community. Recipient information on length of stay in AMRTC as well as appropriateness of treatment after discharge will be based on information from the AVATAR information system used by AMRTC. Length of time on waiting lists will be based on information collected by AMRTC and referring providers. Comparison of cost of stays at AMRTC will be based on the AMRTC financial operations cost and billing information. Information on independent living status of AMRTC recipients after discharge will be based on the Mental Health Information System (MHIS) that collects employment status and living situation status from providers of adult mental health rehabilitative services.

7.2.2 Fiscal Analysis

The fiscal analysis of the proposal is set out at Attachment O. Minnesota will request federal matching funds for expenditures for people for whom Medicaid is the primary source of coverage and for days in which hospital level of care is met. The most comparable care setting is contract beds in metropolitan hospitals with psychiatric units, where the daily rate is higher and facilities are not equipped to admit people with the highest level of psychiatric needs. The comparison is included to demonstrate that AMRTC is the most cost-effective setting in which to

provide the necessary treatment days for Medicaid eligible people with short term, acute hospital-level psychiatric needs. As noted above, this waiver would allow the State to coordinate existing services with AMRTC in a more cost-effective and less disruptive manner while investing in further community mental health services infrastructure development as outlined in the proposed Section 1915(i) proposal at Section 9.1.4 of this document to support individuals with mental illness who are at risk for institutionalization. Investment in this demonstration, as well as lessening the disruption in care caused by loss of Medicaid eligibility while receiving treatment at AMRTC will help Minnesota reduce patient stays. Moving people out of AMRTC on a timely basis would allow people who need intensive treatment to get into AMRTC more quickly, lessening the stress on community mental health providers trying to care for people experiencing a crisis who need a higher level of care than can be provided in community settings.

8 Eligibility for Adults without Children

The passage of the Affordable Care Act (ACA) allowed states to provide Medicaid coverage to adults without children. In March of 2011, Minnesota utilized the new option under the ACA to expand its Medical Assistance program under the state plan to include adults without children with incomes at or below 75% of federal poverty guidelines under this provision. ACA, however, prohibited states from imposing an asset test as a condition of eligibility. As part of this demonstration, DHS now seeks waiver authority to impose an asset test of \$10,000 on adults without children enrolled in Medical Assistance.

Effective August 2011, through the renewal of the Prepaid Medical Assistance Program Plus (PMAP+) waiver by CMS, the state became eligible for Medicaid matching funds for expenditures on behalf of adults without children with income between 75 percent and 250 percent of the federal poverty guidelines. As a condition of federal financial participation, CMS required the state to eliminate the then-existing 180-day durational residency requirement. The 2011 Legislature authorized initial implementation of federally funded MinnesotaCare for this group under these conditions, but required DHS to seek a waiver amendment in order to reinstate the 180-day residency requirement for adults without children in MinnesotaCare.

8.1 Adults Enrolled in Medical Assistance

8.1.1 Background

Prior to June 2010, adults without children with incomes at or below 75 percent of FPG in Minnesota were eligible for health insurance through two state-funded programs, General Assistance Medical Care (GAMC) and MinnesotaCare. For a single adult, the GAMC program had an asset limit of \$1,000. MinnesotaCare imposed an asset limit of

\$10,000. From June 2010 through February 2011, the GAMC program covered only prescription drugs, and a more limited benefit set was delivered through coordinated care delivery systems.

The passage of the ACA allowed states to provide Medicaid coverage to adults without children. In March of 2011, Minnesota implemented the expansion of its Medical Assistance program under the state Medicaid plan to include adults without children with incomes at or below 75% of federal poverty guidelines under this provision. ACA, however, prohibited states from imposing an asset test as a condition of eligibility.

DHS seeks waiver authority to impose an asset test of \$10,000 on adults without children enrolled in Medical Assistance.

8.1.2 Adults Enrolled in MinnesotaCare

Effective August 2011, through the renewal of the Prepaid Medical Assistance Program Plus (PMAP+) waiver by CMS, the state became eligible for Medicaid matching funds for expenditures on behalf of adults without children with income above 75 percent of the federal poverty guidelines enrolled in MinnesotaCare. As a condition of federal financial participation, CMS required the state to eliminate the then-existing 180-day durational residency requirement. The 2011 Legislature authorized initial implementation of federally funded MinnesotaCare for this group under these conditions, but required DHS to seek federal approval to reinstate the 180-day residency requirement for adults without children in MinnesotaCare. Minnesota seeks a waiver to reinstate this requirement.

9 Context of Reform: Current and Proposed Initiatives

Section 9 describes a variety of initiatives in development or underway. This information is included to provide context for the reader and information about how the demonstration proposals interact with other initiatives. These initiatives are related to the demonstration proposals discussed above, but no federal authority for these activities is requested under this Section 1115 waiver proposal.

9.1 Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions.

9.1.1 Introduction

Recent changes at the federal level offer new opportunities for states to restructure their home and community-based services. One of these is a modified 1915(i) State Plan Amendment option, which allows services typically available only in a waiver to be made available to a broader group of people with disabling conditions WITHOUT needing to

meet an institutional level of care. Specifically, a 1915(i) state plan option allows States to include any or all of the services that are allowed under typical 1915(c) waivers. These services include case management, homemaker/home health aide, personal care, adult day health, habilitation, and respite care services. In addition, the following services may be provided to persons with chronic mental illness: day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). The ACA revised 1915(i) so that States may now offer, “such other services requested by the State as the Secretary may approve.” Thus, states may now offer medically necessary home- and community- based services that enable individuals to remain in their homes – and allow children to remain with their families – before they qualify for out-of-home placement or other institutional care. This will allow for earlier intervention and amelioration of more long-term, chronic conditions.

Minnesota will engage stakeholders to evaluate a variety of options for children with an Autism Spectrum Disorder (ASD) diagnosis, including whether the modified 1915(i) state plan amendment approach would be appropriate. Minnesota will also engage stakeholders to develop a proposal for a 1915(i) state plan amendment to coordinate and streamline services for two groups with multiple and complex needs, many of whom are currently receiving services across several programs in DHS:

- (1) individuals with mental illness who are at risk for institutionalization without access to an integrated community-based system of care
- (2) adults diagnosed with complex developmental disabilities and sexual disorders living in community settings.

9.1.2 Services for Children with ASD Diagnosis:

NOTE: DHS received numerous comments to this section of the proposal during the public comment submission period and has amended the proposal to better reflect the intent of the proposal and clarify DHS’s position that autism is a medical condition, requiring medically-necessary rehabilitative and often habilitative services and supports, stretching across several years and sometimes across the lifespan of an individual.

Autism Spectrum Disorder (ASD) is often used as a general term for a spectrum of complex disorders of brain development. These disorders are characterized, in varying degrees, by difficulties in social interaction, verbal and nonverbal communication and repetitive behaviors. They include Autism Disorder, Rhett Syndrome, Childhood Disintegrative Disorder, Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS) and Asperger Syndrome. In addition, ASD can be associated with intellectual disability, difficulties in motor coordination, attention and physical health issues such as sleep and gastrointestinal disturbances. According to the Center for

Disease Control, ASD commonly co-occurs with other developmental, psychiatric, neurologic, chromosomal, and genetic diagnoses. The co-occurrence of one or more non-ASD developmental diagnoses is 83%; the co-occurrence of one or more psychiatric diagnoses is 10%. Recent data from the Centers for Disease Control put the prevalence rate at 1 in 88, up from 1 in 110 just a few years ago.

Early screening and identification of the condition and referral to timely treatment, that may, for some children, mitigate later need for services, is a priority, and often not consistently available. Minnesota will develop autism specific early intervention services to support Medicaid-eligible children who have a diagnosis of Autism Spectrum Disorder (ASD) and meet other eligibility criteria, to be determined by DHS following a stakeholder process, review of data and development of assessment and/or referral protocols. One goal is to develop access to services for children who are on Medicaid and have similar diagnoses and functional needs, and provide a truly integrated service set for these children and their families. Other outcomes include the demonstration of measurable gains and achievement of identified goals, and to have a smooth and effective transition into and coordination with school programs and/or other community services. Additionally, through a stakeholder process, Minnesota will evaluate research and identify effective services to be incorporated into home and community-based services, therapies, rehabilitation and other services to support people with autism across the lifespan, and effective collaboration between state agencies to support people with a diagnosis of ASD and their families holistically. Early intervention is a foundation that is expected to help many children achieve best outcomes, with the acknowledgement that ASD covers a spectrum and treatment and support services will be necessary for some across the lifespan.

A growing number of states are choosing to deliver autism-specific services to young children through a 1915(c) home and community based waiver. In general, 1915(c) waivers provide specific services not generally available to a broader population through the state's Medicaid plan, but they often have budgetary and/or enrollment limits. These waivers are generally developed for those with significant functional impairments who are most at risk of being institutionalized long term. As a result, many waivers (in Minnesota or elsewhere) have waiting lists.

Minnesota does not currently have a home and community-based services waiver targeted at children with ASD. Instead, Medicaid enrolled children with an ASD diagnosis receive services across several programs: home and community-based service waivers (DD or CADI); personal care assistance (PCA) services; children's mental health services, and medical services such as speech and occupational therapy or services to treat medical conditions. Many advocates have requested a waiver specifically for children with ASD; however, because children are being served in current waivers, and a new waiver would only benefit those who meet an institutional level of care, Minnesota

has sought to meet the medical and behavioral treatment needs of children through existing programs rather than through a waiver. One consideration as Minnesota develops an autism specific service set is the 1915(i) option, which allows the state to provide both rehabilitative and habilitative medically-necessary services and supports to a broader group of children with ASD who have significant functional impairments but do not otherwise qualify for a waiver or potentially would be on a waiting list for a waiver.

The program that Minnesota will design for autism-specific services will provide high quality, medically necessary, evidence-supported therapeutic and behavior intervention treatments and associated services. Covered services will seek to improve a child's communication skills, increase social interactions, and reduce maladaptive behaviors for children with ASD at a critical time in their development. The services in this ASD-specific benefit set will be developed with stakeholder input and could include services such as service coordination, evidence-based behavioral interventions, family psychoeducation, psychological counseling, other State Plan medical services and respite. The early intervention services will be individualized, evidence-based, person-centered treatment programs that address the core symptoms of ASD. The transition to more long-term services and supports that may be needed by a child and the family to help the family support the child in the home will also be developed.

Underlying this program model is the expectation that providers demonstrate children are making progress as a consequence of treatment. DHS will work with providers, medical experts and clinicians to develop agreed upon standards, assessment tools and protocols for objectively measuring progress. DHS will also explore the development of a learning collaborative to improve the quality of care for individuals with ASD in community settings. This would involve bringing together key stakeholders, setting goals for quality improvement and taking action to achieve these goals.

Currently, Minnesota does not have established guidelines for medically necessary, evidence-based, early intervention treatment services for children with a confirmed diagnosis of ASD. However, legislation from the 2012 session requires the Minnesota Health Services Advisory Council to review currently available literature regarding the efficacy of various treatments for Autism Spectrum Disorder, including an evaluation of age-based variation in the appropriateness of existing medical and behavioral interventions, and make recommendations for authorization criteria for services based on existing evidence by December 31, 2012. Those recommendations, along with stakeholder input, will guide program policy on type, frequency, and duration of treatment services to be covered by the new service set.

9.1.3 Related Policy Initiative Under Consideration to Advance Coordinated Care for Children with ASD:

Minnesota lacks a system of coordinated care that addresses the unique, intense needs of children with complex conditions such as ASD. For example, early childhood wellness check-up programs and health care homes for coordinating complex medical conditions are administered by the Minnesota Department of Health. Many children with ASD are also receiving special education services through the Minnesota Department of Education. Minnesota is a state that provides a free appropriate public education from birth under federal IDEA law; this requires that special education services and medically related services be provided to children with an assessed need from birth onward. The Department of Human Services provides health care coverage and medically-necessary services for children with Autism that are approved by state and federal authorities. Thus, in Minnesota, the human services, healthcare and education systems share responsibility for early intervention for children with ASD.

DHS intends to explore coordinated strategies for ensuring effective transition from preschool to elementary education settings. The first key transition for the integrated system would be at age three, when infant and toddler intervention services cease being driven by federal IDEA Part C law (birth to third birthday) to IDEA Part B requirements, which begin at age three and follow a child until school graduation. By focusing on developing coordinated services and transitions for younger school age children, all state agencies could learn to bridge key transition points in a coordinated and efficient manner while supporting children and their families during these transitions.

In addition, there is a Minnesota Autism Spectrum Disorder Task Force, a 19 member group consisting of representatives from the following: legislators, family members of individuals with Autism, family practice physicians, Autism advocacy groups, public school support service members, health plans as well as representatives of the State agencies of Health, Human Services, Education, and Employment and Economic Development. The task force has been meeting since February 2012 and is charged with:

1. Developing an Autism Spectrum Disorder statewide strategic plan that focuses on improving awareness, early diagnosis, and intervention and on ensuring delivery of treatment and services for individuals diagnosed with an Autism Spectrum Disorder, including the coordination and accessibility of cost-effective treatments and services throughout the individual's lifetime; and
2. Coordinating with existing efforts relating to Autism Spectrum Disorders at the Departments of Education, Employment and Economic Development, Human Services, and at the University of Minnesota and other agencies and organizations as the task force deems appropriate.

The ASD Task Force is drawing upon recommendations from the 2009 Task Force²¹, as well as the work of the Minnesota Autism/ASD Summit Committee²², in developing a statewide strategic plan that will be presented to the legislature in 2013. DHS is actively participating in that task force and will seek align its policy work with the goals of the task force whenever possible.

9.1.4 1915(i) to develop a new service titled Intensive Mental Health Recovery Services

Minnesota will develop a program under the authority of Section 1915(i) of the Social Security act to develop a new service entitled Intensive Mental Health Recovery Services to support individuals with mental illness who are risk for institutionalization and have insufficient access to an integrated community-based system of care.

Minnesota continues to work toward infrastructure development of a recovery-oriented mental health system of care to promote and improve the health and well-being of individuals with chronic mental illness. Current services include an array of supports such as assistance with basic living skills, medication education, crisis stabilization, assertive community treatment and crisis response services. Yet, issues remain within the available community-based system that result in a fragmented health care delivery system and inadequate access to timely, intensive community supports and specialized services for individualized care. While a percentage of individuals with mental illness as a primary diagnosis may still meet eligibility for home and community-based service waivers, many individuals do not meet the institutional level of care criteria yet still have significant needs for intense services and supports.

Assertive Community Treatment (ACT) is a viable option for some of these individuals. However, in very rural areas of the State with large geographic size and smaller populations, ACT has staffing and service requirements that are neither efficient nor cost effective. Because of this, Minnesota has funded several community-based small (3-5 staff) teams that combine Targeted Case Management funding, Adult Rehabilitative Mental Health Services funding and state grant funding to support an intensive, community-based team approach that meets the needs of individuals in their home community, particularly in more rural areas of the state. These teams have been successful in providing services to some of the individuals described above. In metropolitan areas, ACT is not able to further intensify the services. This complex population requires more daily habilitative services than the ACT teams are designed to

²¹ <http://www.commissions.leg.state.mn.us/asd/AutismTaskForceReport2012.pdf>

²² The Minnesota Autism/ASD Summit Committee a voluntary interagency and multi-stakeholder task force convened to provide leadership in interdisciplinary education, community services, research, and to disseminate information to strengthen the capacity of local communities to support and include individuals with autism and their families in the community.

provide. Most of these individuals need a combination of mental health and home and community-based services to live more independently in the community.

Because of the lack of these services on a statewide basis, many of these individuals are committed or voluntarily hospitalized for treatment at AMRTC. The patients who receive short-term treatment at AMRTC are some of the most complex individuals, with 61% of the non-metro patients (85 of the 140 from non-metro Minnesota in CY 2011) being admitted to AMRTC's Intensive Behavioral unit for people at risk of aggressive or other high-risk behaviors. Upon completion of treatment, they reach a level of recovery which no longer requires hospital treatment. Most of these individuals are able to be discharged and return to the community with little delay. However, approximately 200 people a year are unable to find appropriate services and supports in the community and experience delays in being discharged. These individuals have varying issues related to their mental illness that make housing and service options difficult to put in place for them when needed. Some are in need of intensive waiver services, but do not meet the institutional level of care required to qualify for a waiver. With so few cases per year from smaller, and often rural, communities, it is difficult for these non-metro counties to maintain the local services necessary to support these needs. In addition, the inability to quickly move people out of AMRTC when they no longer need hospital level of care creates longer waits for people who are on the waiting list for AMRTC. Typically, there can be up to 100 people from throughout Minnesota who are waiting for admission to AMRTC. Moreover, moving people back to the community as quickly as possible and providing the services and supports they need to live in the most integrated community setting are important obligations under the Olmstead decision, and this new benefit and service set can assist the State in its efforts to comply with Olmstead.

As mentioned above, a 1915(i) option allows services typically available only in a waiver to be made available to a broader group without needing to meet an institutional level of care. Thus, states may now offer medically necessary home and community-based services and other services that are needed to assure that individuals can be served in the community. Minnesota will develop a 1915(i) state plan option to offer more flexible community supports services that are capable of serving individuals with a serious mental illness or psychiatric condition, who have other co-occurring or complex health needs and do not need hospital level of care.

The Institution for Mental Disease exclusion waiver that Minnesota is requesting is directly related to this request. Minnesota has made great efforts to assure that the majority of care and services can be provided in an individual's home community. This has reduced the average length of stay in state-run mental health hospitals over the last few years to the point that they are beginning to resemble other community hospitals in lengths of stay. This request will be another step in that progress.

The need to provide recovery-oriented community services is an issue of great concern to mental health stakeholders. They also note that while functional limitations of an individual who has a mental illness may appear the same or similar to those of individuals with developmental disabilities, the cause and, therefore, the services provided would be different. There is a concern about the need to assure that providers of services are skilled in working with people who have a mental illness.

This 1915(i) state plan option would target those individuals who have:

1. A Serious and Persistent Mental Illness; and
2. Difficulty in finding and maintaining community services and living arrangements as evidenced by extended stays at a hospital after the staff have determined that they no longer need hospital level of care. OR
3. A risk of psychiatric hospitalization.

DHS will hold a series of stakeholder meetings in August through October 2012 to seek input on details of the target population, the services that would need to be in place to support them and funding options.

9.1.5 1915(i) for a new treatment service called Targeted Clinical and Community Services

Minnesota will engage stakeholders to design a program to be requested under the Medicaid state plan under section 1915(i) of the State plan for a new treatment service called Targeted Clinical and Community Services that will serve adults diagnosed with complex developmental disabilities and sexual disorders living in community settings. There are approximately 134 adults in Minnesota diagnosed with complex developmental disabilities and sexual disorders living in community settings. These are individuals who have engaged in harmful sexual behavior and require monitoring for community safety in addition to treatment. Treatment services available in the community for these individuals include a combination of services such as rehabilitative mental health day treatment services, day habilitation services and adult foster care.

Minnesota does not have a specific service developed to meet the unique needs of this small but complex group; therefore, the treatment services available are a combination of services never designed to meet the safety monitoring, skills training and therapeutic treatment needs of these individuals.

Minnesota proposes to develop a 1915(i) called Targeted Clinical and Community Services for this population to better integrate services so all providers are following

consistent treatment and safety monitoring protocol. A stakeholder workgroup will be convened to develop service components, provider qualifications, eligibility criteria and payment methodology.

9.2 Redesign Home and Community-Based Services

9.2.1 Overview

Minnesota has made considerable progress over the last two decades towards rebalancing the state's long-term care delivery system for older adults and people with disabilities away from largely institution-based, toward more home and community based services (HCBS) and supports. Minnesota is now a national leader in directing a higher ratio of public funds to support persons with disabilities or older adults in more cost effective home and community-based settings rather than institutional settings. In addition, the State is currently implementing several initiatives to emphasize person-centered planning across the system and improve the quality, consistency and long-term sustainability of services. A number of these major initiatives are outlined below.

In addition to the initiatives that are currently underway, Minnesota plans to make further reforms and improvements to its HCBS system in the coming years, in concert with the demonstrations that are outlined in this proposal. This includes:

- Efforts to reach individuals earlier, in order to prevent or delay use of public programs or more costly services;
- Strategies to integrate long-term services and supports with health care reforms and other initiatives;
- Planning activities that are designed to comprehensively study the availability of and statewide access to needed community supports, allowing improved management of resources;
- Further enhancements to 1915(c) waivers;
- Redesign of case management services for people receiving fee-for-service home and community-based services; and
- Strengthened systems for crisis intervention and protection of vulnerable adults.

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).

9.2.2 MnCHOICES

The Minnesota Department of Human Services (DHS), in collaboration with stakeholders, is developing a new web-based comprehensive assessment and service planning application for access to all long term services and supports in Minnesota. MnCHOICES embraces a person-centered approach to ensure services are tailored to an individual's strengths, goals, preferences, and assessed needs. Individuals will not have to go through multiple assessments to determine what services most appropriately meet their needs. Also they will have better and more consistent access to services and supports that meet their needs. By requiring lead agencies (counties, tribes and health plans) to use trained and certified assessors they will be able to improve their ability to assess individuals and develop more appropriate community support plans.

MnCHOICES was designed to assess the functional needs of individuals of all ages and with any type of disability. Based on the assessment and using information from other sources such as diagnostic and clinical assessments, a support plan is developed with the person to address their functional needs and coordinate their long term services and supports with other services including therapeutic or rehabilitative services. A similar functional need may require different services or approaches depending upon why the person needs assistance. As an example, someone who doesn't eat, may not eat because they physically cannot use their hands, or they need to learn how to eat through a structured teaching process, or they are depressed and have no interest in eating and may need cuing to assure they do eat. The approach to services and what is needed to support the person is different and the assessment process is intended to draw out information for these decisions to be made.

MnCHOICES is separate from diagnostic and clinical assessments that a person may need to determine what therapeutic or other treatment services a person may require. Many people who are assessed through MnCHOICES have had these assessments, their disability is known and they are interacting with specialists as needed. In those cases, that information is important to the assessment and support and service planning process. However, people may request assistance without previous diagnostic or clinical assessments. In these instances, MnCHOICES will gather information to prompt referrals so that the appropriate service and clinical expertise can be made available in concert with any community services. These may include a possible mental health condition, or other conditions such as a brain injury, early dementia, a health condition or a developmental disability.

Finally, MnCHOICES will allow for improved data collection that will help lead 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:

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

MnCHOICES was designed for individuals of all ages and with any type of disability or other long term service needs to understand and plan for functional community service needs. MnCHOICES uses information from diagnostic and clinical assessments that have been done to help the assessor and any team members supporting the person understand the underlying issues that result in the function need, and community support planning incorporates this information into the most appropriate service plan. A similar functional need may require different services or approaches depending upon why the

9.2.3 Aging and Disability Resource Center (ADRC)

MinnesotaHelp Network™ – Minnesota’s Aging & Disability Resource Center (ADRC)

The MinnesotaHelp Network™ is Minnesota’s Aging & Disability Resource Center (ADRC). Support is provided in person-centered ways including assistance provided over-the-phone, in-person, through interactive internet tools and through print materials. The ADRC represents a virtual model of local partners (area agencies, centers for independent living, state agencies, non-profits, providers and lead agencies) that results in improved collaboration to support clients. The phone assistance is provided via the Senior LinkAge Line®, Disability Linkage Line® and Veterans Linkage Line™. In-person assistance is provided by Long-Term Care Options Counselors who support consumers by assisting them over the phone or to in person to move from nursing homes through Return to Community (see below). Senior LinkAge Line® phone-based Long-Term Care Options Counselors conduct risk screens and triage high risk older adults into the county-based Long-Term Care Consultation service, which will soon transition into the MnCHOICES assessment.

The network also provides comprehensive web-based information and online navigators through www.minnesotahelp.info®, which is designed for consumers of all ages as well as professionals. Live chat with a long-term care options expert is also available through

the network. Finally, assistance is provided through materials available in print for those unable to access the internet.

First Contact/Regionalized Preadmission Screening (PAS) Demonstration

Currently, preadmission screening (PAS) for people entering a nursing home, as federally mandated by CFR Title 42, Public Health, Chapter IV, Part 483, is conducted through 87 access points across the state at the county level. Currently, funding for PAS, along with funding for long-term care assessments for individuals age 65 and over, is provided to counties through an allocation. As the new assessment tool, MnCHOICES, is launched, the funding mechanism must be revised to support a time reimbursement payment method. Therefore, as the new payment process is put in place, the timing is ripe for considering a reform to the PAS process. The current PAS process itself is ready for modernization. The original intent, to promote successful care transitions, has eroded, and the process has evolved into a primarily into a cumbersome paper and fax-based process, with little opportunity to impact individual decision-making. The current process excludes from PAS requirements individuals who are expected to be in the nursing facility for less than 30 days, as indicated by a physician's orders, which represents approximately 4/5 of the nursing home population. Stakeholders have expressed ongoing concern that the current design overlooks a majority of consumers. Nursing homes are a critical pathway to long-term care and consumers could benefit from follow up and getting connected to long-term care options counseling. To test this theory, in 2009 Minnesota began exploring a new way of conducting and enhancing preadmission screening functions to add more value for consumers with a goal of expanding access to long-term care options counseling, connecting consumers to more service options and increase data integrity by automating portions of the process.

The demonstration was called First Contact and was funded through state grants. It was implemented by Chisago County and the Senior LinkAge Line® Contact Center in St. Cloud. Through this pilot, a virtual model of PAS representing a collaborative approach between the county and contact center was tested and evaluated. The evaluator concluded that the model was significantly more efficient, resulting in less wait time for people who needed a full assessment and reduced time between service completion and data entry into MMIS. Consumers got more service, in a more timely fashion, and the assistance was more comprehensive, even for those in crisis. In addition, relationships between the county and the Minnesotahelp Network contact center (Senior LinkAge Line®) were dramatically improved through enhanced communication technologies. Wait time for long-term care consultation assessment improved for consumers and data entry lag time of county staff was reduced significantly.

Minnesota is currently piloting and evaluating a phase two effort that adds a health care home/hospital system and two long-term care settings to the virtualized call center, in addition to reviewing possible impacts of the First Contact model on the pre-eligible population who is at high risk of spend down to Medicaid, with the goal of documenting potential savings to Medicaid. Minnesota is also in the planning stage for statewide replication of this model through the First Contact initiative. The approach is being reviewed for applicability to people with disabilities and final decision about expansion will be made by June 30, 2013.

Return to Community

In April of 2010, the Aging & Disability Resource Center – named The MinnesotaHelp Network™ implemented a new initiative known as Return to Community (RTC). Supported by the Centers for Medicare & Medicaid Services and the Administration on Aging, Return to Community targets private pay individuals who have been in a nursing facility for less than 90 days, have 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 but are likely candidates for high risk of spend down to Medicaid.

The design of the service is unique and was developed with the advice of nursing home industry discharge planners/social workers. Focusing on follow-up once a consumer goes home, those who are assisted by the options counseling (Senior Linkage Line® Community Living Specialists) get an in-person visit within 72 hours of discharge. Then a rigorous follow-up process begins with contacts made at 14, 30 and 60 days and then quarterly for up to five years over the phone. Those who discharged naturally, with no assistance are contacted a 90 days and offered follow up as well for the five-year period to ensure successful living in the community.

The program provides intervention through a formalized transition program that is targeted to nursing facility residents who have expressed a desire to return to the community. It involves assessment, care planning, service coordination, placement and ongoing monitoring of care in the community. An additional outcome is that the interventions motivate and support nursing facility providers to facilitate discharge to the community through their own efforts or in cooperation with formal transition programs. The initiative was leveraged for the roll out of the new Section Q MDS 3.0 which requires the nursing home assessors to make a referral to a “designated local contact agency”, if the resident indicates a desire to return to the community. It is also being leveraged for the launch of the Money Follows the Person initiative, with the same follow up protocols being adopted by care coordinators and care managers for those on Medicaid and enrolled in the new benefit.

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 launch of the program, over 420 individuals have been discharged to the community after direct assistance from a Community Living Specialist. The program is providing telephone follow-up calls to an additional 500 individuals, who returned home through other assistance such as their family.

Home and Community-Based Services Report Card

Minnesota plans to launch a Home and Community-Based Services (HCBS) Report Card on www.minnesotahelp.info regarding the quality of home and community-based services to help participants make informed purchasing decisions. The Report Card will be modeled after Minnesota's successful Nursing Home Report Card. It will initially include three provider types: housing with services (including assisted living), corporate foster care, and day training and habilitation. The Report Card would educate participants about differences among HCBS service, service providers, and costs; contribute to DHS' response to federal assurances related to access, choice and systems improvement; and support HCBS providers in targeting improvements in their services.

9.2.4 Strategies for Integration of Long Term Services and Supports with Other Initiatives

Administration on Aging (AoA) Integrated Systems Grant

Minnesota was one of four states to receive an Integrated Systems Grant from the Administration on Aging (AoA), part of the new Administration for Community Living. This grant will allow Minnesota to integrate the state's long-term care services and supports system with the state-certified health care homes to maximize individuals' choice, independence and responsibility through dementia capable risk management, self-direction and care transition support.

Alzheimer's Health Care Home Demonstration

Minnesota will implement an Alzheimer's Health Care Home Demonstration by building on the physician's algorithm for early identification of dementia to implement a fully integrated primary health and community service model for patients with Alzheimer's disease and their caregivers.

Health Home Demonstration – Inclusion of LTSS in the integration of behavioral and physical health care

Minnesota has a number of reform efforts underway to integrate services for individuals. Examples include health homes and other purchasing and service delivery models through the ACA as highlighted in sections Two and Three. Of special interest has been the integration of behavioral and physical health care for people with mental illness, and the inclusion of long term services and supports in the demonstration. The community supports and services that are available through the home and community-based service system are a complement to the therapeutic rehabilitation services that support recovery of persons with a mental illness. However, the services too often operate independently of one another. Strategies to further enable and encourage needed integration to holistically support a person with whatever is the right service at the right time will continue to be an area of development through these related reforms.

Evidence-based health promotion

Minnesota will encourage Medicare/Medicaid Integrated Care Organizations and integrated care system partnerships to offer one or more evidence-based health promotion/disease prevention interventions. Interventions include but are not limited to the Chronic Disease Self-Management Program, Arthritis Self-Management Program, Diabetes Self-Management Program and Chronic Pain Self-Management Program.

9.2.5 Planning and Service Development

The Minnesota Legislature recently authorized a number of planning activities which are designed to comprehensively study the availability of and access to needed community supports across the state, and to then manage resources as needed to help people get the right service at the right time.

LTSS gaps analysis

Since 2001, Minnesota has conducted a biennial Gaps Analysis through a collaborative effort with counties and Area Agencies on Aging, to study community resources and services and the status of long-term care services for older adults in Minnesota. The information has been used to develop services to meet identified gaps. This analysis was expanded by the 2012 Legislature to include people with disabilities, including those with a mental illness. The Gaps Analysis must include participation of a number of stakeholders, such as people who receive services, providers, lead agencies, and other stakeholders, and report on: demographics; local and regional plans to address gaps, surpluses and other service and community resource issues; the status of long-term care and mental health services, housing options and supports by county and region, including access to the least restrictive and most integrated services and settings; measures of service availability; and recommendations for the future of services, needed policy and

fiscal changes, and resource development and transition needs. The consolidated Gaps Analysis will be completed by August 2013, and biennially thereafter.

Need determination

Minnesota uses a needs determination process to manage limited services, such as Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD), and provides a planning process for transitions to alternative new service options. A needs determination process for foster care will be completed by February 2013, and conducted annually thereafter to manage the capacity of foster care services within budgetary limits. The information from the needs determination process will be used in the LTSS Gaps Analysis to document areas of service development that are needed to support people in the most inclusive community setting and target foster care services where most needed.

Critical access study for home and community-based services

Minnesota is conducting a study of the use and availability of home and community-based services across the state. Through this study, Minnesota will determine what changes may be necessary to payment rates and where other development incentives are needed to increase access to services, with particular focus on caregiver support and respite. As a result, we hope to create increased provider capacity and access to needed services, regardless of where people live across the state.

Redirect residential and nursing facility services

One expected outcome of the planning, analysis and development strategies in this section is a future restructuring of service access criteria for residential and nursing facility services. Based on what is learned through the Gaps Analysis, Need Determination and Critical Access Study, community capacity will be strengthened to provide services that effectively support people in their homes, and the service eligibility threshold for higher cost residential settings will be raised. At the same time, the threshold that individuals must meet in order to receive nursing facility care after 90 days will be raised, with exception criteria.

9.2.6 Enhancements to 1915(c) Waivers

Minnesota currently operates five 1915(c) Waivers:

- Brain Injury (BI) – for people with disabilities meeting a nursing facility or neurobehavioral hospital level of care
- Community Alternative Care (CAC) – for people with disabilities meeting a hospital level of care

- Community Alternatives for Disabled Individuals (CADI) – for people with disabilities meeting a nursing facility level of care
- Developmental Disabilities (DD) – for people with disabilities meeting an Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) level of care
- Elderly Waiver (EW) – for individuals age 65 and older meeting a nursing facility level of care.

In tandem with the reforms outlined in this proposal, Minnesota plans a number of enhancements to improve the effectiveness of the waivers to provide the right service at the right time and to provide needed flexibility to improve individual outcomes.

Service menus

Minnesota has amended its five home and community-based waivers over the years to create a more common service menu by adding services that are useful in one waiver to the others. Through stakeholder input during the planning for the redesign of home and community-based services as part of Minnesota’s MA reform, we have learned much about what changes to services and provider standards will improve supports to people, and will enable providers to more effectively deliver needed services. A new menu of services will be requested in future amendments to all five waivers. This menu of services builds off what has been most successful; it will consolidate similar services where the differences between them do not make a meaningful difference, and create new services where there are gaps. Examples of new or consolidated services include:

New in-home support composite service for adults who live in their own homes. The service will include a 24/7 emergency response, check-ins as needed, technology as a means to support the person in lieu of staffing and to increase independence, and a “universal worker” that can provide the services needed by the person, in order to provide a meaningful alternative to residential services. Providers of this service will be responsible and have the flexibility to provide the type of service as outlined in the support plan, when it is needed. This is the type of service often available in an assisted living or customized living arrangement. This new service will enable a similar type of service to be available in a person’s home. Individual in-home services will also continue to be available through the service menu.

Technology is increasingly playing an important role to support people, increase independence, support or augment human assistance, and open new doors to support community living. Current definitions of what is covered, how it is paid, and the types of

evaluation and technical assistance to be available to assure appropriate use and selection of technology will be updated in the service menu to increase its access and effectiveness.

Employment is a priority, and the menu of services to support competitive employment is another example of an area where learnings from our Medicaid Infrastructure Grant, Pathways to Employment, will inform the future service menu to make work part of the plan.

Consumer Directed Community Supports (CDCS) are an option for individuals to choose to direct and manage their own services, including hiring their own staff, rather than going through a provider agency. Proposed changes include:

Redesign of a new financial management structure, as reviewed in Section Three on the new Community First Services and Supports, will also be used for CDCS under the waivers. Minnesota's Consumer Directed Task Force provided recommendations for the future financial management system in their design of a 1915(j) option for people using PCA to employ staff and manage their own services. The recommendations from the task force informed the redesign of home and community-based services and will be the basis for the future financial management structure as well as the proposed Community First Service and Support to replace the existing PCA program.

Service definition for CDCS is being evaluated to determine if there are changes that should be made, including what is allowable for reimbursement.

CDCS budget methodology creates individual budgets for those choosing to use this option instead of agency-provided services. The methodology is under review to determine what revisions are possible at this time to enable more people to participate in this self-directed service option without increasing overall waiver spending. There is a current test that will provide an additional increase to the budgets of people between the ages of 18 and 21, who graduate from high school. Continued analysis and recommendations will be considered and the CDCS budget methodology amended as needed.

New budget methodology to serve medically complex seniors who are vent dependent will be included as part of the Elderly Waiver renewal to align needed resources with individuals who are vent dependent. Individuals who are assessed at this level of need can receive Elderly Waiver services in their own home or in housing with services setting, rather than living in an institution to receive needed care.

Creation of individual service budgets for individuals using disability waiver services will be possible in the future with increased information from the MnCHOICES assessment, and the upcoming implementation of a disability waivers payment rates

system. This will provide increased understanding of the dollars available to design support plans, and inform decisions about services and providers.

Threshold for accessing residential services will be established as service improvements are made and capacity developed in the services that support individuals in their homes and non-residential settings. This will target customized living and foster care to those meeting access criteria and choosing this setting.

Medical need service criteria for nursing facilities will be established at the same time as thresholds for accessing residential services to raise the threshold individuals must meet in order to receive nursing facility care after 90 days, with allowable exceptions.

Quality Management is under continuous improvement. There are a number of initiatives in this area, including the State Quality Council, which is comprised of interested stakeholders directed to review and make recommendations to improve the quality of services provided to Minnesotans with disabilities receiving community-based services via changes to the current state quality assurance/improvement and licensing system. The state has established a consistent quality management structure across all home and community-based service waivers, and will continue to adapt and improve practices which will provide assurances to people receiving services and their families, policy makers, administrators, and the public about the valued outcomes resulting from investments made in people and our communities through home and community-based services.

Provider Standards

Along with a revised service menu, provider standards will be amended to provide for basic assurances, as well as outcome standards to evaluate the results of the services. With these standards will be an option for certification of specialized expertise and experience, such as working with people with developmental disabilities, or a mental illness, or complex health needs. These standards will be the culmination of a number of initiatives to drive towards quality outcomes, and quality assurance. There also is work underway to update policies and practices to prohibit the use of seclusion and restraint except in specific emergency situations. Training, technical assistance, and transition planning will be important keys to successful implementation of new standards. Recommendations will be provided to the 2013 legislature for a new licensing and quality outcome system for home and community-based services. Amendments to provider standards in the 1915(c) HCBS waiver plans will be submitted at the conclusion of the legislative session.

9.2.7 Rate Methodologies

The goal of waiver service payment rate methodologies is to create a statewide system that 1) will establish provider payment rates that are based on a uniform process but also capture the individualized nature of the services and the individuals' needs; 2) is transparent, fair and generates consistent pricing across the state; and 3) promotes quality and participant choice. In 2010, a tool of determining the rate for customized living (assisted living) was established in for people using the Elderly Waiver. There was a separate process to determine a disability waivers rate system for all disability services that is in a research period and will be brought to the 2013 legislature for implementation in 2014.

9.2.8 Redesign Case Management

Over the past decade, several case management reports have evaluated and made recommendations on how to improve the current case management structure. While many people have access to various types of case management via the HCBS waivers or specific target groups, others do not have access to the service of case management at all. In addition, the funding structure is complicated, and is difficult to navigate. Other issues that were identified in the recent reports include the challenges of:

- Duplication and redundancy
- Overlapping eligibility for programs
- Variation of rules, standards and reimbursement from program to program
- Variation in quality from case manager to case manager

With the implementation of MnCHOICES, Minnesota is separating the administrative functions that have been assigned to case managers from the service of case management by more clearly defining and paying differently for these functions. Minnesota will also be looking at whether to remove case management as a waiver service and redefine the target populations so the funding streams and payment for case management services would be more consistent across the state. Finally, Minnesota will be looking to increase opportunities for consumer choice of case management and to develop consistent provider standards with a focus on quality outcomes.

9.2.9 Crisis Intervention and Protection of Vulnerable Adults

With 94% of people with disabilities and the majority of older adults living in the community, the home and community-based service system often is the safety net. Crisis services will be expanded, and increasingly must be agile and accessible when needed to individuals, their families, providers, case managers, and others who are involved. More systemic approaches to crisis will be implemented and will include positive behavior training and person-centered approaches to providers, case managers, and others; targeted technical assistance and mobile crisis intervention; indicators of avoidable use of emergency room, civil commitment, and law enforcement that will trigger an evaluation

and planning to more appropriately address underlying issues, and increase crisis response capacity across the state.

Statewide, centralized system for Reports of Vulnerable Adult Maltreatment

Minnesota plans to establish a statewide toll free hotline with 24/7 response and triage to receive reports of suspected maltreatment of vulnerable adults and determine the need for investigation. This will replace the current system of 84 separate county-based “common entry points” for receiving these reports. As this service is launched Minnesota will create a public outreach campaign to raise awareness of vulnerable adult abuse and educate mandated and voluntary reporters on the new reporting system.

9.2.10 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; and
- Increase stability of individuals in the community by strengthening connections among health care, community support, employment and housing systems.

9.3 Promote Personal Responsibility and Reward Health Outcomes

Minnesota seeks to slow the rate of growth in health care cost. One strategy will be to invest in health care delivery models that address behavioral and social circumstances that influence participation in preventive health services. For example, offering economic incentives to people who reach health goals related to difficult changes in life habits such as overeating or smoking may have a positive impact on health outcomes and may decrease growth in health expenditures.

Minnesota will implement *We Can Prevent Diabetes MN* in the January 2013 with the help of a CMS grant. Minnesota intends to continue to seek Medicaid funding for public health interventions and individual and group incentives to encourage healthy behavior and outcomes and prevent the onset of chronic disease. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight and lowering cholesterol, and lowering blood pressure.

9.3.1 Background

Health care cost is recognized as a growing component of the U.S. Gross Domestic Product and a commensurate leading cost driver of state budgets. There is a growing consensus that these costs are unsustainable. Minnesota is committed to reforms to slow the rate of growth in health care cost.

9.3.2 Vision

One promising strategy is to invest in health care delivery models that address behavioral and social circumstances that influence participation in preventive health services. For example, offering economic incentives to people who reach health goals related to difficult changes in life habits such as overeating or smoking may have a positive impact on health outcomes and may decrease growth in health expenditures.

9.3.3 Next Steps

To support this vision, DHS applied for and received a \$10 million five-year grant from CMS under the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant program to test the effects of incentives on the participation and success in diabetes prevention activities for people enrolled Minnesota's Medicaid program. This project, known as *We Can Prevent Diabetes MN*, will provide the opportunity for more than 3,200 Medical Assistance enrollees ages 18 to 75 in the metro area who have a diagnosis of pre-diabetes or significant risk of developing diabetes to participate in a diabetes prevention program. The program, expected to launch in the metro area in January 2013, will include 16 weekly and eight monthly sessions that are free to all participants.

DHS seeks ways to expand the program statewide, either through additional funding from CMS or other innovative financing mechanisms. DHS seeks funding to provide individual and group incentives to encourage healthy behavior and prevent the onset of chronic disease by rewarding improved health outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight and lowering cholesterol, and lowering blood pressure.

DHS is working to implement the activities funded by the grant described above, and makes no specific requests for additional federal authority to further this initiative at this time.

9.4 Encourage Utilization of Cost-Effective Care

In 2008 Minnesota enacted a major bipartisan health reform law to improve health care access and quality and to contain the rising costs of health care. A cornerstone of the law is the Provider Peer Grouping (PPG) initiative at the Minnesota Department of Health (MDH), the purpose of which is to develop a comprehensive system that provides information about health care value – both cost and quality. PPG will compare physician clinics and hospitals based on a combined measure of risk-adjusted cost and quality to offer a clearer picture of each provider's value. As one of the largest health care purchasers in the state, DHS intends to maximize the benefit of PPG by creating incentives to encourage the utilization of high quality, low cost, high-value providers through MA enrollee cost-sharing and other yet-to-be determined incentives.

9.4.1 Background

In 2008 Minnesota enacted a major bipartisan health reform law to improve health care access and quality and to contain the rising costs of health care. A cornerstone of the law is the Provider Peer Grouping (PPG) initiative at the Minnesota Department of Health (MDH), the purpose of which is to develop a comprehensive system that provides information about health care value – both cost and quality. PPG will compare physician clinics and hospitals based on a combined measure of risk-adjusted cost and quality to offer a clearer picture of each provider's value.

Providers will be able to use the results to improve their quality and reduce costs and consumers can use it to make more informed health care choices. Also, the law requires employers and health plans to use it in developing products that encourage consumers to use high-quality, low-cost providers. The first set of provider results will be made public at the end of 2012.

9.4.2 Vision

As one of the largest health care purchasers in the state, DHS intends to maximize the benefit of PPG by creating incentives to encourage the utilization of high quality, low cost, high-value providers through MA enrollee cost-sharing and other yet-to-be determined incentives. As an example, enrollees who seek care from a high value provider could have their copayments reduced or eliminated. Some people on Medical Assistance are exempt from copayments, so other incentives will have to be identified in order for them to take advantage of this initiative. Also, DHS will need to consider if or how the program should be implemented in parts of the state where access to high value providers is limited. Given that the limitations of the PPG data are unknown at this time, DHS may seek data from other sources such as Minnesota Community Measurement and the State Employee Group Insurance Program to support this project.

9.4.3 Next Steps

DHS will work, in consultation with MDH, to develop this project and implement it on Jan. 1, 2014, contingent upon federal approval. In constructing the program, DHS will identify non-cost-sharing enrollee incentives that would effectively influence an enrollee's choice of providers and seek any federal approval necessary to implement these incentives. DHS makes no specific requests for federal waiver authority with respect to this initiative at this time.

9.5 Intensive Residential Treatment Services

The Intensive Residential Treatment Services (IRTS) program provides services in residential settings to adults who have serious mental illness. Individuals served by IRTS have person-centered treatment plans that may include group and individual counseling, medication monitoring, integrated dual diagnosis treatment, assistance with community resources, and illness management and recovery. In addition to their mental illness diagnosis, many individuals served by IRTS have co-occurring complex needs, including chronic physical health needs, which may require additional residential care even after their mental health condition has stabilized. Therefore, some individuals who are discharged from IRTS facilities, despite having their mental health condition stabilized, may have other serious health needs that have gone unaddressed during their time at the facility. These health issues can lead to subsequent, costly and unnecessary hospitalizations or the need for other residential care.

To address the complex physical and mental health needs of individuals receiving IRTS services, the Legislature directed DHS to develop a proposal for the improved integration of medical and mental health services at IRTS facilities and to pursue the development of specialized rates to support this effort.

This project will be developed within the context of a comprehensive health care reform planning process to enhance the state's continuum of care, including State Operated Services (SOS) programs, that is being undertaken by the Chemical and Mental Health Administration in 2012. This effort will examine how DHS can best structure IRTS programs to better serve those who have co-occurring and complex physical and mental health needs.

9.6 Children Under 21 in Residential "IMD" Facilities

Title XIX of the Social Security Act prohibits federal financial participation for the cost of care for Medicaid beneficiaries in facilities that fall under the federal definition of an "institution for mental diseases" (IMD). IMDs are defined as a stand-alone hospital, nursing facility or other institution of more than 16 beds primarily providing diagnosis, treatment or care for persons with mental diseases.

For individuals ages 21 to 64, the IMD exclusion pertains to all aspects of care and treatment. For children, federal payments are limited in a different way. Children may have coverage for treatment they receive in an IMD, but only for the inpatient psychiatric hospital services provided. In what the federal government refers to as “the exception to the IMD exclusion for individuals under age 21,” Medicaid pays for the mental health services, but denies coverage for care (room and board, and other basic care for children’s needs) as well as for all other health care services, regardless of medical need. This circumstance creates major obstacles to both necessary care, in that a child diagnosed with diabetes or leukemia could not be treated for those conditions until discharged from a psychiatric hospital; and to the kind of integrated care which is rapidly becoming industry standard, in that children receiving psychiatric treatment in an IMD also are not allowed reimbursement for dental care, immunizations, or care for routine childhood illnesses such as ear infections.

While the IMD exclusion explicitly applies to psychiatric hospitals, it also applies to children’s psychiatric residential treatment facilities, or PRTFs. This type of non-hospital setting is designed for the treatment of children who continue to need a secure, supervised environment, but not at a hospital level of intensity or medical staffing. Minnesota has not been able to develop this new level of care, despite having at least some capable and willing providers, largely because of the children’s exception to the IMD exclusion.

In recent years, the need for this “intermediate level of care” has been repeatedly identified by stakeholder groups. Following considerable debate over the state’s need for additional child and adolescent inpatient psychiatric beds in the 2008 legislature, a 2009 “Unmet Needs” study submitted to the legislature determined that many children and adolescents could be served in less intensive and more economical settings, if barriers to developing these could be removed. Further, the most similar level of care currently available, in residential facilities licensed for mental health service provision under the Umbrella Rule, works well for some children, but is insufficient for children with complex medical needs or who are highly aggressive, documented in the 2011 Mental Health Transformation report submitted to the legislature. The funding model for the current residential treatment option in Minnesota requires foster care placement by counties, a burden for both families and counties, and county financial coverage of some treatment costs (the non-federal share for children on FFS Medical Assistance) and all room and care costs, a portion of which may be reimbursed through Title IV-E.

Nationally, many entities have attempted to circumvent or overturn the IMD exclusion, including its application to children’s residential treatment. The National Council for Children’s Behavioral Health has been particularly active in providing information to states and lobbying the federal government to rescind the children’s exception; their arguments include the following:

- The IMD exclusion exception violates the EPSDT mandate;

- Medicaid law needs to evolve to cover best practices; and
- Unclear and subjective guidance for identifying IMDs leaves states perpetually exposed to CMS reinterpretation, audits and recoument of federal matching funds.

While the need to fill gaps in the children’s mental health continuum of care has been repeatedly documented, there is no collective desire from parents, advocates, counties and other stakeholders to do so in the current ambiguous and insufficient Medicaid environment. A necessary first step both to protect current residential facilities licensed under the Umbrella Rule and to enable analysis of the feasibility of PRTF development is to seek a federal waiver of the exception to the IMD exclusion for individuals under age 21. In light of recent case law indicating the unlikelihood of success of such a waiver, the Chemical and Mental Health Administration is continuing to evaluate the best approach to address this gap in the continuum of care for children’s mental health.

10 Evaluation

10.1 Introduction

This section sets out the proposed evaluation of the reforms made under the Demonstration to Reform Personal Assistance Services and the Demonstration to Expand Access to Transition Supports described in sections 4 and 5 of this waiver proposal, as well as reforms sought in the previously-submitted Long-Term Care Realignment Section 1115 waiver proposal. The evaluation for the remaining initiatives, including the Employment, Housing and Anoka Metro Regional Treatment Center demonstrations are found in sections 6 and 7 following the description of those demonstration proposals.

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 under contract to evaluate reform efforts currently underway. The proposed evaluation plan has been expanded by department staff to include new proposed 1115 services 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.

Expanding Access to Transition Support. The initiative serves individuals who meet the criteria discussed in Section Five, who in most cases will be seniors over 65. This initiative streamlines and supports business processes with web-based technology, connects hospitals and nursing facilities with the goal to improve transitions between care settings, and connect with individuals earlier and strengthen Minnesota’s Return to Community initiative. Individuals will

receive transition counseling, follow-up, and tracking through the Return to Community program. The First Contact initiative is expected to reduce use of nursing facility and home and community-based waiver services and achieve Medicaid savings.

Essential Community Supports Program (ECS). This initiative will support individuals who are eligible for Medical Assistance (MA) but who no longer meet the new nursing facility level of care (LOC) criteria and who do not meet PCA eligibility criteria. ECS will provide a low cost, high-impact set of home and community-based services to promote living at home longer.

Community First Services and Supports (CFSS) is a new service to replace the current Personal Care Assistance (PCA) program. The initiative provides assistance with and maintenance, enhancement or acquisition of skills to complete ADLs, IADLs, and health-related tasks and back -up systems to assure continuity of services and supports based on assessed functional needs for people who require support to live in the community. In addition, CFSS provides permissible services and supports linked to an assessed need or goal in the individual's person-centered service plan, which may include, but are not limited to, transition costs from institutional services and supports such as assistive technology and adapted modifications that increase a person's independence. The goal is to provide the right service at the right time, in the right way, to individuals in order to achieve better individual outcomes and, through the efficiency that achieves, ensure the sustainability of the system.

Demonstration of Innovative Approaches to Service Coordination (Children with CFSS). Minnesota is proposing a demonstration project with a limited number of providers to develop and test a service coordination models that provide more comprehensive coordination of services across home, school and community to address the child's needs. The demonstration would include up to 1500 children.

10.2 Major Program Processes 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.

Table 1. Major Activities and Measures

Initiative	Major Processes	Primary Outcomes
Expanding Access to Transition Support	<p>Proper targeting of individuals for transition assistance</p> <p>Counseling, follow-up and referral of transitioned residents to community services</p> <p>Active participation of hospitals and nursing facilities in the community transition process</p> <p>Identification of risk factors and unmet need among transitioned individuals and caregivers</p>	<p>Medicaid savings</p> <p>HCBS costs significantly below what nursing home costs would have been for transitioned individuals</p> <p>Medicaid conversion delayed or avoided</p> <p>Nursing home utilization reduced</p> <p>No increase in hospitalizations and ED visits.</p> <p>Health and functioning maintained or improved</p>
Essential Community Supports Program (ECS) serving Medicaid	ECS program provided to low-income individuals who have an assessed need for services but do not meet NF LOC or PCA criteria.	<p>Total LTC Costs</p> <p>HCBS costs</p> <p>Health Care Costs (Medicare and Medicaid)</p> <p>Nursing facility utilization rate</p> <p>Hospitalizations and ER visits</p>

Initiative	Major Processes	Primary Outcomes
Community First Services and Supports (CFSS) and Service Coordination Demonstration	<p>Improve service coordination to achieve better outcomes, including:</p> <p>Increase in enrollee independence.</p> <p>Increased community integration</p> <p>Decreased reliance on institutional care</p> <p>Administrative simplification</p> <p>Fiscal sustainability</p>	<p>Medicaid financial impact</p> <p>No increase in Medicaid nursing home use</p> <p>No increase in hospitalizations and ED visits</p> <p>No increase in out of home placements for children</p> <p>Health and functioning maintained or improved</p>

The following primary questions will frame the evaluation.

Were personal health, functioning, family support, and other individual outcomes maintained or improved by the initiative? All the proposed initiatives have the explicit goal of promoting consumer choice and independence while maintaining or improving health, functioning and other outcomes. With earlier intervention and supports provided under Expanding Access to Transition Support and Essential Community Supports, it is expected that decline in individual outcomes will be delayed.

Were unintended adverse outcomes avoided? Reform efforts run the risk of unintended adverse outcomes, such as decline in health or functioning, increased acute care or nursing facility utilization or additional silos that don't contribute to outcomes. The Expanding Access to Transition Support initiative has well established counseling and tracking processes to avoid adverse events. Essential Community Supports funding provides a safety net for people who fail to meet nursing facility level of care criteria but have an assessed need. Innovative approaches to service coordination for children with CFSS will provide more comprehensive coordination of services to address the child's needs in the community as well as in the school setting to avoid adverse outcomes. Through CFSS, people will have greater flexibility in their services, with an enhanced ability to gain greater independence through skill acquisition, technology and adaptive modifications that weren't previously available except through HCBS waiver services.

Were services provided more efficiently? Each initiative attempts to deliver care more efficiently through better allocation of resources. For example, Expanded Access to Transition Support

First Contact seeks to improve transitions between care settings with web-based technology and connect with individuals earlier in the process, Essential Community Supports seeks to shore up individual and caregiver resources and promotes community-based alternatives so that more costly acuter and long-term care services can be avoided, CFSS offers more flexibility and greater opportunity for self-direction to better support people across all services and Innovative Approaches to Service Coordination for children with CFSS will address develop and test innovative ways to coordinate care across services and settings. Essential Community Supports 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.

Did the initiative achieve Medicaid savings? Expanded Access to Transition Support Contact and Essential Community Supports promises savings to the Medicaid program by intervening earlier in the process to promote less costly alternatives to institutional or waiver services. CFSS seeks to provide more people with services that adequately meet their needs and target waiver services for those most in need. While Medicaid savings is not an expected outcome for CFSS, it is intended to result in a fiscally sustainable model.

As a secondary focus, Minnesota will use this demonstration as an opportunity to test innovative approaches, study the results and use the knowledge gained to inform future design of the system. We will ask the following supplemental questions:

1. Assessment. What are the characteristics of individuals and their circumstances that correlate to positive personal outcomes and stable or reduced costs, and what are those that correlate to poor personal outcomes and high costs? What are indicators from the newly available assessment information from MnCHOICES (an automated, comprehensive, and person-centered assessment and support planning application) that will identify people who could benefit from more intensive service coordination and intervene earlier, to avoid unnecessary costs and poor outcomes? What assessment information correlates the most appropriate service(s) and amount of service (individual budget in the case of CFSS) to meet an individual needs?
2. Service models. What are promising service coordination practices and effective long-term services and supports that improve outcomes and lower costs for people who are at risk of instability, inefficient use of services, poor outcomes and/or high, avoidable costs? How is CFSS used, and what are the benefits of the flexibility in CFSS to increase or maintain stability and independence? Is there a reduction in short term use of waiver services or institutional stays?
3. Budgets and Payment rates. What assessment indicators should be used in the future to determine individual budgets for CFSS and when/what changes in assessed need should correlate to a change in budget? What payment rate methodology should be used for CFSS to ensure provider viability and statewide access? Should rates vary for

providers/agencies that have different skill sets (for example, skills in mental health service delivery or positive approaches to challenging behaviors?) How should budgets and rates be managed to ensure that the program stays within budget constraints?

4. Provider standards. When are different provider standards necessary? What should they be? How should we track and monitor provider standards and qualifications, and communicate them to recipients?
5. Targeted services. We want to learn more about when “differences make a difference” so that services, models or providers need to be specialized. When is it appropriate to offer one set of services (e.g.: CFSS) that can be tailored on an individual basis?
6. Consolidating service coordination. How many systems can intensive service coordination successfully cross? What are successful strategies to provide expertise in population needs, or funding, or service delivery models? Are there other system partners that can be brought into the service (for example, Department of Corrections?)
7. Reducing need for human assistance. What is the outcome of the use of technology or modifications to reduce human assistance in CFSS? Do people receiving CFSS gain skills? Does the use of technology or environmental modifications, or services that help people acquire new skills reduce costs?

10.3 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, especially those experienced directly by the person receiving services.
- 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 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 2009 and the implementation period may extend to 2015.
- The most feasible approach for assessing changes in program outcomes for these initiatives is a “before and after” or interrupted time series design that measures trends in outcomes (e.g., personal outcomes, , participant satisfaction, nursing facility utilization, hospitalizations, Medicaid costs etc.) for target populations and controls on a monthly or quarterly basis during the baseline and implementation periods.

If the initiative is successful, some outcomes should have downward trends, such as one time short term use of waivers, declining Medicaid expenditures or nursing facility utilization. Other outcomes should have upward trends, such as increased community discharges from the nursing facility, community stability with CFSS, or successful diversion from nursing facilities. Some outcomes, on the other hand, should have even trends, particularly unintended adverse outcomes such as emergency department use or hospitalizations, while under the Demonstration of Innovative Approaches to Service Coordination for children with CFSS for example, emergency department use or hospitalizations should decrease.

10.3.1 Study Samples

The study samples will be drawn from the population of interest for each program. 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 Demonstrative of Innovative Approaches to Service Coordination, such as reduced emergency department use or hospitalizations, we need to compare individuals in the baseline period who would have received traditional PCA services with individuals during the implementation period who are receiving the demonstration service coordination. 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. Given the proposed initiatives will likely result in movement between waiver services and traditional PCA services in order to better align individual needs with support services it may be difficult to establish comparison groups on a program specific basis, e.g., traditional PCA services and CFSS. It may be necessary to establish baseline costs and utilization more broadly as general HCBS for comparison purposes. 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	Anticipated Period
Expanding Access to Transition Support	<p><u>Target Population:</u> nursing home admissions after program implementation. (Average acuity of all admissions, average length of stay)</p> <p><u>Comparison Group:</u> nursing home admissions before program implementation. (Average acuity of all admissions, average length of stay)</p>	<p>Minimum Data Set (MDS)</p> <p>MDS</p>	<p>2014-2019</p> <p>2009 - -2013</p>
Essential Community Supports Program (ECS) serving	<p><u>Target Populations: (Medicaid eligibles)</u></p> <p>Nursing facility applicants who fail to meet new NF LOC criteria prior to nursing facility admission</p> <p>Nursing facility residents who fail to meet new NF LOC criteria at their most recent assessment prior to Medicaid eligibility</p> <p>Persons in the community applying to or referred to ECS</p> <p><u>Comparison Groups: (Medicaid eligibles)</u></p> <p>Nursing facility applicants who <u>would</u> have failed to meet NF LOC criteria prior to nursing facility admission</p> <p>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</p>	<p>NF Long-Term Care Consultation (LTCC)</p> <p>MDS</p> <p>Medicaid Claims</p>	<p>2014-2019</p> <p>2009-2013</p>

Initiative	Study Sample	Identified From	Anticipated Period
Essential Community Supports Program (ECS) serving, cont.	<p><u>Target Populations (Medicaid ineligible):</u></p> <p>HCBS applicants who fail to meet NF LOC criteria and HCBS recipients who fail to meet PCA criteria on an annual assessment:</p> <p><u>Comparison Groups (Medicaid ineligible):</u></p> <p>HCBS applicants who <u>would have failed</u> to meet NF LOC criteria and HCBS recipients who <u>would have failed</u> to meet PCA criteria on annual assessment</p>	<p>NF LTCC</p> <p>MDS</p> <p>Medicaid Claims</p>	<p>2014-2019</p> <p>2009-2013</p> <p>-</p>
Community First Services and Supports (CFSS) and Demonstration of Innovative Approaches to Service Coordination (Children with CFSS)	<p><u>Target Population:</u></p> <p>Medicaid enrollees who receive CFSS, Demonstration of Innovative Approaches to Service Coordination or waiver services after program implementation</p> <p>Waiver “wait list” after program implementation</p> <p><u>Comparison Group:</u></p> <p>Medicaid enrollees receiving PCA or waiver services prior to program implementation</p>	<p>Medicaid claims (FFS & Managed Care)</p> <p>MnCHOICES Assessment and Service Plan (FFS & Managed Care)</p> <p>Medicaid claims (FFS & Managed Care)</p> <p>Waiver Wait List</p> <p>PCA</p>	<p>2014-2019</p> <p>2009 – 2013</p> <p>2009 - 2013</p>

Initiative	Study Sample	Identified From	Anticipated Period
	Waiver "wait list" prior to program implementation	Assessment and Service Plans (FFS & Managed Care) MnCHOICES Assessment and Service Plans	2013

10.3.2 Development of Study Samples

Selection of the study samples will be based on operational definitions of the study populations as described in Table 2 above. The proposed initiatives are primarily focused on Medicaid eligible populations which strengthens the ability to follow participants in these programs via claims data and annual assessment data. However, in the expansion of the Return to Community Initiative and First Contact, the study population will likely need to be expanded beyond Medicaid eligible to fully understand the impact of the initiatives.

- Components of the initiative involving nursing facility residents have well-defined samples that can be followed over time through the nursing facility MDS system regardless of Medicaid eligibility.
- People affected by the new 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 Medicaid Management and Information System (MMIS) and MnCHOICES 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 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 PCA criteria and are neither Medicaid nor Medicare eligible.

- The fallback method for following Medicare beneficiaries (dually-eligible or Medicare only) affected by any of the initiatives is 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.

10.3.3 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
- MnCHOICES assessments.
- Participant Experience Survey
- Health plan data systems for people enrolled in managed care (if available)

The adequacy of all data sources – completeness, coverage, and consistency over time -- is yet to be determined. For example, availability of cost data from Managed Care Plans has yet to be established. The data will likely contain many nuances that can only be discovered through experience.

10.3.4 Securing and Preparing Data Files

The Minnesota Department of Human Services will provide data from the MDS assessment system, MMIS, and other administrative data (i.e. LTCC, PCA, Alternative Care or 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 LOC criteria.

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.

10.4 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.

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.

10.5 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.

10.6 Evaluation Timeline

These initiatives have a proposed implementation of January 2014. 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, 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 anticipate this time frame for the evaluation:

Baseline data (4 years prior to implementation)	2009-2013
Begin evaluation	2014
Ramp-up (depending on initiative start date)	2014-2015
Evaluation data collection and analysis	2014-2019
Complete evaluation	2019

11 Public Involvement

11.1 Minnesota State Register Notices Regarding Legislative Actions

Each year after the close of the legislative session, DHS publishes a notice in the Minnesota State Register to inform consumers, medical providers, and the public of statutory changes made to the Medical Assistance Program by the Minnesota Legislature. A summary of the *Reform 2020* legislation was included in the annual notice of statutory changes published in the Minnesota State Register on August 29, 2011.

11.2 Workgroup Process

The State's effort to develop this reform proposal began in August 2011. To ensure agency-wide representation, DHS created workgroups across the major administrations. Subgroups were formed around different policy themes. Workgroups formed include the duals planning grant team for Minnesota Statutes 256B.021, subdivision 4(i), a chemical and mental health team for 256B.021, subdivision 4(j,k,l), several long-term care reform workgroups 256B.021, subdivision 4(e,f,g and h) and separate housing and employment workgroups for 256B.021, subdivision 4 (e).

Each workgroup was directed to engage necessary stakeholders and the public, holding several meetings for their respective initiatives. These meetings typically included an overview of the Medical Assistance reform initiative overall followed by subject-specific information. A discussion then took place to solicit stakeholder feedback for inclusion in DHS's recommendations. A list of stakeholder groups and meetings is available in Attachment F. In addition to the workgroups above, an assistant commissioner level senior leadership group met on a bi-weekly basis to monitor progress and provide recommendations and guidance for workgroups.

Agency-wide Stakeholder Meeting

DHS held an agency-wide stakeholder meeting regarding the Medicaid reform waiver effort on December 5, 2011. The purpose of this meeting was to provide interested members of the public with an update on the work plan and the projects under development as part of the State's

Medicaid reform initiative and to solicit public regarding ideas they would like to see included in the submission to CMS.

11.3 Consultation with Tribes

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

DHS has a designated staff person in the Medicaid Director's office who acts as a liaison to the Tribes. Attachment G is Minnesota's tribal consultation policy.

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.

DHS has consulted with Tribes on the Medicaid reform initiative that is now referred to as *Reform 2020* since it was passed by the Minnesota State Legislature in 2011. The Medicaid reform initiative was included in the legislative summary provided to Tribal Chairs and Tribal Health and Social Services Director at the August 2011 Tribal Health Work Group meetings.

On November 17, 2011 David Godfrey, Medicaid Director attended the Tribal Health Work Group meeting to discuss the components of the Medicaid reform initiative and the State's plans to seek federal authority necessary to implement Medicaid reform.

On May 24, 2012 DHS policy staff attended the Tribal Health Work Group meeting to inform the Tribes of the State's intent to submit a section 1115 waiver request entitled *Reform 2020* and to provide an overview of the waiver proposal. The purpose of this meeting was to update tribal

officials on the status of the waiver request and take comments, questions and suggestions regarding the waiver.

On May 31, 2012 a letter was sent to all Tribal Chairs and Tribal Health Directors requesting their comment on DHS' intent to submit a waiver request entitled *Reform 2020* to the Centers for Medicare & Medicaid Services in order to implement several key components of the overall Medicaid reform initiative. The letter informed Tribes that a copy of the waiver request would be available on the DHS web site. The letter also informed Tribes of the Minnesota State Register notice to be published on June 18, 2012 and the public hearings to be held on June 22, 2012 and June 25, 2012.

On September 24, 2012 a letter was sent to all Tribal Chairs and Tribal Health Directors informing them of the Minnesota State Register notice announcing a second 30-day comment period focusing on the fiscal analysis of those components of the reform initiative requiring federal approval as set out in Attachment O of the *Reform 2020* waiver request and the historical financial data as set out in Attachment P of the *Reform 2020* waiver request. The letter also invited Tribal Chairs and Tribal health Directors to attend a webinar on the *Reform 2020* fiscal analysis and historical expenditure data held on October 12, 2012.

11.4 Public Notice and Comment

11.4.1 Minnesota State Register Notice Requesting Public Comment on *Reform 2020*

A notice requesting public comment on the proposed *Reform 2020* §1115 waiver request was published in the Minnesota State Register on June 18, 2012. This notice announced a 30-day comment period on the *Reform 2020* Section 1115 Medicaid waiver request. The notice informed the public on how to access an electronic copy or request a hard copy of the waiver request. Instructions on how to submit written comments were provided. In addition, the notice included information about two public hearings scheduled to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The time and location for the two public hearings, along with information about how to arrange to speak at either of the hearings, was provided. Finally, the notice provided a link to the State's *Reform 2020* web page for complete information on the public notice process, the public input process, planned hearings and a copy of waiver application. A copy of the Minnesota State Register Notice published on June 18, 2012 is provided as Attachment H.

A second notice requesting public comment on the fiscal analysis and historical expenditure data for the *Reform 2020* §1115 waiver request was published in the Minnesota State Register on September 24, 2012. This notice announced a 30-day comment period on the fiscal analysis of those components of the reform initiative requiring federal approval as set out in Attachment O of the *Reform 2020* waiver request and the historical financial data as set out in Attachment P of

the *Reform 2020* waiver request. A copy of the Minnesota State Register Notice published on September 24, 2012 is provided as Attachment Q. CMS advised that no public hearing was necessary during the second comment period,. However, Minnesota did hold a webinar on October 12, 2012 to provide an overview of the fiscal information made available for the second comment period and posted the materials on the public website.

11.4.2 DHS Website

The DHS web page at www.dhs.state.mn.us/Reform2020 provides the public with information about the *Reform 2020* Section 1115 waiver. The website is updated on a regular basis and includes information about the public notice process, opportunities for public input, planned hearings and additional informational meetings. A copy of the initial draft of the *Reform 2020* 1115 waiver request and the final draft of the waiver request that includes modifications following the public input process are also posted on the website. The main page of the DHS public website includes a new “Public Participation” link to help people quickly identify what comment periods are open. This page contains a link to the *Reform 2020* web page. During the state comment periods, it instructed how to submit comments on *Reform 2020* to DHS. After the comment periods, it was updated to alert web visitors that a federal comment period on *Reform 2020* will be coming soon.

11.4.3 E-mail Notification

On June 18, 2012, an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the state’s intent to submit the *Reform 2020* Section 1115 waiver request and directing them to the Minnesota State Register notice published on June 18, 2012. On September 24, 2012, an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the Minnesota State Register notice announcing a second 30-day comment period on the fiscal analysis of those components of the reform initiative requiring federal approval as set out in Attachment O of the *Reform 2020* waiver request and the historical financial data as set out in Attachment P of the *Reform 2020* waiver request. The email also invited stakeholders to attend a webinar on the *Reform 2020* fiscal analysis and historical expenditure data held on October 12, 2012. The stakeholder mailing list was also used to provide information about additional public meetings that were scheduled during the notice and comment period to provide more information on *Reform 2020*, as well as to notify interested persons when *Reform 2020* was submitted to CMS. The mailing list continues to be updated to include people who submitted public comments and/or provided contact information at public meetings or hearings on *Reform 2020*. A copy of the mailing list is included as Attachment I.

11.4.4 Public Hearings

Two public hearings were held to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The first public hearing was held at the

Minnesota Department of Health on June 22, 2012. Public testimony was given by 15 people, and 48 members of the public were in attendance. The second public hearing was held at the Minnesota Department of Human Services on June 25, 2012. Public testimony was given by 8 people, and 47 members of the public were in attendance. Teleconferencing was available at each hearing to allow interested stakeholders the option to participate in the hearing remotely.

11.4.5 Additional Public Meetings

DHS scheduled additional public meetings in July to ensure ample opportunity for Minnesotans to learn about *Reform 2020* and provide comment. These meetings provided a forum for DHS staff to make presentations and to hold question and answer sessions. A notice informing the public of meeting topics, times and locations was posted on the *Reform 2020* website and disseminated to the stakeholder email list. The following meetings were held for the general public:

- **Comprehensive Overview of *Reform 2020* Initiative**

Tuesday, July 10, 2012 from 6:30 – 9 p.m.

Brian Coyle Pillsbury Community Center, 420-15th Ave S, Minneapolis, MN 55454

- ***Reform 2020* and Mental Health**

Monday, July 9, 2012 from 9 a.m. – Noon at DHS Lafayette Building, 444 Lafayette Rd, St. Paul, MN 55155, Room 5134

- ***Reform 2020* and the new Community First Services and Supports benefit**

Tuesday, July 10, 2012 from 2 – 5 p.m. at DHS Elmer L. Andersen Human Services Building, 540 Cedar St, St. Paul, MN 55164, Room 2370/80

- ***Reform 2020* and Services for Children with Autism**

Wednesday, July 11, 2012 from 2 – 5 p.m. at DHS Elmer L. Andersen Human Services Building, 540 Cedar St, St. Paul, MN 55164, Room 2370

- ***Reform 2020* Public Comment on Mental Health and MnCHOICES**

Friday, August 3, 2012 from 8:30-10:30 a.m. at DHS Elmer L. Andersen Human Services Building, 540 Cedar St, St. Paul, MN 55164, Room 2380

- ***Reform 2020* Webinar on *Reform 2020* Fiscal Analysis and Historical Data**

Friday, October 12, 2012 from 1:30-3:30 p.m. at DHS Elmer L. Andersen Human Services Building, 540 Cedar St, St. Paul, MN 55164, Room 2380

In addition, DHS received valuable input from stakeholder groups prior to and during the comment periods. See Attachment F.

11.4.6 Forum with Minnesota Counties

On July 11, 2012 DHS held a forum for county representatives to meet with the Commissioner and other DHS leaders to share comments regarding the *Reform 2020* draft waiver proposal. Several county representatives participated in the forum remotely via teleconference.

11.5 Public Comments

DHS received numerous verbal comments and over 100 timely written comments from stakeholders regarding the *Reform 2020* draft waiver proposal during the first comment period from June 18 to July 17, 2012. In addition, DHS received 552 timely copies of a petition signed by concerned stakeholders concerning services for people with autism spectrum disorder. Copies of the written comments received during the comment period are included at Attachment L. Comments that included private medical or public assistance information regarding the commenter have been redacted to remove individually identifying information. DHS' response to the written comments received by July 17 is included at Attachment K, and is also reflected in modifications that have been made throughout the main body of the waiver proposal.²³

DHS received four written comments from stakeholders during the second 30-day public comment period on the the *Reform 2020* waiver proposal. Copies of the comments received during the second 30-day public comment period and DHS' response to the written comments are included at Attachment R.

Authorities requested

Several commenters responded that it was difficult to tell which initiatives described in the waiver proposal require Section 1115 waiver authority. DHS has included a chart at Attachment J to communicate what federal authority is being requested under this waiver proposal.

²³ DHS continues to receive comments following the comment period (including more than 800 more copies of a petition concerning services for people with autism spectrum disorder), and will continue to review these comments. However, comments received after July 17 are not included at Attachment L.

Payment and Service Delivery Reform

DHS appreciates the many comments and high level of interest in this topic. The recommendations of the Care Integration and Payment Reform Work Group under the Governor's Health Reform Task Force will guide the planning of this effort, and DHS will engage the provider community, including managed care organizations, in the development of this effort. Minnesota is committed to ensuring that robust consumer protections are in place under the new system to ensure access to care, choice of providers and quality of care.

No Cuts in Personal Care Assistance or Services for Children with Autism

Minnesota has one of the most generous Medicaid benefit sets in the country for people in need of home and community-based services and supports. The *Reform 2020* waiver was not intended to solve years of difficult budgets. Instead, in general *Reform 2020* proposals work to most effectively utilize the resources that are currently available.

Redesign of Personal Care Assistance

First, DHS wishes to reassure stakeholders that the redesign of the Personal Care Assistance Service is not a cut in benefits. The same eligibility criteria applies. However, the benefit has been made more flexible and more consumer-directed. In addition, the proposal does increase the lowest home care rating from the current 30 minutes allotted in PCA services to a lowest average daily amount of 90 minutes to be authorized in CFSS. This lowest average daily amount is based on a base home care rating of 75 minutes with additional time for identified behaviors and/or complex health-related needs. See Attachment M for a comparison of the current personal care assistance benefit to the proposed Community First Services and Supports (CFSS) benefit.

Personal Care Assistance and Nursing Facility Level of Care changes

The additional flexibility and the additional PCA minutes for people included in the Demonstration to Reform Personal Assistance Services with the lowest home care rating (raising the lowest average daily amount from 30 to 90 minutes) provided in the Demonstration to Reform Personal Assistance Services is intended in part to accommodate the needs of people who may lose eligibility for home and community-based waivers due to the proposed change of the nursing facility level of care discussed in the Long Term Care Realignment waiver. Attachment N shows the interaction between the change in nursing facility level of care and personal care assistance.

Autism

DHS received numerous comments regarding services for children with Autism Spectrum Disorder during the public comment submission period. DHS has amended section 9.1.2 of the proposal to better reflect the intent of the proposal and clarify DHS' position that autism is a medical condition, requiring medically-necessary rehabilitative and often habilitative services and supports, stretching across several years and sometimes across the lifespan of an individual.

DHS would also like to clarify that DHS was not and is not intending to request federal permission to change autism services in the *Reform 2020* waiver proposal. *Reform 2020* includes only preliminary information about possible future autism reforms. DHS will meet with community members to develop a proposal for a new state law on services for people with autism. DHS meetings will begin in late summer 2012. DHS is also working with other state agencies that have responsibility for helping people with autism (Minnesota Department of Health, Minnesota Department of Education, etc.)²⁴

Demonstration of Innovative Approaches to Service Coordination (Children with CFSS)

In response to public comment about the proposal for school-based demonstration to test innovative approaches to care coordination for children with complex service needs, DHS revised the proposal from placing the demonstrations solely within schools to asking local interested entities to put together collaborative proposals for participating in this demonstration. The Departments of Human Services (both the Disability Services and Children's Mental Health Divisions) and Education agree that there would be many challenges to making this a school-only centered service. At the same time, we believe that it is imperative to increase the capacity for coordination that incorporates education as children spend much of their time in schools, and receive many critical services in school settings. For this reason, we would like to see schools be part of collaborative efforts with other community entities to develop innovative strategies for coordination that would be effective in their localities. There is much work to be done to further develop the proposal before implementing this demonstration. DHS will rely upon input from our stakeholders and our partners at the Department of Education to shape the final design.

²⁴ In addition, the Health Services Advisory Council or HSAC is now working on recommendations related to autism services. Meetings began in June 2012. HSAC will submit its recommendations about autism services in December 2012. (HSAC's role is to recommend what treatments should be covered in Minnesota public health care programs, based on scientific studies.) The DHS autism web page will include information about all of these activities. Please check the DHS autism web page at www.dhs.state.mn.us/autism

Reform 2020 and Minnesota's Mental Health System

The *Reform 2020* waiver is not intended to present an overarching plan for Minnesota's mental health system moving forward. The *Reform 2020* waiver seeks federal matching funds for services provided at AMRTC and provides a framework for additional proposals under 1915(i) that have yet to be fully developed with stakeholder input. The Mental Health Division is beginning a stakeholder process in August to lay the foundation for more comprehensive action focused on the mental health system.

Nursing Facility Level of Care changes and mental health concerns

Concerns were raised that the proposed changes to the nursing facility level of care set forward in the Long Term Care Realignment waiver proposal would result in thousands of people with a mental illness no longer being eligible for the CADI waiver and the *Reform 2020* waiver should therefore provide services to fill this new gap. DHS is sensitive to this concern. DHS analysis of the impact of the proposed change in the nursing facility level of care in the Long Term Care Realignment waiver has demonstrated that the proposed change does not reduce eligibility by CADI by a large percentage, nor does the change disproportionately affect people with a mental illness who are participating in the CADI waiver.²⁵

Please note that the revised nursing facility level of care 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. This is discussed in more depth in the Long-Term Care Realignment waiver proposal.

Demonstration to Empower and Encourage Independence through Employment Supports

Several commenters asked why IPS wasn't being utilized and noted that this is an evidence-based approach for people with serious mental illness. DHS agrees that additional approaches are needed to provide employment supports for people with mental illness, and this approach will be considered in the context of the proposed 1915(i) for Intensive Mental Health Recovery Services described at section 9.1.4.

²⁵ An analysis shared with stakeholders at a Partners Panel meeting showed that CADI participants with a past or current mental health diagnosis were underrepresented in the group expected to lose CADI. Appendix XI of the Long-Term Care Realignment waiver shows that out of almost 17,000 current CADI waiver participants, only 501 or 3% of current waiver participants would not appear to meet the revised level of care, based only on the quantitative information. (This estimate is likely high because more subjective evaluation of "risk of self-neglect" that would be performed by assessors in the field would likely prevent some of this group from losing CADI.) The additional flexibility and the additional PCA minutes for people with the lowest home care rating (raising the lowest average daily amount from 30 to 90 minutes) provided in the Demonstration to Reform Personal Assistance Services is intended in part to accommodate the needs of people with mental illness potentially losing CADI.

Housing Stability Services Demonstration

Several commenters stated that this demonstration is too limited and doesn't go far enough to address needs of young people and people with serious mental illness. The Housing Stabilization Services demonstration is changing to respond to comments. For example, the program is no longer limited to people that meet a functional assessment. Services to support access to and maintenance of housing for people with serious mental illness will be considered in the context of the proposed 1915(i) for Intensive Mental Health Recovery Services described section 9.1.4.

DHS appreciates the thoughtful written comment and public testimony provided by all stakeholders and has extensively discussed and analyzed the issues raised during the public input process. DHS encourages members of the public to continue to stay involved during the upcoming federal notice and comment period, which will be announced on the DHS website and via an email to the stakeholder's list. DHS' responses to written comments received by July 17 is included at Attachment K, and is also reflected in modifications that have been made throughout the main body of the waiver proposal.

12 Organization and Administration

12.1 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.

12.2 Key Personnel of the Demonstration

Lucinda Jesson is commissioner of the Minnesota Department of Human Services and is responsible for directing the activities of the department. DHS is the state's largest agency, serving well over one million people with an annual budget of \$11 billion and more than 6,000 employees throughout the state. The department administers a broad range of services, including health care, economic assistance, mental health and substance abuse prevention and treatment, child welfare services, and services for older people and people with disabilities.

Anne Barry is Deputy Commissioner for DHS, where she provides leadership and operational direction to all of the programs and divisions of the agency.

Charles E. Johnson is the chief financial officer (CFO) and chief operating officer (COO) for DHS. As CFO, he oversees the agency's budget development as well as financial analysis and operations. As COO, he oversees the Office of Inspector General, including the Licensing

Division, the Compliance Office, Information Technology/Enterprise Architecture, communications and public affairs.

Scott Leitz is assistant commissioner of Health Care for DHS. He oversees Minnesota's Medicaid program. DHS is one of the largest health care purchasers in the state serving more than 700,000 program enrollees. Leitz is responsible for eligibility and benefit policy, state MinnesotaCare operations, provider contracts and payment systems, and health reform initiatives in publicly funded programs. He was appointed to his post in January 2011.

Carol Backstrom is the state Medicaid director for the Minnesota Department of Human Services. She oversees department relations with the federal Centers for Medicare & Medicaid Services, including negotiating changes to the state's Medicaid plan and waivers.

Jim Golden is Deputy Assistant Commissioner of Health Care within DHS and has responsibility for providing leadership and operational direction to the programs and divisions within Health Care.

Pamela Parker is Manager of Special Needs Purchasing in the Purchasing and Service Delivery Division within the Health Care Administration of DHS. She has responsibility for Minnesota Senior Health Options, Minnesota SeniorCare Plus, Special Needs Basic Care and the proposal to Redesign Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility.

Loren Colman is assistant commissioner for Continuing Care at 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 Aging and Adult Services, Disability Services, Deaf and Hard of Hearing Services and Nursing Facilities.

Jean Wood is the Director of the Aging and Adult Services Division within the Continuing Care Administration of DHS and has responsibility for administering publicly-funded health care programs for older Minnesotans. Ms. Wood is also the Executive Director of the Minnesota Board on Aging. The 25 members of the board are designated by the Governor. The Board on Aging is the designated State Unit on Aging under the Older Americans Act and is administratively placed at DHS.

Alex Bartolic is the Director of the Disability Services Division within the Continuing Care Administration of DHS and has responsibility for administering publicly-funded health care programs for Minnesotans with disabilities and HIV/AIDS who need long term services and supports. Programs include four home and community-based service disability waivers, home care, intermediate care facilities for people with developmental disabilities, day services, case management, guardianship, and state grants.

David Hartford is the Acting Assistant Commissioner for Chemical and Mental Health Services Administration within DHS. He is responsible for the policy divisions of Adult Mental Health, Children’s Mental Health, and Alcohol and Drug Abuse.

Cynthia Godin is the Adult Mental Health Director within the Chemical and Mental Health Services Administration of DHS. She is responsible for leadership and vision for a comprehensive, effective adult mental health system. As director, Ms. Godin manages the evolution of a continuum of services in accordance with state and federal requirements to strategically plan resources and activities across state agencies, counties, tribes, and the provider system, with consumer input to advance the recovery message and minimize the effects of chronic mental illness.

Erin Sullivan Sutton is the Assistant Commissioner for Children and Family Services within DHS. She is responsible for programs and policies that promote economic stability, child safety and permanency, opportunities for children to develop to their potentials and successful transition for immigrant families.

Mark Toogood is the Director of Transition to Economic Stability within the Children and Family Services Division Administration of DHS and has policy responsibility for the Minnesota Family Investment Program (Minnesota’s TANF program), the Diversionary Work Program, SNAP, General Assistance, MSA, Group Residential Housing, the Office of Refugee Resettlement, the MAXIS Help Desk and the Public Assistance program training unit.

Jane Lawrenz is the Manager of Community Living Supports within the Transition to Economic Stability within the Children and Family Services Division Administration of DHS and has responsibility for General Assistance, Group Residential Housing, Minnesota Supplemental Aid, SSI Advocacy, and Long-Term Homeless Support Services.

13 Waiver Authorities Requested

13.1 Accountable Care Demonstration

All Minnesota categorically needy and medically needy populations would be affected by the Accountable Care Demonstration proposal.

13.1.1 Title XIX Waivers

Minnesota seeks CMS guidance to determine which, if any additional waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act are necessary to enable the state to carry out the demonstration

13.1.2 Costs Not Otherwise Matchable

Minnesota seeks CMS guidance to determine what, if any authority Minnesota may require under Section 1115(a)(2) of the Act to regard expenditures for Medicaid coverage for enrollees in accountable care organizations as expenditures under the State's Title XIX plan for the period of this waiver.

13.2 Demonstration to Reform Personal Assistance Services

The Demonstration to Reform Personal Assistance Services includes Community First Services and Supports (CFSS) for a 1915(k)-like population group, CFSS for a 1915(i)-like population group and the Innovative Approaches to Service Coordination demonstration for children.

The 1915(i)-like group has the following characteristics:

- Eligible for Medical Assistance
- Any age
- Does not meet institutional level of care (nursing facility, hospital, or ICF/DD level of care)
- Have an assessed need for assistance with at least one activity of daily living (ADL), or, be physically aggressive towards one's self or other or be destructive of property that requires the immediate intervention of another person ("Level One Behavior" per Minnesota Statute).

Eligibility requirements for the 1915(k)-like group are as follows:

- Eligible for Medical Assistance or would otherwise be Medicaid eligible if the State had elected the group described in section 1902(a)(10)(A)(ii)(VI) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program.
- Any age
- Meets institutional level of care (nursing facility, hospital, or ICF/DD level of care)
- Have an assessed need for assistance with at least one activity of daily living (ADL), or, be physically aggressive towards one's self or other or be destructive of property that requires the immediate intervention of another person ("Level One Behavior" per Minnesota Statute).

To be covered under Innovative Approaches to Service Coordination demonstration for children, participants must:

- Receive CFSS and meet the criteria under the 1915(i)-like group or the 1915(k)-like group
- Have an IEP/IFSP that includes health-related services billed to Medicaid, and
- Have more than 2 complex health-related needs (e.g. gastrojejunostomy tube; total parenteral nutrition; multiple wounds) or;
- Receive mental health services or;
- Demonstrate physical aggression towards oneself or others or destruction of property that requires the immediate intervention of another person (Level 1 behavior).

- Be enrolled in a participating school district

13.2.1 Title XIX Waivers

Minnesota seeks the following waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act to enable the state to carry out the Demonstration of Innovative Approaches to Service Coordination (Children with CFSS) component of the Demonstration to Reform Personal Assistance Services:

Statewideness/Uniformity. Minnesota requests a waiver of Section 1902(a)(1) as implemented by 42 CFR 431.50 to the extent necessary to enable the State to allow local variation in service delivery and allow the Demonstration of Innovative Approaches to Service Coordination (Children with CFSS) to be limited to participants enrolled in certain school districts, and to limit the number of participants to 1,500.

Amount, Duration and Scope. Minnesota requests a waiver of section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b) to the extent necessary to enable the State to vary the services offered to individuals within eligibility groups or within the categorical eligible population, based on the limited availability of slots for the Innovative Approaches to Service Coordination demonstration participants.

Enrollment Target. Minnesota requests a waiver of waiver of Section 1902(a)(8) of the Act to enable the State to establish enrollment targets and maintain waiting lists. This waiver is only to the extent necessary to manage the Demonstration of Innovative Approaches to Service Coordination (Children with CFSS) segment of the demonstration.

13.2.2 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard expenditures for people participating in the Demonstration to Reform Personal Assistance Services who are not covered under the State plan as expenditures under the State's Title XIX plan for the period of this waiver:

217-Like Elderly Home and Community-based Services (HCBS) Group. Expenditures for medical assistance for individuals over age 65 who meet the institutional level of care and who would otherwise be Medicaid eligible if the State had elected the group described in section 1902(a)(10)(A)(ii)(VI) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program.

217-Like Elderly and Disabled Home and Community-based Services (HCBS) Group. Expenditures for medical assistance for disabled individuals who meet the institutional

level of care and who would otherwise be Medicaid eligible if the State had elected the group described in section 1902(a)(10(A)(ii)(VI) of the Act, if enrolled and receiving services under a 1915(c) HCBS waiver program.

Enhanced FMAP for expenditures to provide CFSS services to the 1915(k)-like group.

13.3 Demonstration to Expand Access to Transition Support

The Demonstration to Expand Access to Transition Support includes services for three populations in need of transition support: Return to Community Transition Support participants, Long-Term Care Options Counseling participants, and Expanded Transition Support participants.

The following eligibility criteria must be met to participate in Return to Community Transition Support:

1. Be a nursing home resident who has been admitted for over 60 days but not more than 90, and
2. Have expressed a desire to return to the community, and
3. Fit a discharge profile that indicates a high probability of community discharge, and
4. Would otherwise become long stay residents based on the status of their peers, and
5. Are Minnesota residents, and
6. Are not yet eligible for Medicaid or Money Follows the Person Benefit, and
7. Could benefit from discharge planning assistance based on the Community Living Mini Assessment developed by Dr. Greg Arling, and
8. Are Minnesota residents or planning a move to Minnesota, and
9. After an inquiry by a long-term care options counselor request that a Community Living Specialist begin the process of helping them return home, or
10. Have stayed longer than 90 days and then are referred to the Senior LinkAge Line® (the local contact agency) by nursing home staff after responding affirmatively that they wish to return to a community setting in response to Section Q of the MDS.

The following eligibility criteria must be met to participate in Long-Term Care Options Counseling:

- Is intending to move to an Registered Housing with Services Setting as either recommend by their family or because they need services or have safety concerns, and
- Are of any age, and
- Is a Minnesota resident or is an individual that is planning a move to the state, and
- Is not yet enrolled in a Medicaid waiver falls into the pre-eligible high risk of spend down category, and

- Are not seeking a lease-only arrangement in a subsidized housing setting (exempts people who are not using service), and
- Is not receiving or being evaluated for hospice services, and
- Does not have a long-term care plan that covers planning for incapacitation with sufficient assets covering 60 months housing and services costs, or
- Has been referred by a hospital discharge planner because the hospital determined, using the Community Living Mini Assessment that the individual was:
 - In need of home modifications, or
 - At risk of falls
 - In need of medication management
 - In need of access to transportation or support to get to primary care physician follow up appointments
 - In need of access to caregiver or
 - Have caregiver stress or
 - In need of chronic disease management follow up and education or
 - In need of service coordination to manage activities of daily living.

The following eligibility criteria must be met to participate in Expanded Transition Support:

- Entering a nursing home or planning a move to assisted living
- Has dependencies in two activities of daily living, and
- Has had one or more institutional stays and is at risk of a future stay because the person had one or more readmissions within one calendar year of the initial admit and fall into a target “Rate Utilization Group (RUG)” category,
- At risk due to:
 - Need for home modifications, or
 - At risk of falls
 - In need of medication management
 - In need of access to transportation or support to get to primary care physician follow up appointments
 - In need of access to caregiver or
 - Have caregiver stress or
 - In need of chronic disease management follow up and education or
 - In need of service coordination to manage activities of daily living.
- Is age 70 or older or at high risk, and
- A Minnesota resident or is an individual that is planning a move to the state and,
- Has not been determined eligible for Medicaid due to availability of assets but is at high risk of spend-down of assets with 24 months

13.3.1 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard the following expenditures as expenditures under the State’s Title XIX plan for the period of this waiver:

Expenditures for transition support services for participants who are not otherwise eligible for Medicaid under the State plan but meet the eligibility requirements of Return to Community Transition Support, Long-Term Care Options Counseling, or Expanded Transition Support.

13.4 Demonstration to Empower and Encourage Independence through Employment Supports

Populations covered under this demonstration include those members of the following groups who are employed or have been employed within the past year and have experienced a decrease in income or job loss within the past year:

- Medical Assistance Expansion recipients age 18-26 with a potentially disabling serious mental illness as identified used ICD-9 diagnostic codes (290-301 and 308 – 319) and health care claims associated with these diagnoses within the past 12 months. Preliminary numbers indicate 3,950 potentially eligible.
- Medical Assistance for Employed Persons with Disabilities recipients age 18-26. Preliminary numbers indicate 141 potentially eligible participants.
- Minnesota Family Investment Program parents who have turned to cash assistance as minor parents or because of the demands of caring for a seriously ill family member.
- Medical Assistance recipients identified as in transition from the Department of Corrections. Services will be offered to approximately 300 Medical Assistance recipients in a yet to be determined region.
- Medical Assistance recipients ages 18-26 exiting foster care.

13.4.1 Title XIX Waivers

Minnesota seeks the following waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act to enable the state to carry out the demonstration:

Amount, Duration and Scope. Minnesota requests a waiver of section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b) to the extent necessary to enable the

State to offer benefits that vary from the State plan to participants in the Work: Empower and Encourage Independence Demonstration.

Enrollment Target. Minnesota seeks a waiver of Section 1902(a)(8) of the Act to enable the State to establish enrollment targets and maintain waiting lists for the Work: Empower and Encourage Independence demonstration participants.

13.4.2 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard the following expenditures as expenditures under the State's Title XIX plan for the period of this waiver:

Expenditures for employment support services for Work: Empower and Encourage Independence demonstration participants.

13.5 Housing Stabilization Services Demonstration

This demonstration aims to better serve adults with chronic medical conditions, frequent use of high cost medical services (e.g. inpatient medical and psychiatric hospitalizations, emergency room visits, and ambulance transports) and identified housing instability. Housing Stabilization Services include service coordination plus one of more of the following most needed to maintain stability and independence in the community: Outreach/In-Reach, Tenancy Support services, and/or Community Living Assistance. Consistency of care will be increased through help in establishing a relationship with a primary care provider.

Eligibility will be informed by risk factors indicating function needs rather than solely on certified diagnosis. To be eligible under this demonstration, participants fit the characteristics of Target Group One or Target Group Two.

Target Group One

- Medicaid recipient
- Eligible for General Assistance with one of the following bases of eligibility according to MN Statute 256D.05:
 - Permanent Illness or Incapacity
 - Temporary Illness or Incapacity
 - SSI/RSDI Pending
 - Appealing SSI/RSDI Denial
 - Advanced Age
- Homeless: Lacks a fixed, regular and adequate nighttime residence, meaning the individual has a primary nighttime residence that is a public or private place not

meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less, and who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

- o **Target Group Two**
- Medicaid recipient
- Eligible for Group Residential Housing, which requires a basis of eligibility for General Assistance according to MN Statute 256D.05, or identified as aged, blind or disabled as determined by eligibility criteria by the Social Security Administration for Supplemental Security Income, and living in one of the following settings:
 - o A housing with services establishment as described by MN Statute 256I.04, Subd. 2a
 - o The supportive housing demonstration for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome according to MN Statute 256I.04, Subd. 3 (4)

13.5.1 Title XIX Waivers

Minnesota seeks the following waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act to enable the state to carry out the demonstration:

Enrollment Target. Minnesota seeks a waiver of Section 1902(a)(8) of the Act to enable the State to establish enrollment targets and maintain waiting lists for the Housing Stabilization Services demonstration.

Amount, Duration and Scope. Minnesota requests a waiver of section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b) to the extent necessary to enable the State to offer benefits that vary from the State Plan to Housing Stabilization and Services demonstration participants.

13.5.2 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard the following expenditures as expenditures under the State's Title XIX plan for the period of this waiver:

Expenditures for housing stabilization services for Housing Stabilization Services demonstration participants.

13.6 PATH Critical Time Intervention Demonstration

PATH eligible individuals are adults with a serious mental illness, or a serious mental illness and substance abuse, who are homeless or at imminent risk of becoming homeless and being served by a Minnesota PATH program. Eligible individuals served include persons contacted via PATH outreach and in-reach services and persons that become enrolled in PATH services.

13.6.1 Title XIX Waivers

Minnesota seeks the following waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act to enable the state to carry out the demonstration:

Local funding. Minnesota seeks a waiver of 42 CFR 433.51 to the extent necessary to allow the ability to use funds contributed voluntarily by local units of government as State matching funds for federal financial participation.

Enrollment Target. Minnesota seeks a waiver of Section 1902(a)(8) of the Act to enable the State to establish enrollment targets and maintain waiting lists for the PATH CTI demonstration.

Amount, Duration and Scope. Minnesota requests a waiver of section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b) to the extent necessary to offer benefits that vary from the State plan to PATH CTI demonstration participants.

13.6.2 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard the following expenditures as expenditures under the State's Title XIX plan for the period of this waiver:

Expenditures for destitute homeless individuals served under the PATH CTI program, including persons who are not yet connected enough into the system to have been determined eligible for Medicaid.

13.7 Anoka Metro Regional Treatment Center Demonstration

This demonstration population is adult age 21-64 receiving treatment in an IMD who would otherwise be eligible for Medicaid.

13.7.1 Title XIX Waivers

Minnesota seeks the following waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act to enable the state to carry out the demonstration:

IMD Exemption. Minnesota requests a waiver of Sections 1396d(a)(1),(a)(4)(A), (a)(15) and (c) of the Act as implemented by 42 CFR § 435.1009e(a)(2) and 42 CFR §435.1010 to exempt the state from IMD exclusion for adults between the ages of 21 and 65 who meet Medicaid eligibility requirements and are receiving services at Anoka Metro Regional Treatment Center Demonstration.

13.7.2 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard the following expenditures as expenditures under the State's Title XIX plan for the period of this waiver:

Expenditures for services provided to Medicaid-eligible adults receiving inpatient psychiatric services in Anoka Metro Regional Treatment Center.

13.8 Adults without Children Eligibility

13.8.1 Title XIX Waivers

Minnesota seeks the following waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act to enable the state to carry out the demonstration:

Minnesota requests the following waivers under the authority of Section 1115(a)(1) of the Act to implement eligibility reform for adults without children:

Waiting Period. Minnesota requests a waiver of Section 1902(a)(8) and Section 1902(b)(2) as implemented by 42 CFR 435.403 to the extent necessary to allow the State to impose a waiting period of up to 180 days on MinnesotaCare Adults without Children applicants with income above 75% of the federal poverty guidelines who have not lived in the state for 180 days.

Asset Test. Minnesota requests a waiver of Section 1902(a)(10)(A)(i)(VIII) of the Act to the extent necessary to allow the State to impose an asset limit of \$10,000 on Medical Assistance Adults without Children applicants with incomes at or below 75% of the federal poverty guidelines.

13.8.2 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard the following expenditures as expenditures under the State's Title XIX plan for the period of this waiver:

Expenditures for medical coverage for Adults Without Children reform participants.

Attachment A: Minnesota Demographics

Chart 1: Projected number of Minnesotans 85 years and older: 2010-2050

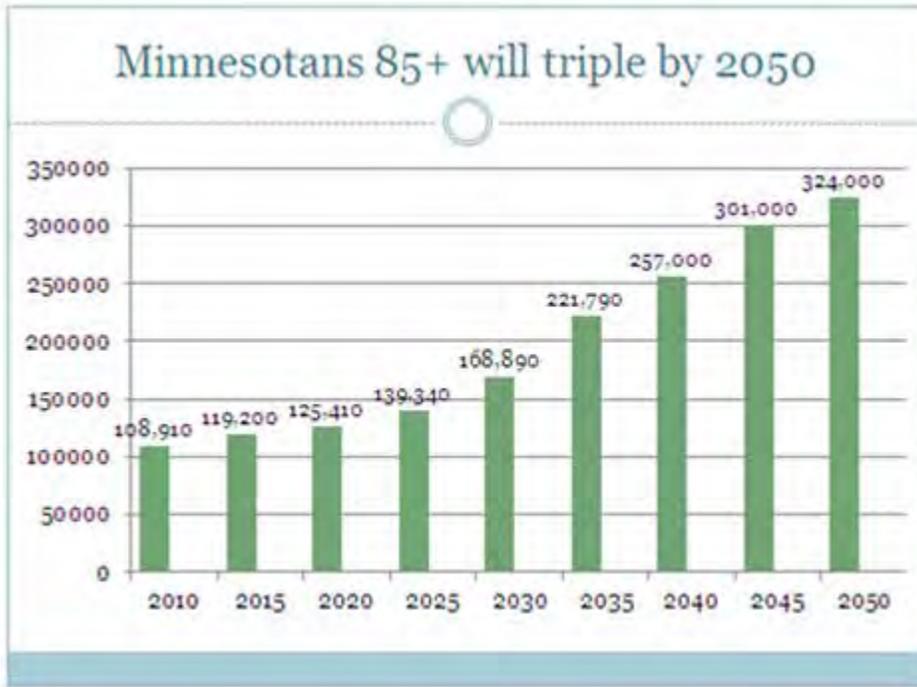
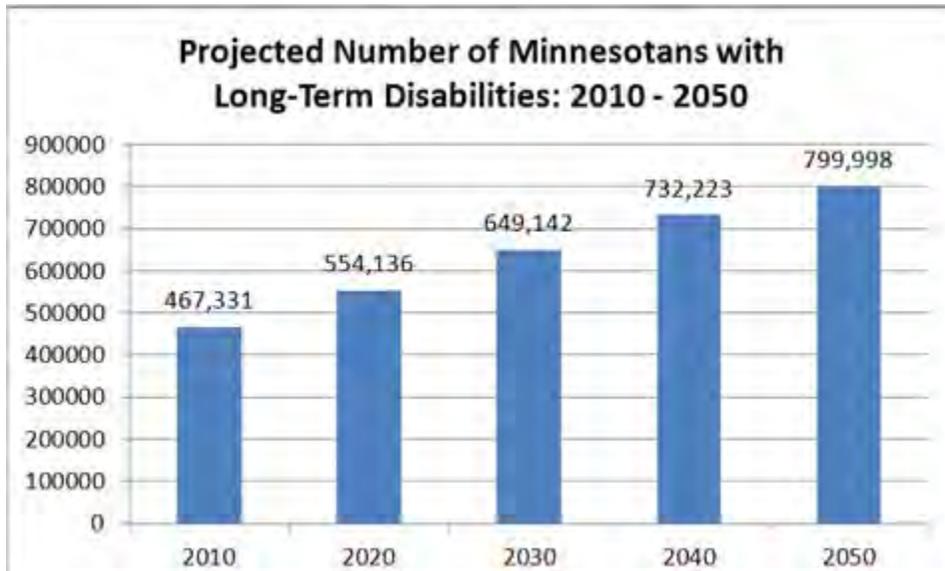
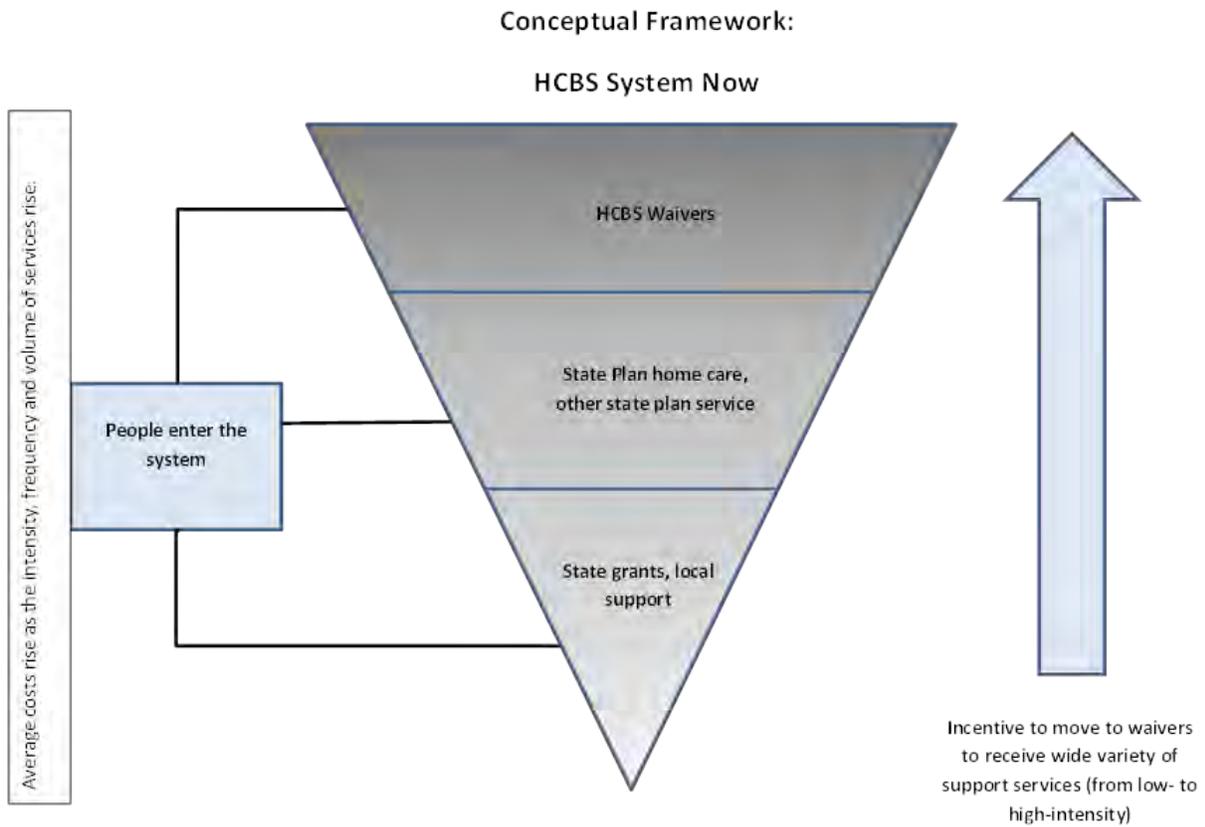


Chart 1: Projected number of Minnesotans with Long-Term Disabilities: 2010-2050

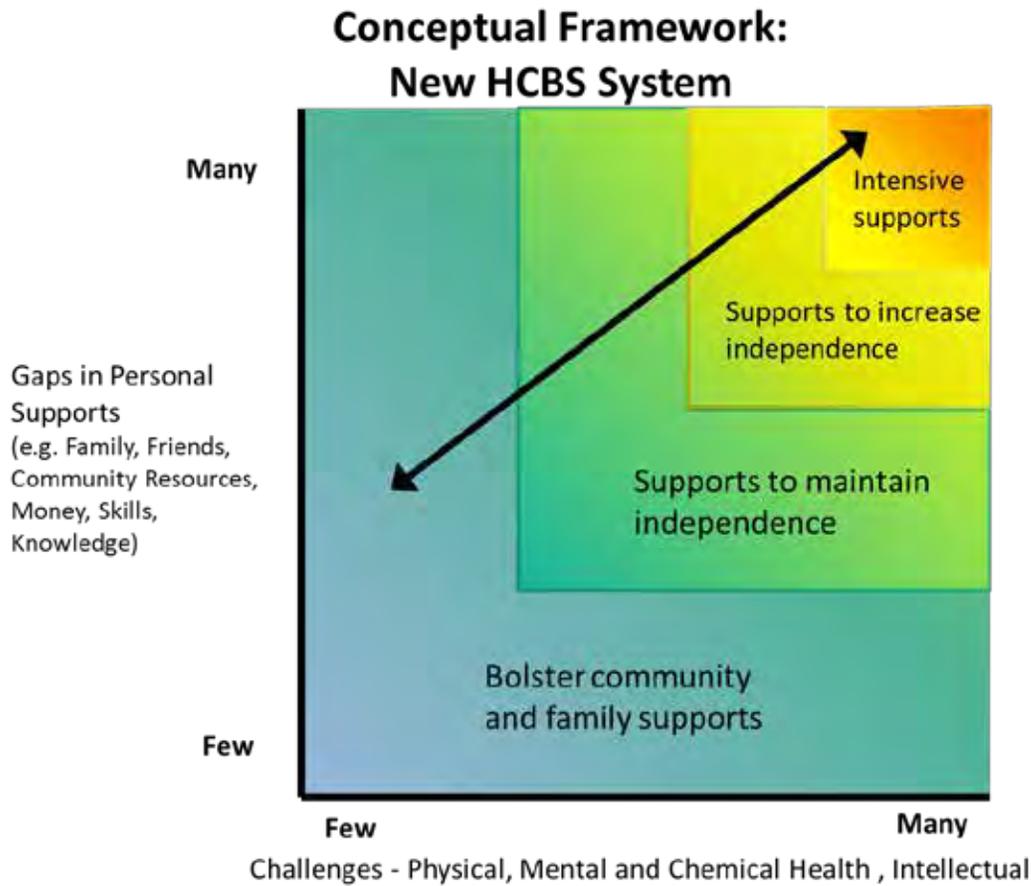


Attachment B: HCBS System “Now”



Current System Dynamic: There is pressure to move into waived services in order to receive services that aren't available otherwise. Once on a waiver a person has access to a waiver-specific menu of services. There are people with low needs and high needs on the same waiver program.

Attachment C: HCBS System “Future”



Desired System Dynamic: People get the right service at the right time. System is flexible and fluid, so that people get a higher level of service when needed, but stay at or return to lower levels when those are sufficient.

Attachment D: Institutional Level of Care Criteria

ICF/DD

ICF/DD level of care is required for the Developmental Disabilities (DD) Waiver. To meet the requirements for ICF/DD level of care, a person must meet all of the following:

- Be in need of continuous active treatment
- Have a diagnosis of developmental disability or a related condition
- Require a 24-hour plan of care
- Require aggressive and consistent training due to an inability to apply skills learned in one environment to a new environment

Nursing Facility Level of Care (current)

Nursing facility level of care is required for the: Brain Injury Nursing Facility (BI)Waiver and Community Alternatives for Disabled Individuals (CADI)Waiver, a person must meet one or more of the following:

- Cognitive or behavioral condition
- Existence of complicating conditions
- Frailty or vulnerability
- Functional limitation
- Need for complex care management
- Need for restorative and rehabilitative or other special treatment
- Unstable health

To be eligible for the Brain Injury - NF Waiver, the person must require the level of care and types of specialized service available in certain nursing facilities that support persons with brain injury who have significant cognitive and significant behavioral needs.

Hospital Level of Care

Hospital level of care is required for the Community Alternative Care Waiver (CAC). A person must meet the four following requirements:

- Need professional nursing assessments and intervention multiple times during a 24-hour period to maintain and prevent deterioration of health status.
- Have both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes due to the person's health condition.
- Require a 24-hour plan of care, including a back-up plan, to reasonably assure health and safety in the community.
- Require frequent or continuous care in a hospital without the provision of CAC waiver services.

Neurobehavioral Hospital Level of Care

Neurobehavioral hospital level of care is required for the Brain Injury Neurobehavioral Waiver.

A person must meet the nursing facility level of care and all of the following:

- Require specialized brain injury services and/or supports that exceed services available through the TBI-NF Waiver.
- Require a level of care and behavioral support provided in a neurobehavioral hospital to support persons with significant cognitive and severe behavioral needs. A person does not have to be a resident of a neurobehavioral hospital to require this level of care.
- Require a 24-hour plan of care that includes a formal behavioral support plan and emergency back-up plan to reasonably assure health and safety in the community.
- Require availability of intensive behavioral intervention.

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 <i>impaired cognition</i> : <ul style="list-style-type: none"> • Short term memory loss • Disorientation of person, place, time or location • Impaired decision-making ability OR <i>Frequent history of the following behavior symptoms:</i> <ul style="list-style-type: none"> • Wandering • Physical abuse of others • Resistive to care • Behavior problems requiring some supervision for safety of self or others • Severe communication problems 		<i>Self neglect:</i> 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 <i>Neglect, abuse, or exploitation:</i> 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 <i>admissions</i> , 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)

Attachment F: Reform 2020 Stakeholder Work Groups and Meetings

Partner Panel meetings

August 12, 2011
September 29, 2011
December 9, 2011
January 6, 2012
March 9, 2012
April 4, 2012 (Data webinar)
May 11, 2012
June 18, 2012
July 13, 2012
October 12, 2012

Aging Workgroup Meetings

October 13, 2011
November 10, 2011
December 1, 2011

Disability Workgroup Meetings

October 21, 2011
November 10, 2011
December 1, 2011

Aging and Disability Workgroups Joint Meetings

December 16, 2011
January 10, 2012
March 23, 2012

Consumer-Directed Task Force Meetings

February 16, 2012
February 24, 2012
March 2, 2012

Leadership Council on Aging

January 3, 2012

Minnesota Association of County Social Services Administrators

April 2012

Olmstead Committee

May 3, 2012
June 21, 2012

Employment Services/MFIP Providers

January 20, 2012
January 23, 2012
February 01, 2012

County-State Work Group

October 28, 2011
November 18, 2011
January 27, 2012
March 23, 2012
May 18, 2012
June 22, 2012
August 24, 2012
October 26, 2012

Mental Health Stakeholders

May 1, 2012
July 9, 2012
July 11, 2012

Minnesota Interagency Council on Homelessness

Subcommittee on Medicaid and Support Services

Second Tuesday and fourth Wednesday of every month since April 2011

Minnesota Home Care Association and Aging Services of MN

February 7, 2012

Association of Residential Resources in Minnesota CFO

June 20, 2012

Autism Advisory Council

October 15, 2012
October 23, 2012

Attachment G: 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.

Attachment H: June 18, 2012 State Register Notice

Department of Human Services

Health Care Administration

Request for Comments on *Reform 2020* Section 1115 Medicaid Waiver

DHS is announcing a 30-day comment period on the *Reform 2020* Section 1115 Medicaid waiver Request. The 2011 Minnesota Legislature directed the Department of Human Services (DHS) to develop a proposal to reform the Medical Assistance Program. Goals of the reform include: community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs.

In order to accomplish this goal, the legislature designated twelve separate initiatives to be examined. Several of these initiatives will result in the need for a waiver request under section 1115 of the Social Security Act. DHS has developed the section 1115 Medicaid waiver request entitled *Reform 2020* in order to implement several key components of the overall Medicaid reform initiative.

A copy of the waiver request can be found at <https://edocs.dhs.state.mn.us/lserver/Public/DHS-6535A-ENG> or http://www.dhs.state.mn.us/dhs16_169839. To request a paper copy of the waiver request, please contact Quitina Cook at (651) 431-2191.

Written comments may be submitted to the following email mailbox:

Reform2020Comments@state.mn.us. DHS would like to be able to provide copies of comments received in a format that is accessible for persons with disabilities. Therefore, we

request that comments be submitted in Microsoft Word format or incorporated within the email text. If you would also like to provide a signed copy of the comment letter, you may submit a second copy in pdf format or mail it to the address below. Comments must be received by July 17, 2012.

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

In addition to the opportunity to submit written comments during the 30 day public comment period, public hearings will be held to provide stakeholders and other interested persons the opportunity to comment on the waiver request. If you would like to attend a hearing via telephone, please send an email request to Reform2020Comments@state.mn.us to obtain the call-in information. If you would like to attend a hearing in person, the time and location for the two public hearings are provided below. If you plan to testify by telephone or in person, please send an email to Reform2020Comments@state.mn.us.

Public Hearing #1

Date: Friday, June 22, 2012
Time: 2:00 - 5:00 pm
Location: MDH, Snelling Office Park, Mississippi Room, 1645 Energy Park Drive, St. Paul, MN 55108.

Public Hearing #2

Date: Monday, June 25, 2012
Time: 9:00am - Noon
Location: DHS, Elmer L. Andersen Human Services Building, Room 2370/80, 540 Cedar St., St. Paul, MN 55164.

Attachment I: *Reform 2020* Stakeholder List

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Attachment I: *Reform 2020* Stakeholder List

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Attachment I: *Reform 2020* Stakeholder List

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Attachment I: *Reform 2020* Stakeholder List

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Attachment I: *Reform 2020* Stakeholder List

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Attachment J

Initiative	Does DHS request federal authority for the project under this waiver?
Health Care Homes (Section 2.3)	No, federal authority was granted under the Medicaid state plan.
Health Care Delivery Systems Demonstration (HCDS) (Section 3.2.1)	No, federal authority was granted under the Medicaid state plan
Hennepin Health (Section 3.2.2)	No, this project is allowable under existing managed care authority
Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility (Section 2.3)	No, this is being negotiated separately with CMS under the Demonstration to Integrate Care for Dually Eligible Individuals. See www.dhs.state.mn.us/dualdemo
Long-Term Care Realignment Section 1115 (Section 2.2)	No, this is being negotiated under the 1115 waiver request submitted February 2012. See http://www.dhs.state.mn.us/dhs16_167144.pdf
Accountable Care Demonstration (Section 3)	No, Minnesota seeks additional guidance from CMS regarding what additional federal authority may be necessary to contract with provider organizations for total cost of care.
Demonstration to Reform Personal Care Assistance Services <ul style="list-style-type: none"> • CFSS for individuals who meet institutional level of care (Section 4.2.1) • CFSS for individuals who do not meet institutional level of care (Section 4.2.2) 	Yes The proposal refers to Sections 1915(k) and 1915(i) of the Social Security Act because the demonstration has components that match up with CMS guidance related to those new options under the Medicaid state plan. Service models will be developed in collaboration with the Implementation Council
Demonstration of Innovative Approaches to Service Coordination (Children with CFSS) (Section 4.2.3)	Yes Program design will be further developed in collaboration with the Implementation Council
Demonstration to Expand Access to Transition Services (Section 5)	Yes
Demonstration to Empower and Encourage Independence through Employment (Section 6.1)	Yes
Housing Stability Services Demonstration (Section 6.2)	Yes ; Implementation Council to participate in service design.
Project for Assistance in Transition from Homelessness (PATH) Critical Time Intervention Demonstration (Section 6.3)	Yes
Anoka Metro Regional Treatment Center Demonstration (Section 7)	Yes
Eligibility for Adults without Children (Section 8)	Yes

<p>Coordinate and Streamline Services for people with complex needs</p> <ul style="list-style-type: none"> • Services for Children with ASD Diagnosis (Section 9.1.2) • Intensive Mental Health Recovery Services (Section 9.1.4) • Targeted Clinical and Community Services (Section 9.1.5) 	<p>No</p> <p>Plan to seek state plan authority under 1915(i) following stakeholder process and legislative action.</p> <p>State will engage ASD Task Force and seek to align policy work with goals of the Task Force.</p>
<p>Redesign HCBS (Section 9.2)</p>	<p>No; necessary changes to 1915(c) HCBS waivers may be sought</p>
<p>Promote Personal Responsibility and Reward Health Outcomes (Section 9.3)</p>	<p>No; activities funded through a federal grant</p>
<p>Encourage Utilization of Cost-Effective Care (Section 9.4)</p>	<p>No</p>
<p>Intensive Residential Treatment Services (Section 9.5)</p>	<p>No</p>
<p>Children Under 21 in Residential IMD Facilities (Section 9.6)</p>	<p>No</p>

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Comments	DHS Response
<p>2.2 Long Term Care Realignment Section 1115 Waiver</p> <p>Several commenters expressed support for Minnesota’s request for federal matching funds on the Alternative Care and Essential Community Supports (ECS) programs in the Long-Term Care Realignment Section 1115 waiver proposal submitted in February, 2012.</p> <p>Several commenters questioned whether State Plan home care and/or ECS services will be sufficient to meet the needs of individuals who no longer meet level of care criteria. One commenter raised concern about individuals who will be displaced when Nursing Facility Level of Care is implemented and asserted that there will be extraordinary challenges across the system. Lack of infrastructure and services in many rural areas will make transition problematic.</p> <p>Another commenter supported modifying the criteria for NF services, but advocated that the state decouple the NF LOC standard from the standard for HCBS waivers. Some commenters suggested increasing the ECS benefit amount and services eligible under ECS in order to address gaps or to include specific services, such as adult day services. Another commenter suggested exploring a new 1915(i) for people losing eligibility for the Elderly Waiver due to changes in level of care.</p>	<p>DHS appreciates the support of stakeholders in the pursuit of federal matching for services intended to support lower needs individuals with Alternative Care (AC) and Essential Community Support (ECS) services to help maintain independence, community living, and self-sufficiency in meeting emerging long term care needs.</p> <p>Essential Community Supports or ECS was described in detail under the Long Term Care Realignment waiver. DHS responded to public comments submitted related to the Long Term Care Realignment Waiver (changes to nursing facility level of care and other reforms), and included those responses in the application submitted to CMS on February 13, 2012. These responses, many of which addressed similar comments, can be viewed at http://www.dhs.state.mn.us/main/dhs16_167144 at Appendix VI of that waiver document. DHS encourages commenters to review information in that waiver regarding the changes to level of care criteria and the populations eligible for Essential Community Supports.</p> <p>DHS believes that the demonstration to redesign the personal care assistance program described in Section 4 of the Reform 2020 waiver proposal contains valuable elements that will assist people who no longer meet nursing facility care but remain eligible for Medical Assistance and who meet the criteria for personal care assistance. The new Community First Services and Supports (CFSS) service allows more flexibility and self-direction to help fill the needs of some of these individuals.</p> <p>The evaluation of ESC will inform Minnesota’s efforts to determine what benefits might be meaningful and cost effective under a Section 1915(i) approach in the future. DHS will be flexible within budget and legal constraints in ECS to meeting the needs of people who no longer meet nursing facility level of care, including individuals who no longer remain eligible for Medical Assistance.</p> <p>At this time, ECS services available for individuals on Medical Assistance are limited to those individuals who are part of the “transition” group:</p> <ul style="list-style-type: none"> • are receiving HCBS waiver services on the effective date of implementation of the changes to the level of care criteria, and • no longer meet level of care at their next reassessment, and • remain eligible for MA, and

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<p>One commenter asked whether Essential Community Supports or ECS is intended to support MSHO/MSC+ seniors with less than four ADLS.</p>	<ul style="list-style-type: none"> • have an assessed need for an ECS service as defined in statute. <p>As part of DHS’s strategy to provide supports to older individuals to delay or prevent spend-down to Medical Assistance, the ECS program will also be available to non-MA individuals age 65 and older, including new applicants who do not meet level of care and who meet AC financial eligibility criteria. Counties and tribes will continue to manage the Alternative Care program and will also manage non-MA ECS.</p> <p>To clarify, the LOC criteria based on ADL needs is <i>one</i> of three “critical” ADLSs (toileting, positioning or transferring), <i>or</i> four ADLs. However, ADL needs are not the only basis of LOC, and LOC is not dependent on ADL needs being present under other criteria.</p> <p>As proposed in the Long Term Care Realignment waiver, individuals who no longer meet LOC at their next reassessment after implementation and who remain eligible for MA can access ECS services for which they have a need, including individuals enrolled in MSHO/MSC+. DHS will work with health plans and other stakeholders in implementing ECS under managed care purchasing and delivery models.</p>
<p>2.3 Redesigning Integrated Medicare and Medicaid Financing for People with Dual Eligibility</p> <p>One commenter raised the concern that the current health-plan centric model does not allow for true integration of acute and long-term care services and supports</p>	<p>The proposed demonstration models allow for primary, acute and LTC provider involvement along with continued Medicare integration. Outside of Medicare Advantage, there is no other federal vehicle for integration of Medicare that allows provider payment reform along with the flexibility to rearrange funds to provide substitute services to allow opportunities for such provider involvement.</p>
<p>3 Accountable Care Demonstration</p> <p><u>Accountable Care Demonstration-</u> Demonstration Design</p> <p>Please consider the recommendations of the Governor’s Health Reform Task Force</p> <p>Several commenters argued that it is essential to ensure that new models of</p>	<p>DHS appreciates the many comments and high level of interest in this topic. The recommendations of the Care Integration and Payment Reform Work Group under the Governor’s Health Reform Task Force will guide the planning of this effort, and DHS will engage the provider community, including managed care organizations, in the planning of this effort. Minnesota is</p>

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Comments	DHS Response
<p>care delivery and payment result in easier and more affordable access rather than additional complexity, administrative costs, and discontinuity of care as people move among programs to avoid disruption of care due to churning now and after Exchange coverage begins in 2014</p> <p>Is DHS committed to ensure that the same plans that offer commercial products in the exchange are also offering a Medicaid product to mitigate breaks in continuity of care if eligibility changes?</p> <p>Are the costs of long term care services, including nursing facility and HCBS, included among the services for which HCDS sites will be at risk?</p> <p>We believe that it is premature to move quickly down this road when there are, as yet, no results from the HCDS or Hennepin Health experiences.</p> <p>Describe why the state would be moving away from such important consumer safeguards as statewideness and freedom of choice or financial accountability standards as actuarial soundness. The state should make clear why these changes are needed and how inequities, lack of choice or financial risk will be managed to the benefit of Minnesotans.</p> <p>Concern about request for waiver of freedom of choice Health plans have been able to demonstrate effective coordination of care while maintaining freedom of choice. Concern of violating program participant’s right to choose and DHS moving away from a person-centered delivery system towards a provider-centered delivery system.</p> <p>Some commenters raised concerns about the integration of long-term services and supports with health/medical care because of the likely emphasis on the medical model of service provision. While we certainly support effective coordination of health care and LTSS, we oppose control over all of one’s LTSS services by a medical care provider without experience in housing, employment, transportation and social relationships in the community. Rather than assigning medical entities or health plans the authority and risk for every project, we recommend seeking proposals where the community support providers are in charge and can subcontract for medical services. This would be of particular value for persons with high LTSS costs and average to low medical costs or those whose costs are quite stable year to year. We think it is essential to assure that persons who need long-term support services to remain</p>	<p>committed to ensuring that robust consumer protections are in place under the new system to ensure access to care, choice of providers and quality of care. DHS will also pursue multi payer reform under the recently announced State Innovation Models Initiative administered by the Center for Medicare and Medicaid Innovation. The waiver requests for this initiative are in addition to that.</p> <p>Minnesota seeks federal guidance regarding whether Minnesota’s existing freedom of choice waiver will be sufficient to allow ACO’s to create a provider network and require ACO enrollees to seek care within that network unless the network is insufficient. This authority is used in Minnesota’s managed care delivery system to allow managed care organizations to limit coverage to their own networks except in certain circumstances. Minnesota seeks federal guidance regarding whether Minnesota’s existing statewideness waiver will be sufficient to allow implementation to be phased in by geographic area. Initially it may be impossible to provide ACO coverage across the entire state. DHS is committed to ensuring that robust consumer protections are in place under the new system to ensure access to care, choice of providers and quality of care.</p> <p>DHS is committed to thoughtful reform, and will continue to engage stakeholders.</p>

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Comments	DHS Response
<p>as independent as possible in their communities are able to direct their own services based upon a person-centered plan rather than directed by a medical clinic or hospital.</p> <p>We urge that this proposal include clear safeguards, data reporting, appeal rights and disability-relevant outcome requirements for the provider.</p> <p>How will enrollment work? Assignment When can a person leave an ACO?</p> <p>Need more detail on consumer protections available under ACO model, including appeals</p> <p>What are the enrollment and opt-out options for consumers who choose not to enroll in an ACO</p> <p>Commenters urged DHS to establish robust consumer protections and accountability measures for the accountable-care demonstration.</p> <p>Consumer protection, especially for the frail elderly and persons with disabilities, needs to be a built-in feature yet the proposal was virtually silent on consumer rights. Currently it appears the only consumer protection is the ability to “walk”—to leave one program/provider and move to another. By removing choice of vendor, consumers, especially in rural communities where options may already be limited, are particularly vulnerable.</p> <p><u>Accountable Care Demonstration - Role of Health Plans</u></p> <ul style="list-style-type: none"> • We believe that maintaining successful operations of ACOs and other integrated care provider options hinges on an active partnership between providers and health plans. • There is an important role for managed care organizations “at the table” in ACO discussions and planning. • Does DHS contemplate a role for health plans only in the care delivery for dual eligibles, but not in other forms of accountable care models? • Health plans can help with facilitating population health management, providing advanced IT infrastructure for clinical, operational and administrative functions, managing networks, assuming risk to ensure financial stability • Successful operation of ACOs hinges on an active partnership between providers and Minnesota’s health plans. 	

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<ul style="list-style-type: none"> • Given our work in the last few years to integrate health care systems with supportive housing, Hearth Connection has come to an appreciation of the role played by Minnesota’s Health Plans in coordinating services and incubating innovations to reduce costs. Will Housing Stabilization Services Demonstration be delivered by ACOs, MCOs or fee for service? Several different pieces of the proposal threaten to fragment our existing MSHO care model, such as case management reform and the implementation of direct provider contracting approach to managing care for dual eligibles. • Preferred Integration Network (PIN) Demonstration is an integrated approach to the delivery of physical and mental health care for adults and children with mental illness or emotional disturbance while assuring coordination with needed social service supports. This demonstration has been successful as it created partnerships between Medica Health Plan, Dakota County Social Service and Medica Behavioral Health to meet the diverse needs of the specific population. Concern that ACO model will disrupt progress made under this demonstration. <p><u>Accountable Care Demonstration - ACO Financial Risk and Solvency Requirements</u></p> <ul style="list-style-type: none"> • Level playing field: To the extent HCDS/accountable care arrangements take on responsibilities often fulfilled by managed care organizations, they must be held accountable for meeting solvency, coverage and other requirements that apply to MCOs. • ACOs and/or ICSPs are to be risk- bearing entities receiving public funding. DHS should require similar transparency requirements for financial reporting and independent auditing as is required for HMOs • Regulation of the financial solvency of risk-bearing provider organizations in ACOs is important to ensure market stability. • Need for transparency on risk/gain sharing arrangements <p><u>Accountable Care Demonstration- Freedom of Choice/ Adequacy of ACO networks</u></p> <ul style="list-style-type: none"> • Concern about adequacy of ACO provider networks • One commenter has concerns regarding DHS’s request to waive patients’ freedom of choice of provider. Waiving such choices has the potential to result in an adverse impact on access to and continuity of care. Please build in consumer protections that specifically look at access issues. This includes, but is not limited to, regular data collection and tracking of health care access, 	<p>DHS is committed to ensuring that robust consumer protections are in place under the new system to ensure access to care, choice of providers and quality of care.</p>

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<p>adequate safety-net programs and provider networks, mechanisms to ensure continuity of care, and an easy and accessible appeals process to obtain care outside the accountable-care program to ensure that the patient’s health outcome remains paramount to any short-term savings.</p> <p>Accountable Care Demonstration – Support Several commenters support the Accountable Care Demonstration</p> <ul style="list-style-type: none"> • One commenter supports DHS’s request for waiving state-wideness for the Hennepin Health project. Hennepin Health builds on the Preferred Integrated Network project in Dakota county and has the potential to provide better coordination of treatment and supports. Starting in one county and learning how to do this effectively before going statewide makes sense. • We are generally supportive of the proposed accountable care demonstration, particularly to the extent that it focuses on a fully-integrated model that is similar to Program of All-Inclusive Care for the Elderly (PACE), where all payment streams are combined and the incentive is to provide the most appropriate care for the least cost, with rewards to providers who are able to do that. As with many of the concepts in the reform proposal, there are not enough details at this point to know for sure whether an accountable care demonstration can achieve these goals and be workable for providers and consumers, but we view it as a positive step that is worth investigating. • The new accountable care models have real promise to create a more sustainable and integrated service delivery system. <p>Accountable Care Demonstration - Data Sharing Needs of ACOs</p> <ul style="list-style-type: none"> • Concern about inabilities to share data among network participants, which creates a barrier to communication and streamlined service delivery. • Supportive of DHS proposals to develop innovative and effective Medicaid payment and delivery models. 	<p>DHS appreciates stakeholder support as we move forward on these reform initiatives.</p>
<p>4 Demonstration to Reform Personal Assistance Services – CFSS</p> <p>Self-Direction/Individual Choice/Person-Centered Planning</p> <ul style="list-style-type: none"> • Self Direction - We support the self-directed component of this proposal and commend DHS for incorporating previous stakeholder work on the 1915(j) recommendations • Self Direction - We support the proposed changes in financial management system, budget methodology, and flexibility in services • Case management- We applaud increase in consumer choice of case manager and the ability to hire and fire case managers 	<p>Self-Direction/Individual Choice/Person-Centered Planning: DHS appreciates stakeholder support of self-direction as a key feature of CFSS and the reform of personal assistance services. DHS intends to maintain a focus on the intended recipients of the new service throughout the development and implementation of CFSS.</p> <p>DHS appreciates the support for the direction of case management system</p>

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Comments	DHS Response
<ul style="list-style-type: none"> • It is important to invest public dollars in people’s lives so individuals with disabilities can become more independent • Please keep the focus on the intended recipients and not on systemic elements of policy reform. • The reform effort must deal with the tension between “choice” and “risk” and self-direction may not be a good option for everyone. • Urges that Implementation Council’s recommendations to the legislature take into account necessary relationship in self-direction between choice and risk; participants, in exercising choice, should be able to assume certain risks which they understand and choose to assume. <p>General Strengths of Proposal</p> <ul style="list-style-type: none"> • Emphasis on teaching, coaching and prompting; support plans aligning with goals and outcomes; scaffold towards self-direction; emphasis on high-impact services and decreased reliance on costly services are all strengths of the proposal. • One commenter supports CFSS flexibility, simplification, strengthening community support, options for those who do not meet institutional level of care, and innovative approaches to service coordination within select school districts. 	<p>changes. We agree that it is essential to wisely invest public dollars so that individuals with disabilities are as independent as possible with supports that further CHOICE values:</p> <ul style="list-style-type: none"> • Community membership • Health welfare, and safety • Own Home • Important Long Term Relationships • Choice over services and supports • Employment earnings and stable income. <p>DHS agrees that while self-direction is a successful strategy for having services delivered in the most appropriate, effective way for individuals, there may be some people for whom it is not a good option. Through person-centered planning people will have the opportunity to choose whether or how much control they wish to have over their services and supports.</p> <p>DHS appreciates the challenges that will occur between supporting individual choice and providing for health and safety (managing risk) and will assure that this issue is addressed by the Implementation Council during the development phase of CFSS.</p> <p>General Strengths of Proposal: DHS appreciates stakeholder support of components of the CFSS proposal. DHS agrees with stakeholder comments that cited the emphasis in CFSS on skill acquisition, flexibility, person-centered planning, self-direction, functional assessments, availability of assistive technology and environmental modifications, and service coordination as strengths of the proposal. DHS agrees with the importance of ensuring that CFSS services are accessible to current PCA recipients regardless of whether or not they meet level of care criteria.</p>

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<ul style="list-style-type: none"> • Strongly agree with proposal, especially due to additions of prompting, coaching and additional flexibility; need well-trained, highly skilled and adequately-compensated workforce to meet demographic challenges, promote stability and ensure quality. • Waiting Lists - We applaud that CFSS as a new viable alternative for those who are currently on HCBS waiver waiting lists • The value/vision, emphasis on functional impairment rather than disability categories, focus on outcomes rather than process, and promotion of person-centered planning are all strengths of the proposal • Several commenters expressed strong support for using 1915(k) federal authority, using special eligibility rules for those at LOC, employing both the 1915(k) and the 1915(i) option to provide CFSS services to those that don't meet LOC as well as those who do. • Several commenters expressed support for aspects of 1915(k) including skill acquisition, assistance with health tasks and updated description of IADLs; and requirement that it be provided in most integrated setting. • Supports consumer direction, expanded eligibility and minimum service levels, simplification of access and planning, flexibility to include skills acquisition and assistive technology, addition of service coordination. • Several commenters expressed strong support for increasing minimum amount of time for those with 1 dependency or Level 1 behavior to at least 90 minutes per day. • Supports providing CFSS with case management/service coordination and hope that it will improve Minnesota's home care quality of care indicators scores • Support enhanced care coordination services • Strongly support assistive technology and home modifications <p>Quality Assurance/Program Integrity</p> <ul style="list-style-type: none"> • Quality - We recommend utilizing best practices in quality measurement. The primary question should be whether consumers are achieving the outcomes they want. • We agree with unhooking PCA access from waivers and believe working to promote quality assurance is essential. • Several commenters expressed concern about the potential for fraud, misuse or abuse with self-directed services in CFSS • An annual review of the budget may not provide adequate oversight • Recommend continued RN supervision for those with complex medical 	<p>While the proposal does increase the lowest home care rating from the current 30 minutes allotted in PCA services, it is important to clarify that the 90 minutes cited in the proposal is the lowest average daily amount to be authorized in CFSS. This lowest average daily amount is based on a base home care rating of 75 minutes with additional time for identified behaviors and/or complex health-related needs.</p> <p>Quality Assurance/Program Integrity: DHS agrees that an effective quality assurance plan across CFSS and other home and community-based services is essential. A quality assurance plan will be established to monitor services and CFSS providers using strategies from our existing section 1915(c) home and community-based waivers. Minnesota will work with the Implementation Council to develop plans and protocols to help build the program we envision.</p> <p>DHS agrees that accountability will be key to the success of this new model. DHS will work with the Implementation Council to build on the work we have done over the past few years, increasing provider standards and requiring basic</p>

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<p>needs</p> <ul style="list-style-type: none"> • What will supervision and quality of care look like in CFSS to mitigate risk for fraud/waste/abuse in a larger consumer directed program? Important to protect the integrity of the service. <p>Communication/Transition</p> <ul style="list-style-type: none"> • Please work with MN State Council on Disability to help communicate information regarding the waiver proposal and further developments to the public. Transparency of Implementation Council will be vital to success. • Several commenters expressed concern about the need to transition from PCA to CFSS with the least amount of disruption to individuals receiving the service. • Include community-based disability organizations as partners in communication plan about these changes. • Strongly urge the inclusion of those who have been receiving and providing PCA services in the Implementation Council to make key decisions about service design <p>Access Criteria for CFSS and the change in Nursing Facility Level of Care (NF LOC) Described in the Long Term Care Realignment waiver</p> <ul style="list-style-type: none"> • Concern about the need to meet NFLOC • Will the new NFLOC be used for the 1915(k) portion of CFSS? • Support changing PCA access criteria so that anyone who meets LOC meets access criteria • Urges extending the eligibility standards for CFSS from one dependency/Level One behavior to a functional analysis that would assess a need for services to remain in the community – broaden the criteria for the CFSS 1915(i) to be the same as the criteria for Housing Stability Services. Alternatively, DHS should augment the HSS service package to include CFSS-like benefits. • A single program is insufficient for all people with disabilities, and CFSS will not address the needs of people with mental illness • Concern that eligibility criteria will not align with the needs of people with mental illness—specifically “Level One behavior”. People with mental illness may not display behavioral symptoms once/week and thus might 	<p>direct care worker training to assure that checks and balances are in place.</p> <p>Communication/Transition: DHS intends to work with stakeholders through the Implementation Council to make decisions about the further design of CFSS. DHS agrees that transitioning from PCA to CFSS with the least amount of disruption to individuals receiving those services is an important hallmark of successful implementation and that an effective communication plan is essential to ensuring a smooth transition. DHS will rely on engaged stakeholders to assist in communicating information about CFSS at each stage of its development.</p> <p>Access Criteria for CFSS and LOC: DHS agrees that needing to meet an institutional level of care would exclude some people from accessing CFSS, thus the waiver requests that CFSS be allowed for any person meeting the functional criteria whether they meet an institutional level of care or not. The 1915(k) portion of CFSS will use NFLOC, hospital, and ICF/DD level of care criteria, and evaluate whether it is necessary to include IMD level of care in the final submission.</p> <p>While DHS understands there are limitations in current policy for PCA eligibility criteria that may need to be explored, changing current policy, and expanding the number of people to be served, would impact the cost and change assumptions in the fiscal analysis as well as require statutory changes. DHS intends to begin the demonstration with current PCA eligibility criteria and examine data over time to determine what policy changes need to be made that may better fit the needs of individuals in light of all the reforms underway, and the fiscal impact of those proposed changes.</p> <p>The proposed design of CFSS is to allow more flexibility than the current PCA</p>

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<p>not qualify.</p> <ul style="list-style-type: none"> • Concern about criteria for CFSS not capturing the needs of people with mental illness—may not have ADL or Level One behavior and symptoms may be episodic • Medicaid reform must address the loss of eligibility that occurred in previous changes where many people with mental illness were no longer eligible or had services reduced. • Concern that people who are now receiving only ½ hour of services are receiving insufficient care – please address • Support use of special income eligibility rules but supports expanding the population to whom this applies including those who do not meet LOC • Several commenters recommended including IMD as an institutional level of care under the proposal • Several commenters recommended changing the definition of dependency to include “prompting and cuing” to ensure compliance with the 1915(k) • DHS should ensure “uniformity in program eligibility criteria” in designing reforms • Greater clarity about eligibility for programs; specifically about level of care criteria/CFSS <p>Details of Implementation</p> <ul style="list-style-type: none"> • Support for high-level principles; concern about the details to be determined • What about people who don’t have a “family home”? How does CFSS intersect with housing proposals? • Recommend more clearly defined goals, objectives, and timelines • Will all services and supports to be purchased be determined by the assessor? Or case manager? • Where will the care coordinators come from? Can they be family members? Is coordination billable? • What groups/categories of individuals does DHS expect to receive home care service coordination under CFSS (page 26)? In MCOs and fee for service? Only PCA recipients? • Supports providing CFSS with case management/service coordination; Need for better definition of this service, eligibility, and intersection when person qualifies for more than one • More clearly define which programs are impacted by reform (fee-for 	<p>program so that it will better meet the needs of individuals with all types of disabilities, including those with mental illnesses. CFSS and other LTSS are intended to support people in the community. They are not treatment services such as ARMHS or IRTS but can augment those treatment services.</p> <p>DHS acknowledges that people with episodic needs may find it more difficult to access services at times. However, DHS will work with the Implementation Council to design CFSS so that it can better meet needs that are more episodic in nature and analyze options for future policy changes in this area.</p> <p>The proposal will utilize current PCA eligibility criteria. Under this proposal, minutes for people with the lowest home care rating are increased from the current 30 minutes allotted in PCA services to a new lowest average daily amount of 75 minutes with additional time for identified behaviors and/or complex health-related needs.</p> <p>Details of Implementation: DHS agrees that the proposal, at this point in time, does not contain many of the details of CFSS that will need to be developed prior to implementation. Further work on service design, definitions of terms, roles and responsibilities, provider standards, etc. will be done with the Implementation Council during the planning and development phase, in conjunction with work already underway on provider standards and quality measures.</p> <p>It is in DHS’s long-term reform plans to offer Targeted Home Care Case Management to people who do not already have access to case management. It is not part of this proposal.</p> <p>Services that are offered through CFSS will be available to eligible individuals—those on waivers as well as those who are not; people in fee-for-service and people in managed care.</p>

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<p>service, waiver, managed care)</p> <p>Provider Standards/Training</p> <ul style="list-style-type: none"> • Not enough detail about provider standards • Creating areas of specialty is important and needs to be accompanied by a rate differential to support the additional training and oversight needed • Education needed on how skill acquisition differs from hand-on, “doing for” an individual ; implications for provider training/standards • Efforts needed at recruitment and retention of qualified staff to provide CFSS, including relatives. • Training for case managers include information on needs of children with disabilities • No reference to mediator models (training caregivers to provide on-going behavioral support) • There is not enough specificity about person-centered planning. Many people say they do it but their practices are far from current “best practices”. <p>Stakeholder Input</p> <ul style="list-style-type: none"> • One commenter lists several ways in which their organization, members and practice model can be of assistance with MA Reform • We are pleased there will be an Implementation Council to gather input from consumers and stakeholders. • Supports Implementation Council and requests to be a part of it • Support of individualized budgeting for greater individual control and independence; stakeholder input needed, highly transparent methodology for determining individual budgets recommended • Several commenters recommended that the determination of the budget administrative cost of the self-directed option be conducted with stakeholder input. <p>Simplification</p> <ul style="list-style-type: none"> • Streamlining of regulations is necessary and increased reimbursement rates • Concern about the complexity involved in implementing both 1915(k) and 1915(i) options • What features of the current PCA delivery system does DHS consider 	<p>Provider Standards/Training: Developing provider standards and appropriate training to ensure high-quality services are delivered is important to DHS and we welcome input from stakeholders on this work. DHS intends to work with the Implementation Council to determine provider standards, training requirements, and best practices. A goal of MA reform is to provide the right service, at the right time, <i>in the right way</i>. It is imperative for providers to have appropriate skills in order to deliver the service <i>in the right way</i>. Assessor training in person-centered planning is included in the roll-out of MnCHOICES. Training and standards for case managers will be addressed as part of case management reform. Service models, such as mediator services, may be best offered through another option (e.g.: HCBS waiver services, or the new autism services that will be developed. CFSS, while flexible, is not intended to provide specialized support that a more intensive service array can offer.</p> <p>Stakeholder Input: Stakeholder input will play an essential role in determining many of the details of CFSS including: the development of standards for CFSS providers and financial management entities; the design of an effective quality assurance system; the selection of service models available through CFSS; and procedures for individual budget determinations. The DHS will also draw on the advice and recommendations of the HCBS Partner Panel and the Consumer Directed Task Force.</p> <p>Information will be issued this summer about the formation of the Implementation Council through the State Register, the Disability Service list serves, and to our stakeholder committee e-mail lists.</p> <p>Simplification: DHS is working to reduce administrative complexity across home and community-based services. While the inclusion of both a 1915(k) and 1915(i) option is necessary in CFSS in order to avoid a reduction in services for people currently using PCA services, DHS intends to make that distinction invisible to individuals accessing CFSS.</p>

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<p>most complex (page 25)? What barriers, gaps, and redundancies does DHS believe prevent people from accessing the service they need?</p> <p>Service Models</p> <ul style="list-style-type: none"> • Does the agency option look like Agency with Choice under CDCS? • Will there be a service authorization for agencies to bill from if a recipient chooses the agency model? • Recommend retaining PCA Choice Option by offering three models for CFSS: a fully agency directed support service, an agency service that maintains aspects of PCA Choice Option, a new self-directed option with an individual budget. • Recommend retaining option similar to PCA Choice where recipients/families have independence in directing service without all the administrative duties. <p>Financial Management Entities (FME) responsibilities</p> <ul style="list-style-type: none"> • Who has the authority to approve the service plan? The assessor? The county? The FSE? The agency? • Are there services/supports to be purchased outside of the FME? • DHS should consider having more than 2-4 FMS service providers for more consumer choice • FSE system needs need to be better defined w/ transparency and stakeholder input. • Assure that consumers will have meaningful choice between at least two high-quality FSEs • Question the need to reduce number of FSEs; limits access and choice; lack of competition would increase costs; with increased number of users, there should be an increased number of FSEs • Support for role of Financial Management Services and use of RFP process for selection; urge preference for those FMEs with proven track record • Build from proven track record of FME for new FME contracts • Concern about limiting providers of FME as limiting choice and impacting the quality of the services provided <ul style="list-style-type: none"> ○ Need for choice of service coordinators – competition important to maintaining quality of services <p style="text-align: center;">§ Recipients should be able to choose to have service</p>	<p>The current system, including the PCA program, and what DHS would like to change are described in sections 4.1.1 and 4.1.2.</p> <p>Service Models: Further definition and selection of service models available under CFSS will be done in collaboration with the Implementation Council. DHS intends to build upon the successes that have been achieved over the last several years of developing self-directed services.</p> <p>FME responsibilities: Further work on the role and responsibilities of the Financial Management Entities will be done with the Implementation Council during the planning and development phase. This work will include the design of the RFP process for the selection of the FMEs, and address efficiencies, accountabilities, and quality assurance. It will build on the recommendations that were made by the Consumer Directed Task Force. DHS will ensure that consumers have the choice of at least two FMEs, regardless of where they live in the state.</p>

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<p style="text-align: center;">coordination and financial management provided by the same entity</p> <p>County responsibilities</p> <ul style="list-style-type: none"> • Will CFSS cause an increase workload for county case workers? Will they be expected to provide case management to CFSS recipients? • Proposal does not address who is responsible for education and oversight to clients choosing self-directed option. Counties' role is unclear. • More information needed about the role of counties in the reform efforts. Metro counties are ready to participate with DHS to implement Reform 2020. <p>Managed Care role</p> <ul style="list-style-type: none"> • How does CFSS interact with managed care? • Specific language addressing role of MCOs is needed • Will MSHO retain current structure? • How will payers reimburse in cases where recipients elect to pay their own providers? • Define role of MCOs • Does DHS expect PCA to continue to be delivered by MCOs? • Lack of role definition for MCOs <p>Interaction with HCBS Waivers</p> <ul style="list-style-type: none"> • Can CFSS recipients purchase waiver services such as respite? From any agency currently providing that service? • How will CFSS intersect with MSHO and EW? • Clarification on intersection between CFSS and the existing 1915(c) waivers – is extended PCA an option? • Will CFSS be available to waiver recipients or not? • Shared services should be allowable across programs (e.g. CDCS and CFSS) • Common service menu is supported <ul style="list-style-type: none"> § ILS therapies § Day Services § Personal supports § Respite 	<p>County responsibilities: DHS expects to work with lead agencies, including counties, and other stakeholders through the planning and development of CFSS to further define the role of counties in the implementation of CFSS and the reform of case management. The recommendations from the Consumer Directed Task Force included separate training and technical assistance activities for those choosing self-direction by an entity other than the county. There are plans to improve and support the ability of current case managers to incorporate CFSS, and to offer case management to those with a need, who choose it and do not have access to case management. Provider standards have not yet been developed.</p> <p>Managed Care role: CFSS will be a service that can be provided either through fee for service or through managed care. DHS will assure that managed care providers have input into the service design and communication and training about how CFSS will work in managed care as well as fee-for-service will be provided.</p> <p>Interaction with HCBS Waivers: In order to manage and evaluate the CFSS portion of the 1115 demonstration waiver efficiently, DHS is managing CFSS entirely outside the waivers. However, services within the waivers will be adapted to mirror CFSS. Therefore, regardless of whether a person is on a waiver or not, if they meet the CFSS eligibility criteria they will have access to this new service. For example, participants in home and community-based waivers can access needed assistive technology, environmental modifications, and support services that would mirror those available through CFSS.</p> <p>While there is increased flexibility in the services and supports available through CFSS compared with PCA, individuals receiving CFSS will not be able to purchase the array of HCBS waiver services through CFSS. It's origins, and the outcome of the service is to meet functional needs of people in</p>

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<ul style="list-style-type: none"> • Does CFSS affect recipients of traditional PCA, PCA Choice, CDCS and CSG? • Since PCA services do not align with LOC criteria it is unclear who will be eligible for CFSS. Will numbers served increase or decrease? <p><i>Need for data/fiscal analysis</i></p> <ul style="list-style-type: none"> • Proposal lacks data to evaluate the full impact. • Is there any financial benefit to the reform given rates, the potential for fraud, the administrative structure and the need for supervision? • Estimated number of PCA recipients and individual PCAs to be affected by the reform? • What portion of existing PCA recipients would not be eligible to access CFSS? • Several commenters expressed the need to review the fiscal analysis to fully evaluate the proposal • Is there evidence that providing a lower level of service to individual with lower needs is beneficial overall to health outcomes? • Concern about adequate funding to implement CFSS given the commenter’s perception of expanded access under CFSS. 	<p>areas related to activities of daily living.</p> <p>While the development of a consistent set of services across home and community-based waivers remains an aspect of reform under consideration by DHS, it is not an aspect of reform addressed by this section of the proposal.</p> <p>PCA will be replaced by CFSS. Eligibility criteria will be the same as the current PCA. The Consumer Support Grant will also be incorporated into CFSS. PCA and CSG will not continue as they do now in the future as CFSS is implemented. The waiver service Consumer directed Community Supports (CDCS) will continue as a service option for those accessing one of the five HCBS waivers.</p> <p>For now, CFSS eligibility remains the same as PCA eligibility so no one will lose eligibility. Some people who were eligible for PCA, but who did not access PCA previously because it did not meet their needs may choose to use CFSS because of the flexibility and support that CFSS provides. The fiscal analysis shows the numbers we anticipate using the new program. The evaluation of CFSS will be important to understand its impact and future adaptations that may be needed.</p> <p><i>Need for data/fiscal analysis:</i> The fiscal analysis is included at Attachment O. DHS will discuss the assumptions and the fiscal analysis with stakeholders.</p>
<p>4.2.3 Demonstration of Innovative Approaches to Service</p>	<p><i>Changes made in proposal after public comment period:</i> After reading public</p>

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<ul style="list-style-type: none"> • If child leaves the school their service coordination is disrupted • Parents with private insurance can deny permission to bill to it due to FAPE. Putting this service in the schools exacerbates that problem. • Many families don't want medical information shared with schools and teachers • Concern about guidance counselors with no medical training finding community resources, determining and managing needs. School staff aren't licensed or qualified as MH professionals or care coordinators. Don't know autism. Don't know kids needs in the community. Most school personnel aren't clinicians. • Does not support schools being lead for service coordination demo • There is a shortage of nurses, counselors and psychologists in schools; may not have full complement of staff. • Structure to deliver services does not exist in most schools unless related to school-linked MH grant • Shifts financial responsibility to fiscally strapped schools. Extra burden on school staff. • There could be contracting issues for districts • IIIP did not work • Urge substantial changes before submitting using current human service system and experienced providers 	<p>demonstration, we want to be clear that this is not a therapeutic service, rather it is coordination function. Also, while we anticipate that many, children with mental health and behavioral challenges will be enrolled, the demonstration is not limited to them. The demonstration will be open to children with various needs who receive CFSS and have complex service system involvement.</p> <ul style="list-style-type: none"> • <u>School schedules/Continuity of service</u> Many responders were concerned that schools are not available year-round, 24/7. We agree that providers for this service would have to be available year-round. We anticipate that by working in collaboratives, this service can be available 12 months/year. Details of the demonstration will be worked out with input from stakeholders. It is not typically a requirement of service coordinators to be available 24 hours/day. This is not intended to be a crisis or therapeutic service. • <u>Burden on schools</u> We anticipate that only districts willing to participate in the demonstration, based on their own personnel and financial resources, will choose to join a collaborative effort to join this demonstration. One responder raised a concern about possible cost-shifting. The future of service coordination/case management in Minnesota requires a separation of service authorization. We do not agree that schools will be able to shift their education obligations to MA. MA is mandated under federal regulation and state statute to reimburse districts for services authorized in an IEP/IFSP if that service is otherwise a covered service and all criteria for reimbursement are in followed. • <u>IIIP did not work</u> The purpose of, roles and responsibilities, and the approach to the demonstration are different. Hopefully, we can learn from what does not work in IIIP and use it as we plan and develop the demonstration. We also know that service coordination for birth to three has some great successes and perhaps we can build upon them.

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<p>Partnership Needed</p> <ul style="list-style-type: none"> • Revise proposal with input from school-linked MH providers and children's MH advocates • DHS school-linked MH grants and MDE PBIS need to be at the table • offers to provide in-service support and technical assistance to districts that participate in demo • Urge close collaboration with school staff and MDE in design of demonstration <p>More Information Needed</p> <ul style="list-style-type: none"> • Will families be able to opt out? • Role of parents is not clearly defined • How does this intersect with existing school-linked mental health services? • Unclear how schools will interface with ABA-based providers and incorporate ABA-based treatments • Plan for end user or recipient input not clear; the specific innovation is not clear. • Needs definition of service coordination/case management. • There may not be 1,500 students meeting definition of CFSS + IEP with related services in demo districts • Cultural competence is not mentioned 	<p>Partnership needed: DHS will include stakeholders in the planning, development, implementation and evaluation of the demonstration.</p> <p>The school-linked mental health grant program is a successful model that will be looked at in the design of this demonstration.</p> <p>More information Needed: Participation in the demonstration will be voluntary. School-linked mental health services are one of a myriad of services with the service coordinator would link with. It is also a model that we will look to in designing the demonstration.</p>
<p>5 Demonstration to Expand Access to Transition Support</p> <ul style="list-style-type: none"> • We support keeping seniors at home; Neighborhood-based approach/ block nurse approach is best because it utilizes volunteers and is cost effective; non-emergency transportation is the primary need for elders in the community; block nurse organizations appreciate DHS support (public hearing) • Disagree with the assumption that transitioning individuals to their own home is always the best option; encourage DHS to evaluate per-person cost benefit of transition initiatives; utilize the latest research on effective transitions for persons with Alzheimer's and their caregivers; conduct analysis of why individuals chose to move to nursing home or assisted living settings; identify total costs over time • Return to Community transition supports should be available to persons in nursing homes of any age, not limited to 65+. • Generally supportive of transition efforts as they will reduce spend-down 	<p>Support for referrals to Living At Home Block Nurse: DHS is in agreement that block nurse programs are a key community resource. Community living specialists refer to these programs where available.</p> <p>Concern about assumptions related to cost benefit of transition support: The Return to Community service is being evaluated by the Centers on Aging and Indiana University and the U of M. The evaluation is a preliminary assessment of the RTC program and will focus on the following objectives:</p> <ol style="list-style-type: none"> 1) Compare the characteristics and utilization patterns of NH admission cohorts before and after implementation of RTC to determine if: <ul style="list-style-type: none"> • The RTC target population changed between periods • Community discharge rates of targeted residents increased between periods 2) Describe the characteristics of persons who met the RTC target profile. Draw comparisons between:

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<p>to Medicaid; unresponsive of long-term care options counseling about community-based housing options as it is intrusive and unnecessary</p> <ul style="list-style-type: none"> • How will health plans intersect with pre-eligibles? • Strongly supportive; with increasing numbers of older individuals, it is important to offer long term care planning earlier and more often; there is a real need for unbiased information for consumers regarding long-term care, including financial options • Adult Day Services are a key service for people returning home from a nursing home 	<ul style="list-style-type: none"> • Persons not discharged to the community • Actively transitioned by the CLS (target, Section Q, or referral) • Persons transitioned during the targeting window who were not actively transitioned. <p>3) Among persons in RTC target group who remain in NH at 90 days, describe reasons given by the NH for their failure to discharge and compare their health and functional conditions between admission and 90 days.</p> <p>4) Examine the RTC initial CLS assessments in the NH and follow-up assessments to the community in order to:</p> <ul style="list-style-type: none"> • Determine the accuracy and completeness of initial assessments and 90-day follow-ups • Describe the characteristics of residents at their initial assessment and follow-up <p>Preliminary findings note that the rates of community discharge during the intervention increased between periods for both post-acute and other admissions. The evaluator concluded that the findings suggest that either directly or indirectly, the program is having its intended impact. The top two barriers to community discharge were decline in health and personal choices. Nearly one fourth of the residents would have failed to meet the new state minimum level of care criteria.</p> <p>DHS is in agreement that remaining at home is not always an option. Options counseling ensures a person-centered approach is used to best meet the needs of the individual according to each unique situation and that they are aware of all of their options.</p> <p>DHS works closely and monitors new evidence-based services and recommendations for managing Alzheimer's including actively participating in the Preparing Minnesota for Alzheimer's 2020. The Alzheimer's Association is a partner with numerous DHS and MN Board on Aging initiatives and also provides training to the Senior LinkAge Line® staff.</p> <p><i>Support for extending Return to Community to younger adults with disabilities:</i> It is the intention of DHS to explore the applicability of these efforts to the younger adult population within a year of this implementation. There are people who contact the Senior LinkAge Line® in the current model that are younger adults. In those situations, the staff works hard to triage to the</p>

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	<p>county or for those that are not on Medicaid, to the local Center for Independent Living for help with transition assistance and support.</p> <p>Support for transition and concern for housing options counseling: Thank you for your general support for transition. Related to the comment about long term care options counseling for registered housing with services, DHS and the MN Board on Aging worked very closely with a number of stakeholder groups including managed care and provider representatives to design something that highly un-intrusive. The stakeholders and staff have learned a great deal in the first year of roll out. The initiative rolled out in October 2011 and to date close to half of consumers opt for the full long term care options counseling protocol which includes a risk management discussion and the rest are offered an easy decline. Customer satisfaction data shows that most consumers understand the need for the service, even if they do not choose the full counseling protocol.</p> <p>Intersection of Health Plans with pre-eligibles: Some pre-eligibles are members of health plans due to their enrollment in Medicare Advantage, and may interact with the Senior LinkAge Line services mentioned in this section based on the need for health insurance counseling and supports from the community living specialist around benefits access. However, generally speaking, the transition support work will not intersect with Health Plans unless the consumer ends pre-eligibility and becomes eligible for Elderly Waiver and is either auto-enrolled or chooses a health plan.</p> <p>Support for transition and unbiased information: Thank you for your strong support for this concept. Long Term Care Options Counseling does include assistance with understand benefits and financial options including those that the consumer may tap into for long term care supports including accessing consumer direction options.</p> <p>Support for referrals to Adult Day Services: DHS is in agreement that Adult Day Services are a key community resource and service for individuals transitioning from nursing homes. All of the Adult Day Service agencies are included in www.minnesotahelp.info. Senior LinkAge Line® refers to these services.</p>
6.1 Demonstration to Empower and Encourage Independence through Employment Supports	

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Comments	DHS Response
<p><i>Support for the proposal</i></p> <ul style="list-style-type: none"> • Focus on building independence and stability in community-based employment are strengths of the proposal • Supports the MA-EPD portion of the initiative • Supports inclusion of 18-26 year olds in first phase • Comment supporting proposed data elements in evaluation encouragement that this data will inform future DHS efforts • Comment supporting navigator qualifications • We support increased efforts around employment for persons with disabilities; individuals with disabilities are significantly over-represented among citizens who experience long-term poverty; without an increase in competitive employment, individuals with disabilities will continue to have limited access to the opportunities, choices and quality of life available to other citizens; we ask that the reform emphasize competitive employment as a desired outcome <p><i>Concern about design elements</i></p> <ul style="list-style-type: none"> • The proposal uses the word “navigator” which may be confusing when health insurance exchanges are up and running • Concern that the DB101 website is not effective, that individuals do not use it and that people may not have computer access • Eligibility requirement concerns regarding current proposed requirement that participants be employed or have experienced an employment shift in 	<p><i>Support for the proposal:</i> DHS appreciates the support for this proposal.</p> <p><i>Concern about design elements:</i></p> <ul style="list-style-type: none"> • <u>Term “navigator”, proposed staff qualifications</u> DHS was able to contract with a community organization to provide navigation services for DMIE and that organization was able to staff the project with people who met the qualifications outlined in this proposal. Navigators themselves are not required to be mental health professionals. DHS will consider changing the terminology from “navigator” to something else better suited to avoid confusion with future health insurance exchange navigators. • <u>DB101</u> It will be a resource used to find quick and easy answers to questions participants may have. Navigators will be able to use DB101 estimator sessions to provide participants with benefits planning options. DB101 is not intended as a replacement for an individual benefits analysis conducted by Work Incentives Connection. Navigators will refer participants to necessary and appropriate outside entities for individualized benefits planning sessions that DB101 is unable to provide. • <u>Eligibility requirements</u> Unlike DMIE, participants will not be required to undergo a clinical diagnostic assessment to be eligible for the demonstration. In reaction to public comment, we have changed eligibility requirements and will now offer the demonstration

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<p>the past year</p> <ul style="list-style-type: none"> The MN DMIE report data provided regarding outreach is a concern; first, is the low response rate of 16% and the fact that only half of them were approved, leaving just 8% of the total mailing; granted, this is higher than most market research efforts; however, in terms of reaching people to prevent them from going on to a variety of disability programs, we believe it is low; outreach to enroll people under the new proposal includes mailings and phone calls - to people who do not have stable home addresses and who may not have cell phones; will reaching fewer than 8% be viewed as successful? Telephonic navigation not a good match for the needs of this group; need outreach approach Concern that services based on DMIE will not be effective Concern that navigator functions don't include information about housing benefits 	<p>to people who are currently unemployed.</p> <ul style="list-style-type: none"> <u>Outreach efforts, participant engagement, program uptake and similarities to DMIE</u> Unlike DMIE, participants in this demonstration will not be required to change health care programs to access services. Participants will not be required to undergo a diagnostic assessment either and (due to changes via public comment) participants will not need to be employed to access services. We believe this revised eligibility criteria will promote better enrollment than DMIE. Minnesota exceeded the enrollment target for DMIE and that demonstration achieved nearly 75% retention rate over three years. Data indicates that the proposed demonstration may have upward of 7000 potential participants annually. With an enrollment cap of 800 participants at any given time, participant response rates similar to DMIE would be considered successful. <u>Telephonic navigators embedded in the DLL, will not be effective</u> We have clarified language in the waiver proposal to reflect the fact that navigators will not be a component of DLL, but rather have access to DLL technology and resources. Community organizations will be contracted to provide navigation services. Regarding the concept of telephonic navigation as a whole, the majority of DMIE navigator's encounters (72.7% - page 24 of the DMIE Final Outcome Report) with participants were conducted via phone. See comments below for DMIE outcomes and success information. <u>Services based on DMIE will not be effective</u> According to The Final Outcome Evaluation Report, DMIE, with its provision of health care, navigation and employment services succeeded in significantly reducing disability applications among working adults with mental health conditions. Program participants also demonstrated significant improvements in: earnings, level of functioning, quality of life and preventative care utilization. The groups included in this proposed demonstration have similar needs and Minnesota would like the opportunity to demonstrate that similar supports will garner similar outcomes with several groups of participants. DMIE Final Outcome Evaluation Report Navigation services and housing benefits Information about housing benefits was included in the navigator function of

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<ul style="list-style-type: none"> How will this section impact MCOs? <p><i>More information requested</i></p> <ul style="list-style-type: none"> Provide reasoning for selecting particular groups <ul style="list-style-type: none"> Will the navigators be trained in person centered planning? <ul style="list-style-type: none"> What is the anticipated reduction in use of SSDI, medical service savings and increased taxes? Any available projections? Has there been any testing of the idea that DLL is now providing employment and job placement services? 	<ul style="list-style-type: none"> <u>Health Exchanges</u> This demonstration is intended to inform design of a service which could potentially function in the future health insurance exchange. <u>DEED, DOC, MDE</u> These agencies were engaged in the development process for the proposed demonstration and they will be engaged as partners in future development. <u>Primary healthcare, MH and workforce</u> Navigators will provide a referral system to services which best help participants pursue their self-identified employment, health and personal goals. Navigators will have access to the DLL referral network and will assist participants in accessing appropriate services. <u>MCOs</u> Navigators will occasionally contact MCOs on a participant's behalf to clarify benefits, coverage etc. Prior to project launch, DHS and will work with MCOs to determine best practices for navigators to communicate with MCOs <p><i>More information requested:</i></p> <ul style="list-style-type: none"> <u>Why these groups?</u> DHS is interested to demonstrate that successes of DMIE could translate to other groups. -Wanted to offer services to people earlier in life (transition age) to promote better health and employment outcomes early in life. -Wanted to test how navigation, employment services and benefits planning model could work with several different groups(foster care, DOC, MFIP, expansion group with SMI) -Interested to test these services with people who have a disability and are employed to determine health and employment outcomes (MA-EPD) <u>Person Centered Planning</u> DMIE navigators were trained to provide a person centered, client driven service that tailored service to client needs and goals. This demonstration will utilize the same training principles. <u>Anticipated cost reductions and tax revenue</u> These are discussed in the revised budget section of the final waiver request <u>Has DLL providing employment and job placement services been tested?</u> Navigation and employment services were facilitated for the DMIE by navigators located in Minnesota Resource Center. Job placement services were not available in DMIE and will not be available in this demonstration. Community providers will be responsible for navigation services, not the DLL

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<p>6.2 Housing Stabilization Services Demonstration</p> <ul style="list-style-type: none"> • Functional assessment is not a good approach. Mental illness manifests in very different ways; functional assessments should be adaptable for people who are experiencing homelessness (several comments received) • Target population should be expanded (several comments received) • MnCHOICES is not applicable to people who are homeless (several comments received) • Ensure that the successful providers of housing stabilization services are comfortable with how qualified service providers are defined; use providers that are best at creating meaningful and lasting relationships (several comments received) • Proposal contains only a partial list of the recommendations from the supportive housing community. Enhance the current service package by adding CFSS services or services to help people maintain their housing (several comments received) • Providers are experiencing an increase in the number of younger individuals with serious and persistent mental illness and / or chemical dependency with a health condition being admitted into nursing facilities and assisted living establishments; hope that this demonstration can include a special focus on this population (several comments received) • Limiting the Housing Stabilization Services to people who are 18 and older (several comments received) • Do not limit the program or have a cap to the number of people to be served (several comments received) • Limit the population not the specific benefit set of services. Maintain a 	<p>We are revising this section and eliminating the need for a functional assessment.</p> <p>We are changing the target population to persons on General Assistance and homeless or in setting that receives Rate 2 funding for housing with services establishment or the metro demo.</p> <p>We believe that MnCHOICES should be and can be made applicable to people who are homeless and we will continue to work with MnCHOICES to achieve that goal. We do not list it as a requirement for implementation of Housing Stabilization Services.</p> <p>We will establish and consult with an Implementation Council on provider qualifications. We are committed to using peer support specialists as possible providers of services.</p> <p>We are concerned that our target population will not meet the criteria for CFSS services and have added Community Living Assistance defined as: 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.</p> <p>We are targeting people who are homeless or at risk of homelessness including people in nursing facilities who have no place to go upon discharge.</p> <p>In our revised section we have eliminated the requirement that the target population is 18 or older.</p> <p>If financing allows, we will eliminate the cap on number of people to be served.</p>

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Comments	DHS Response
<p>rate structure that allows providers to provide the necessary services even if it means reducing the number of people who can be served (several comments received)</p> <ul style="list-style-type: none"> HealthPartners would like additional information about funding streams for providing housing services for individuals that are being discharged from hospital settings <p><i>Comments of support</i></p> <p>One commenter agrees that stable housing is a key component to improving health outcomes and reducing health-related expenditures; thank you for including housing-related support services.</p> <ul style="list-style-type: none"> Several commenters support the proposal’s initiatives to stabilize housing as an essential intervention in reducing health care costs. Sufficient options for housing with appropriate services, however, continue to be a challenge for both crisis and stable clients. One commenter supports the proposal with respect to the Housing Stability Services; supportive housing is a cost effective approach to assure that persons with mental illness can remain in the community and avoid costly hospital stays One commenter supports the modification under consideration to include persons who are homeless, General Assistance are frequent users of high-cost medical services; the inclusion of people now in supportive housing is especially important Commenters support the demonstration to add housing stabilization and services to the State Plan; strongly support the inclusion of persons leaving 	<p>DHS appreciates the comments of support and looks forward to continuing to work with stakeholders to refine the program.</p> <p>DHS agrees with this comment and is structuring the proposal accordingly.</p> <p>We would like to direct HealthPartners to the Hospital to Home partnership between Regions Hospital and Guild, Inc. We would be willing to share other housing resources for people discharging from the hospital.</p> <p>DHS appreciates all the comments and letters of support.</p>

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<p>correctional facilities, residential chemical dependency treatment and inpatient facilities as well as nursing facilities</p> <ul style="list-style-type: none"> • One commenter agrees that there are significant challenges in finding stable housing for individuals in need • One commenter supports the proposal to expand housing options for persons with disabilities; housing services are one of the most critical services for assuring that vulnerable individuals retain the supports necessary to remain in the community • One commenter supports the inclusion of Housing Stabilization Services in the demonstration projects; safe, stable housing is at the foundation of health • One commenter supports the modifications of the proposal to expand the target population and include Community Living Assistance in the set of services • One commenter proposes several initiatives in our <i>Blueprint for Reform</i> to help individuals secure and maintain their housing; the additional supports in the waiver application will build on our efforts and we support them; however, more resources and attention must address the housing needs of individuals with complex physical disabilities and health needs 	
<p>6.3 PATH Critical Time Intervention Demonstration</p> <ul style="list-style-type: none"> • One commenter supports the demonstration • One commenter supports the request to obtain federal Medicaid match for those who have not yet been determined eligible for Medical Assistance because they have been homeless and disconnected from services • One commenter believes that the use of CTI is an effective way to transition individuals receiving services from a high level of service to a lower level, and to effectively increase the number of people served by transferring more clients off PATH caseloads • One commenter identifies that the first-come, first-serve policy will result in a lack of services for the most vulnerable PATH clients with mental illnesses; historically people experiencing homelessness with the highest level of mental health need do not request services • One commenter states CTI is only as effective as the community supports that exist for PATH providers and that housing and case management supports can be limited for PATH providers; for CTI to be effective, there must be services for PATH clients in place before the demo is 	<p>DHS continues to strongly support access to healthcare and the use of evidence-based practices for persons with SMI.</p> <p>The CTI transition of participants from targeted intensive services to person-directed community services and natural supports is consistent with the PATH strategy of outreach, engagement in services, and transition to stable housing and supports.</p> <p>CSH is correct that the first-serve policy is inaccurate and does not reflect the outreach strategies employed by PATH to engage persons who are homeless with a SMI. The policy will be revised to highlight the focus on outreach to persons who are literally homeless.</p> <p>CSH’s identification of the need to assure access to housing and services for the transition of PATH CTI participants is true for current PATH services and for the demonstration. Strategies are needed and utilized at the provider, local and regional levels to maximize availability of housing and service resources. DHS strategies include cross agency partnerships to identify and create services, such as CFSS, and housing opportunities. DHS also partners with</p>

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implemented; a good fit would be the CFSS services proposed to support once a client is in housing	other State, regional, and local stakeholders to facilitate housing and service development and access.
<p>7 Anoka Metro Regional Treatment Center (AMRTC) Demonstration</p> <ul style="list-style-type: none"> • Support the request to exempt the state from the IMD exclusion for adults between the ages of 21 and 65 who meet Medicaid eligibility requirements as long as the services are intensive, short-term medical services and the increased funding is used to divert or assist to return to the community persons with significant mental illnesses • Also support the exemption from IMD status in order to be able to qualify persons who have received intensive psychiatric services and are ready to return to the community for the Money Follow the Person initiative • Would MCOs be responsible for paying for Medicaid services in IMDs • Articulation of the necessity to arrange the home/community environment to better support the person after transition from AMRTC is a strength of the proposal • The footnote on page 73 states that there are 12 beds for individuals with mental illness and “intellectual” disabilities.” Are these the individuals who were transferred from METO/MSHS to Anoka? If so, they come under the Jensen Settlement Agreement and that should be mentioned • Would a demonstration under the Section 1115 Waiver Proposal allow individuals at Anoka RTC to become Medicaid eligible and could they then transition to the community under the Money Follows the Person initiative? • Would a section 1915 (i) waiver apply to individuals with multiple disabilities and complex conditions? • In our experience, we have not seen impediments when individuals are discharged from Anoka Metro Regional Treatment Center to the community because of their IMD status and believe there is continuity of care when individuals are discharged back to the community; we seek clarification and additional information from DHS around the goals DHS hopes to achieve through these proposed changes. • Urge more specificity on how the increased funding would be used to both divert persons from Anoka Regional Treatment Center and assist people to return to the community as soon as possible after treatment at Anoka or other psychiatric inpatient settings • No intentional connections between this initiative and person-centered positive behavioral supports that are emphasized in the value/vision. 	<p><i>Comments expressing support</i> DHS appreciates the support for this proposal.</p> <p><i>Are health Plans required to pay for services if this waiver is approved?</i> Health Plans would be required to pay for all medically necessary services rendered for MA-eligible patients who meet criteria for treatment at AMRTC.</p> <p><i>What is the goal of the IMD exclusion waiver?</i> The goal of the waiver is to allow MA funding to pay for medically necessary services to treat the individual and assist with discharge planning and return to community (e.g., inpatient mental health treatment that occurs at AMRTC; case management and other care coordination services, eligibility for an ACT Team that should continue; physical health services that the individual may need during the period that they are receiving inpatient mental health services.)</p> <p><i>Are the 12 beds reserved for individuals who have a mental illness and developmental disability for people who have been transferred from the METO program?</i> No, these beds are reserved due to recognition that individuals with the specialized needs that accompany a dual diagnosis of developmental disability and a mental illness need specialized services. The staff at AMRTC also recognize that people with other combinations of issues (medical and mental health’ mental health and behavioral) need specialized services and work to provide individualized services for them.</p> <p><i>Would an IMD exclusion waiver allow people at AMRTC to become eligible for MA and become eligible for “Money Follows the Person”?</i> Most of the individuals who receive services at AMRTC are MA eligible until they are admitted to AMRTC. This waiver would allow them to keep this eligibility. If granted, DHS would amend its Operation Protocol under MFP to seek permission from CMS to add these people to the MFP Demonstration.</p> <p><i>What is the relationship between the proposed 1915(i) and waivers/services under the CFSS proposal and those with complex co-morbidities?</i> People</p>

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<ul style="list-style-type: none"> • Is there an estimated number of individuals for whom a section 1915 (i) waiver would apply? What is the target for a section 1915(i) waiver here? • The discussion on page 36 above (page 8 of our comments) regarding Section 1915 (i) and Section 1915 (k) waivers would suggest that, since these are individuals meeting an institutional level of care, would not a section 1915 (k) waiver apply here? • The length of stay is mentioned but are there data on the range of stays? 	<p>leaving Anoka no longer meet hospital level of care, and some may not be eligible for the CFSS services. In addition, the services offered under CFSS not specifically tailored to address serious psychiatric disabilities and complex comorbidities common among those who experience lengthy delays in leaving Anoka as the 1915(i) for this target population would do. The 1915(i) provides intensive supports for moving home.</p> <p>The proposed 1915(i) would provide special attention to people with SMI who have completed treatment at Anoka AMRTC and need help going back home. It could help bring service together for people with high SMI needs who currently may have to piece services together through different programs and places. It could help provide skill building services and supports to help people with SMI, such as a counselor to help build relationship with the landlord and solve disagreements or teaching skills and provides supports needed to keep a place to live, such as help to keep apartment clean and free of clutter. The 1915(i) could provide support to get a job and stay employed that is tailored to people with SMI as well as training to help learn better skills for good friendships and relationships with other people.</p> <p><i>Does the IMD exclusion keep all people from moving to the community?</i></p> <p>Many people make use of AMRTC services and move back to the community fairly smoothly, although not as smoothly as they might if Medicaid eligibility was not disrupted by the IMD exclusion. This waiver will have the most impact for a small group of individuals who have barriers such as past history of fire setting, assaultive, and/or sexual behavior or medical issues that make serving them in the community challenging. These barriers make it difficult to make the transition back to a community setting and leave AMRTC once hospital level of care is no longer met. The lack of MA eligibility does impact continuity of care and access to community care providers during treatment and in discharge planning, since non-MA eligible individuals are not able to access community based services while at AMRTC.</p>
<p>8 Eligibility for Adults without Children</p> <p>Several commenters opposed the proposed changes to eligibility for adults without children.</p>	<p>DHS thanks commenters for their input, and will take these comments into consideration. State law requires federal approval for these changes to be sought.</p>

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<p>Commenters questioned whether this approach was allowable under the maintenance of effort requirements under the Affordable Care Act.</p> <p>Commenters raised concerns that the asset test and the residency requirement would create an additional barrier for people with very low incomes, discourage people from saving money to become self-sufficient and cost the state more by increasing the number of uninsured.</p>	
<p>9.1.2 1915(i) for kids with ASD</p> <p>[Summary of more than 35 comments submitted by consumers, family members, and relatives of someone with ASD not commenting on behalf of an organization]</p> <ul style="list-style-type: none"> • Intensive behavioral therapy/ABA is a proven, evidence-based practice (multiple comments) • ABA was the only approach that worked for my child and it made a tremendous difference (multiple comments) • ABA should be a covered service in MA, and mandated under EPSDT • Do not cut coverage at age 7 (multiple comments) • Cutting coverage at age 7 disproportionately affects minority kids because they are diagnosed much later than white children • The long-term savings for Minnesota from early intervention for kids with autism far outweighs the short-term cost (multiple comments) • Schools are not equipped to provide the needed intensive behavioral therapy for kids with autism (multiple comments) • Clarify that children will have access to medically necessary services after age 7 and outside of public school system (multiple comments) • Parental fees are unaffordable • More oversight of ABA providers by DHS is needed (several comments) • DHS should model its program after other states that have autism HCBS waivers • Minnesota needs to study why there is an increasing rate of autism • Minnesota needs to study outcomes/effectiveness of autism treatment approaches (numerous comments) • Services must be based on medical necessity, functional need, and not on age (multiple comments) 	<p>NOTE: DHS does <u>not</u> intend to seek federal waiver authority under this Section 1115 Waiver Demonstration for services for children with autism spectrum disorder. DHS will seek federal authority under a different vehicle after further discussions with stakeholders. DHS put forward a conceptual framework for policy development it has committed to undertaking to develop an autism specific benefit set, with a focus on young children and effective transition to an educational setting. Our response to main themes raised by comments is included below:</p> <p><i>Concerns that the intent of the proposal is to cut off autism services at age 7 and shift responsibility for services to the schools:</i> In response to numerous commenters who believe DHS is proposing a cap on services for children with autism at age 7, DHS has re-written the proposal to eliminate any reference to age, but maintains an emphasis on early identification and intervention for younger children, and smooth transitions between care providers, schools and community support systems. A few providers and advocates specifically supported the concept of better coordinating activities among DHS, MDH and MDE. However, DHS did not intend to require all future medical services over the age of 7 be delivered through the public schools and the proposal has been re-written to clarify this.</p> <p><i>Support for development and inclusion of medically-necessary services across a range of ages:</i> Several autism providers and advocates commented that they are generally supportive of the proposal to identify evidence-based, medically necessary services that focus on outcomes and ensure quality provider standards. DHS welcomes their expertise as the services are designed and we are developing a stakeholder process to design services, criteria and standards. <u>In response to commenters, DHS has substantially re-written the policy proposal to make clear that medically necessary services will continue beyond the age of 7, and that eligibility and provider qualifications for such</u></p>

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<ul style="list-style-type: none"> • Do not cut services delivered out of school (multiple comments) • Provide opportunity for input from parents, therapists, clinicians (multiple comments) • Support coverage of emerging treatments with evidence development • Support use of board certified behavior analysts <p>[DHS also received over 1,500 “petition” emails requesting that coverage for children who have autism be based on medical necessity, include coverage for evidence-based, clinically effective treatment and asking DHS to provide formal opportunities for members of the autism community, including health care professionals who treat individuals with ASD, to provide input before finalizing policy changes]</p> <ul style="list-style-type: none"> • Targeting the benefit to children under the age of seven aligns with the research on where intensive treatment models have the most benefit, so we support this definition. • As we understand it, the intent on the school IEP driving services for older children is to reduce the number of different assessments currently required to access services; we believe this is a good idea • We strongly urge the state not to be rushed by this waiver application to implement benefits without due consideration of the evidence base for benefits and services • HealthPartners supports evidence-based care and interventions • We are very interested in the development of the time-limited service set and seek information about how this will be defined • We seek additional information about and are very interested in the development of agreed upon standards, assessment tools, treatment plans and protocols for objectively measuring progress • Support the proposed initiative to develop a 1915(i) waiver to deliver early intervention services to children ages 0 – 7 • Services should be individualized, based on a sound understanding of research in autism spectrum disorders and be evidence-based • We strongly support the intention to coordinate program services with medical and educational services; however, CEA feels that the proposed autism waiver should also include a family-centered approach that considers the value of family empowerment to the development of children with ASD 	<p><u>services will be developed through a formal stakeholder process set to begin this fall.</u></p> <p>Lacks clarity: We agree that the proposal, at this point in time, is not detailed or specific (and the specificity we did provide – an age range – created confusion that services would be capped and end after the stated age.) Details, including definitions of terms, will be done with stakeholder input during the planning and development phase.</p> <p>Will DHS wait for treatment recommendations to be developed through the Health Services Advisory Council (HSAC), charged with completing this task by December 2012? The Health Services Advisory Council or HSAC is now working on recommendations related to autism. Meetings began in June 2012. HSAC will submit recommendations about autism services in December 2012. (HSAC’s role is to recommend what treatments should be covered in Minnesota public health care programs, based on scientific studies.) More information about HSAC, including meeting dates and a membership list, is available on HSAC’s webpage. DHS appreciates the concerns raised by several commenters that HSAC’s work should inform the development of any autism-specific services.</p> <p>Desire for DHS to Solicit Input from Stakeholders: The DHS has a long list of stakeholders we plan to include during the development of the proposal. The list includes advocates, clinicians, providers, parents/caregivers of children with autism, health plans, pediatricians, representatives from county and state agencies (health, education). Developing provider standards to ensure high-quality services are delivered is extremely important to DHS and we welcome input from stakeholders on this work.</p> <p>Several commenters acknowledged an encouraging direction in seeking to better coordinate activities of state agencies DHS, Health and Education: We agree that if health care and education can come together to serve children with disabilities we should be able to do great things for children and their families. We agree that more clarity is needed on how this coordination would look across multiple state agencies and diverse funding streams.</p> <p>The State agencies are represented on the Minnesota ASD Task Force and are already working on projects and strategies to facilitate enhanced coordination</p>

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<ul style="list-style-type: none"> • We are glad to see attention to the need for specialized services for children with ASD issue in the Reform 2020 proposal • We would encourage the administration to reconsider this decision given how many individuals with autism are not diagnosed until after age 7, as well as the significant service needs of those with ASD over age 7 • Support the proposal to ask CMS for technical assistance to assure that children from families with income over 150% FPL qualify for Medicaid under TEFRA or HCBS waivers; urge that this issue be carefully reviewed with stakeholders given the pending changes to the nursing facility level of care (NF-LOC) • Also urge caution in developing criteria before HSAC has had a chance to weigh in • One commenter supports the stated intent to deliver coordinated early intervention services for children ages 0-7 with a diagnosis of ASD; the need to provide children with ASD and their families with comprehensive services and supports is long overdue • One commenter has major concerns with ending this comprehensive approach at age 7 and with the reliance on the Individualized Education Program (IEP) for special education under the Individuals with Disabilities Education Act (IDEA) for services for students with ASD over age 7 • One commenter has an issue with the lack of detail included in this proposal, as this section raises many questions and offers few answers • One commenter urges close collaboration with the Minnesota Department of Education, as well as with parent advocacy organizations specializing in special education if this effort is to move forward • One commenter remains concerned about the lack of clarity in this proposal and recommends that DHS provide interventions that would taper off as the child progresses or extend to at least the age of 21 • Need to better coordinate medical and educational services • We applaud DHS for considering the establishment of a learning collaborative to improve quality of care in community settings for individuals with ASD • The conceptual framework in the proposal has many key recommendations that will move Minnesota forward in serving children with ASD • The portion dealing with ASD is also very needed and timely; the idea of 	<p>among activities across the life span of an individual with ASD.</p>

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<p>integrating or collaborating around the health care and education needs of these children is encouraging</p> <ul style="list-style-type: none"> • The scope, content, and mission of the 2020 Reform document is impressive and clearly positions Minnesota as a national leader in providing services to individuals with special needs; based on previous meetings and interactions with DHS staff charged with the Reform proposal, I believe that DHS is taking to heart the stakeholder feedback which will result in well-coordinated, evidence-based services to the citizens of Minnesota and their families struggling with mental health disorders • My understanding of the proposal's intent is to break down barriers to effective service delivery across diagnostic categories, service categories, and age groups • Proposal should insure that intensive ABA services are available at the very earliest age autism can be diagnosed and provided at the maximum intensity and funding mechanisms must allow for services to occur in all necessary environments • Proposal should insure that intensive ABA services are available at earliest age that diagnosis is possible to help remediate symptoms and to promote placement in a mainstream classroom • The proposed waiver will help many young children with autism spectrum disorder (ASD) more easily access evidence-based, medically-necessary treatment, behavioral intervention and family supports; want to participate in stakeholder process • Concerned that it appears limited to age 7 • Support for a 1915(i) waiver to prevent Minnesota from creating a waiting list that would hamper early intervention • Recommend extending the age of coverage of the 1915(i) waiver to 12 years • Applied Behavior Analysis can assist in resolving concerns regarding the section on Autism Services in the proposed waiver • We support the proposal to develop a 1915(i) State Plan amendment for a range of intensive services for young children with autism • To support and augment this proposal, we urge that DHS support a private insurance mandate for coverage of the variety of medically necessary treatments and services for children with autism 	

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<ul style="list-style-type: none"> • Another related effort which will support the proposal, is to assure that behavior analysts are recognized as a professional category within our state Medicaid program • Regarding ASD service coordination with schools, strong concerns by parents that their child with ASD would not be able to access medical services outside of school after the age of seven • We recommend that this proposal be changed to reflect a general idea to be developed with a stakeholder group over the next two years to assure that children’s rights to a free, and appropriate education be assured, and that medically necessary services be available depending upon individual need • Supports forward thinking perspective of DHS including consideration for providing coverage of treatment approaches that may be well-founded, science-based, and time-tested treatment approaches, but lack the rigor of controlled-trial evidence and are still in the “evidence development” stages • Wants to see consideration of developmental interventions in addition to ABA/behavioral interventions • Concerns about the limitations on services for children over age 7 • To conclude that after age 7 child will be enrolled in school and receiving services in a school environment does not contemplate that the child continues to need intensity to address their needs associated with ASD diagnosis, an intensity that schools are ill-prepared to provide; as with other medical conditions, primary care of child with autism should reside with specialist • Reform 2020 should more clearly acknowledge the need and right to specialized autism care into adulthood • The goal of developing one program that can provide an integrated set of services for Medicaid eligible children with similar diagnoses and functional needs is quite worthy and ambitious, but it’s not clear how the Section 1115 Waiver Proposal will be able to achieve that end result; a section 1915 (i) waiver may give children with ASD better access to a broader range of services that are actually available; a coordinated system of care is another issue; could these distinctions be made? • Standards, assessment tools, protocols, and learning collaboratives are proposed; how will these activities be connected with a single program, fully integrated benefit set of services, especially when the scope of 	

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<p>services is pending?</p> <ul style="list-style-type: none"> • Focus should be on ensuring that children have improved access to timely and effective medically necessary care, and support the fact that the services to be developed will improve access to treatment for children enrolled in MA-PMAP • Concerned that as written the proposal would only be available for children under the age of seven and after that children would only get therapeutic services through their public school system • Any coverage limits should be based on functional need and medical necessity, not on arbitrary age cap or diagnostic label • Proposal should state that there will be no reduction of coverage for treatments, services or supports to children who have autism • Coverage should include treatment recommended as medically necessary by a child's treating clinician • Parents need choices among treatments that provide access to effective treatments • Focus on outcome measures to ensure treatments are clinically effective • Cover evidenced-based practices and commonly used autism practices • Include experts, providers and families in the development of the new service set 	
<p>9.1.4 1915(i) to support individuals with mental illness who are at risk for institutionalization without access to an integrated community-based system of care; called Intensive Mental Health Recovery Services</p> <ul style="list-style-type: none"> • Focus on institutional level of care to qualify for services excludes too many people with mental illness (several) • To be eligible you have to be so ill; services brought in too late • Initiative should focus on intervention with lower needs people rather than this group • Services not robust enough to support individuals • Include study of CBHHs and role in community, i.e. why they are not full • We strongly support the development of a 1915(i) State Plan option to provide services which are flexible in terms of type, such as in-home services, employment supports or other therapeutic services and flexible in terms of intensity • The criteria for qualifying is very restrictive; support broadening in order 	<p><i>NOTE:</i> DHS does <u>not</u> intend to seek federal waiver authority under the Reform 2020 Section 1115 Waiver Demonstration for this program. DHS plans to submit a request for a state plan amendment under Section 1915(i) of the Social Security Act after additional stakeholder input has been gathered. DHS put forward a conceptual framework for policy development it has committed to undertaking to develop a targeted, intensive mental health 1915(i) benefit set, with a focus on people no longer meeting hospital level of care at Anoka Metro Regional treatment Center to assist with effective transition back to the community Our response to main themes raised by comments is included below:</p> <p><i>Focus on institutional level of care to qualify for service excludes too many people with mental illness.</i> Many advocates mentioned that the target group is very small and very ill. Transitioning individuals who remain in an institution beyond need for one is the focus of this policy proposal.</p>

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<p>to provide services to persons before they end up in psychiatric hospitals, prisons, jails or nursing facilities</p> <ul style="list-style-type: none"> • The targeting of behaviors that are “specifically related to symptoms of the person’s mental illness” is confusing and needs to be clarified and the criterion in “F” (p. 85) of “inability to function in the community or inability to find supportive services in the community” should not be limited to persons who have a mental illness and a co-occurring other illness, condition or disability • We also recommend that DHS work with stakeholders to develop a 1915(i) for children, especially those 16 and older at risk of commitment • DHS should revise Adult Rehabilitative Mental Health Services (ARMHS) to review funded services and billing as well as consider new rehabilitative services and billing units not currently funded by the Rehabilitation Option • Is there an estimated number of individuals for whom a section 1915(i) waiver would apply? What is the target for a section 1915(i) waiver here? The discussion on page 36 above (page 8 of our comments) regarding Section 1915(i) and Section 1915(k) waivers would suggest that since these are individuals meeting an institutional level of care, would not a section 1915(k) waiver apply here? • Articulation of the necessity to arrange the home/community environment to better support the person after transition from AMRTC is a strength of the proposal • No intentional connections between this initiative and person-centered positive behavioral supports that are emphasized in the value/vision. • can assist with training and technical assistance 	<p>DHS has found that the AMRTC bottleneck is a major disruptor system-wide in the ability to provide the right services at the right time for people needing mental health treatment. By helping people transition out of AMRTC at the appropriate time, the AMRTC can be more available as a specialized setting for intensive treatment when that is needed.</p> <p>However, DHS recognizes that other individuals in the community could benefit from similar additional services. DHS will be holding a series of stakeholder meetings from August to October to reexamine the services and to assess the possibility of broadening the target populations.</p> <p>Revise Adult Rehabilitative Mental Health Services: DHS will be holding a series of stakeholder meetings from August to October to reexamine these services and to assess the possibility of including changes to them under a 1915(i) State Plan option.</p> <p>Is there an estimated number of individuals for whom a section 1915 (i) waiver would apply? What is the target for a section 1915(i) waiver here? The estimated number of individual that would be eligible for this service is 15 to 18 per month or 180 to 216 per year. The target group is individuals who are currently at AMRTC and cannot find community services and living options due to past history of aggressive or risky behavior that occurs because of their mental illness.</p> <p>Since these are individuals meeting an institutional level of care, would not a section 1915 (k) waiver apply here? The target group is made up of individuals who no longer need an institutional level of care and would not be eligible for a 1915k.</p> <p>No intentional connections between this initiative and person-centered positive behavioral supports that are emphasized in the value/vision. The value vision that is identified in the earlier sections of this document is assumed to apply to the remainder. However, like other mental health services, DHS expects these services to focus on the recovery plans of the individual and assist them in reaching those goals.</p>
<p>9.1.5 1915(i) for adults with co-occurring DD, SMI and sexual disorder, called Targeted Clinical and Community Services</p>	<p>Initiative should focus on intervention with lower needs people rather than this group. This is a high need group that crosses disabilities and service</p>

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<ul style="list-style-type: none"> • Focus on institutional level of care to qualify for services excludes too many people with mental illness • To be eligible you have to be so ill; services brought in too late • Initiative should focus on intervention with lower needs people rather than this group • One commenter supports this effort • One commenter supports the development of a 1915(i) service for this population to better design effective services and community supports for this population. 	<p>needs. Their services are not always coordinated and some services are not provided or provided without reimbursement.</p> <p>DHS recognizes that other individuals in the community could benefit from similar additional services. DHS will be holding a series of stakeholder meetings from August to October to reexamine the services and to assess the possibility of broadening the target populations.</p>
<p>9.2 Redesign Home and Community-Based Services</p> <ul style="list-style-type: none"> • Several initiatives emphasize person-centered planning, including earlier intervention services; the integration of LTSS, behavioral and physical health care; enhancements to 1915(c) waivers; case management reforms; crisis intervention and protection protocols and health care reforms. The list, however, does not necessarily connect to person-centered planning principles • Need to use people-first language in all waiver descriptions • Need details about new financial management structure; what prompted this? What have we learned from current system? • Assisted living is mentioned on page 97 but unclear who would be moving into AL • Keys to reaching people early and preventing decline are 1) begin adult day services early, and 2) provide continuity and frequency that meet the individual's needs. 	<p>Person-centered planning principles are the core of reform, and have been the driving force in many initiatives that lead the way to this proposal; we will look at how to make that more explicit.</p> <p>The Consumer-Directed Task Force developed recommendations for a self-directed option to the PCA program, and how those recommendations could be applied across all self-directed options in a report to the legislature in 2008. The administrative structure for a future financial management structure and changes in administrative functions related to self-directed services to be used in PCA and HCBS waivers is outlined there. Since that time, there has been continued work by that committee and additional interest by others in revamping the structure to support self-determination based on what we have learned, and what has been successful in other states, now that more states offer this option. There will be an Implementation Council, comprised of at least 50% of people who use services, as well as other stakeholders, that will help develop the CFSS, and assist with the final design for the financial management structure.</p> <p>Assisted Living is primarily used by older adults. The Centers for Medicaid and Medicare are reviewing public comment to a proposed definition of home and community-based services, which will affect allowable settings for people receiving HCBS services. Minnesota also has state law that specifies the characteristics of home and community-based settings https://www.revisor.mn.gov/statutes/?id=256B.492</p>
<p>9.2.2 MnCHOICES</p>	<p>DHS has worked in collaboration with stakeholders and those who use services</p>

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<ul style="list-style-type: none"> • Appreciate efforts to make changes to this tool to more accurately assess the needs of people with mental illness; however, more work is needed. • Is MnCHOICES consistent with best practices? • Further discussion is needed about funding mechanisms; need to transition away from financing assessments for people 65+ through NF rates • Urge further discussions of use of MnCHOICES in primary care/health care home settings, including funding mechanisms • Further detail needed regarding transition from LTCC and Customized Living Tool to MnCHOICES; this should include changes to CL tool • Support statewide assessor training and certification and standardized, automated audits which should improve consistency • Must assure proper consideration of those who have needs to due to mental health conditions • Additional work is needed to improve the assessment for people with serious mental illness • MnCHOICES does not adequately assess the needs of people with mental illness • Hope for a phased-in approach to implementation of MnCHOICES • Encourage early referral to Services for the Blind to reduce/eliminate/prevent need for support services • MnCHOICES should be flexible enough to be delivered in a variety of environments 	<p>to develop MnCHOICES, which is the assessment and service planning process for access to long term services and supports. This has specifically included people with a mental illness, the mental health divisions, and mental health stakeholders, and we will continue to do so.</p> <p>DHS understands that the needs of persons with mental illnesses need to be addressed in the MnCHOICES assessment tool. It is important to note that the MnCHOICES assessment does NOT take the place of any <i>diagnostic</i> or clinical assessments that are required for mental health services such as ARMHS or IRTS or ACT; nor does it assess the need for mental health targeted case management. The MnCHOICES assessment is a <i>functional</i> assessment to identify a person’s need for LTSS services and will provide referrals to appropriate mental health professionals for mental health services that can be provided in conjunction with LTSS.</p> <p>MnCHOICES is currently in testing; revisions have been and will continue to be made in response to what is learned through the development process and the subsequent evaluation as it is implemented.</p> <p>There is a distinction between the assessment of needs, and the services that are available to meet those needs. Service eligibility criteria are based on policies that can be better evaluated using the assessment and outcome information that will be gained through MnCHOICES.</p> <p>MnCHOICES will include those data elements that are currently used for eligibility and resource allocation determinations to prevent unintended changes in service access as it is implemented. Over time, policy decisions can be made about future changes as we learn what additional assessment and outcome data gained from MnCHOICES are better able to identify needed services, and resource levels.</p> <p>Assessors using MnCHOICES will be trained and certified every three years to assure that they are able to effectively conduct the assessment and service planning. Lead agencies are asked to have a team of assessors who bring different experience and expertise in order to work effectively with the diversity of people to be assessed.</p> <p>The MnCHOICES assessment is intended to assess for LTSS eligibility. DHS is not clear on why it would be used in primary/health care home settings</p>

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	<p>except that information may be able to be shared with those settings to inform them of the services that an individual is receiving.</p> <p>DHS appreciates and agrees with the comment that the funding mechanism for assessments for people 65+ must be redesigned and is taking steps to do so. Removing this funding mechanism from the nursing home rates will result in a more streamlined system that is easier for all parties to administer.</p>
<p>9.2.3 Home and Community-Based Services Report Card</p> <ul style="list-style-type: none"> • HCBS is unlike nursing home services in that they are varied and flexible, even within a subsection of services; concern that there is little uniform data available; do not believe that the project, as stated, will actual measure outcomes, but will focus on provider descriptions; the report card will not be useful to consumers. • HCBS report card is an exciting initiative but needs more detail; there are several things listed here that are elsewhere in the proposal; what level of effort will be needed to accomplish this? 	<p>DHS has been developing this concept for several years. The report card visually will be modeled after the Nursing Home Report Card but will contain a different set of measures. As the draft measures have been developing, stakeholder representatives from provider associations and consumer advocacy organizations have and will continue to be engaged in reviewing the conceptual framework and identify potential data sources. We agree that one of the strengths of HCBS services is their variation and flexibility. The potential data sources for development of a report card are also varied.</p> <p>Current data sources may not translate well into quality measures; therefore, new data sources may need to be explored, and collaboration with the other state agencies and stakeholder groups will be critical. Current data sources under consideration include:</p> <ul style="list-style-type: none"> • Consumer feedback and participation input from the MnCHOICES assessment tool; • Waiver and provider contracting and rates changes as a part of ongoing reform efforts; • DHS licensing data sets; • Uniform Consumer Information Guide and Registration Housing With Services registration database maintained at the Department of Health; • Other consumer input and surveys collaboratively designed with stakeholders; • Other data sources that may be collected by lead agencies. <p>More detail will be developed as additional design meetings, data source discussions and conceptual review take place. The level of effort needed to accomplish this objective is manageable.</p>
<p>9.2.4 Strategies for Integration of Long Term Services and Supports</p>	

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<p>with Other Initiatives</p> <p><i>Alzheimer's Health Care Home Demonstration</i></p> <ul style="list-style-type: none"> • One commenter suggested that DHS consider certain parameters, which build on existing work, when developing the Alzheimer's Health Care Home demonstration. • Two commenters were supportive of the demonstration 	<p>DHS is in agreement and plans to consider all parameters in the development of an Alzheimer's Health Care Home Demonstration.</p>
<p>9.2.4 Health Home Demonstration</p> <ul style="list-style-type: none"> • Strongly support the state seeking funding under Health Home Demonstration to include services for people with mental illness and physical or other complex health care needs. • One commenter was supportive of the demonstration. 	<p>DHS welcomes the support of stakeholders as it explores development of one or more health homes under Section 2703 of the ACA</p>
<p>9.2.4 Evidence-Based Health Promotion</p> <ul style="list-style-type: none"> • Supportive, and welcome future opportunities to collaborate 	<p>DHS looks forward to re-engaging with health plans and other partners to further our effort to support health promotion for people with disabilities and older adults.</p>
<p>9.2.5 Planning and Service Development</p> <p><i>Critical access study for HCBS</i></p> <ul style="list-style-type: none"> • Consider both current and future workforce issues, particularly in rural areas. 	<p>DHS is in agreement and will incorporate current and future workforce issues into the scope of the study.</p>
<p>9.2.5 Redirect residential and nursing facility services</p> <ul style="list-style-type: none"> • Must first implement and evaluate the implications of nursing facility level of care changes before increasing service eligibility threshold again; better data is needed to measure the impact; communities must be ready to respond to fill gaps 	<p>DHS fully intends to link any strategy for redirecting more intensive services to individuals with higher needs to other strategies related to community capacity assessment and services development, and will incorporate "critical access" NF and "critical access" HCBS evaluations, as well as ongoing impact analysis of implementing the changes to NF level of care, in the final design of this reform component.</p> <p>In addition, DHS will develop and implement exceptions processes and criteria that may prove to be necessary in order to meet the needs of citizens in all communities statewide.</p>

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<p>9.2.6 Enhancements to 1915(c) Waivers</p> <ul style="list-style-type: none"> Minnesota has a very long way to go in developing adequate quality assurance/improvement for our home and community-based waivers. The state doesn't even have data on emergency use of restraint. We strongly support a robust effort to collect and analyze outcome data as well as incident reports in order to understand trends and improve services. <p>Service Menus</p> <ul style="list-style-type: none"> A "universal worker" needs to have the skills and education needed to work with people with mental illness; in general, provider standards should include the option to specialize in working with people with mental illness Description of "supported employment" should include PIS, not simply Pathways to Employments Consider how to make better use of technology for waiver clients who live in housing with services More clarification and detail needed in discussion of new menu of services for waivers, i.e. home of your own, changes to provider standards, universal worker and technology in lieu of staffing Clarity needed in terminology of technology and assistive technology, e.g. devices and services What does the statement "the state has established a consistent quality management structure across all waivers" refer to? Allow individuals to share services within the same program (like we do in PCA) and across programs to assure sustainability of services. Recommendations for adding a number of current waiver services to other waivers For the budgets for individuals choosing CDCS, allow a higher budget; reduce current discount of 30% to 10% over what an individual would otherwise use in traditional waiver services; many more individuals would choose self-directed services if the discount was reduced System changes over lifetimes w/ simpler system to enhance service access, efficiency – create a daily rate for independent living services (ILS) to allow individuals to move out of foster care, so those facilities can serve individuals requiring that level of care <p>CDCS Changes</p> <ul style="list-style-type: none"> Page 39....Changing from 15 Fiscal Support Entities (FSE) to 2 Fiscal 	<p>DHS has many initiatives to enhance quality assurance. For example, the stakeholder group on revisions to behavioral supports standards will recommend data to be collected and analyzed for trends and areas needing improvement.</p> <p><i>Provider standards</i> for waiver services are in the process of moving towards a single set of (health, safety and rights) standards. Optional provider certifications for mental health, autism and other specialty expertise will be developed to help individuals select the most appropriate provider.</p> <p>The input for service menu changes in the 1115 Waivers will be considered in the development to create a common set of services across waivers.</p> <p>DHS developed a set of consistent performance measures across all HCBS waivers. Data is collected and reviewed regularly to determine when improvement strategies are indicated. DHS is continuing to work on enhancing the performance measures across waivers and all home and community based services.</p> <p>When to allow individuals to share services within a program and across programs is a good topic for stakeholder discussion and recommendations and will be incorporated into the work to design the future service menu.</p> <p>MA Reform is required to be cost neutral to the state, and not spend more state dollars. The DHS as agreed to evaluate options to the budget method for CDCS to improve access without increasing Medicaid costs. Additional proposals that may increase cost would have to be considered by the legislature in a budget proposal.</p> <p>The Consumer Directed Task Force recommended changing from the service of Fiscal Support Entities to administrative entities providing Fiscal</p>

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<p>Management Entities (FME) will reduce individual's choice.</p> <ul style="list-style-type: none"> Allow providers to provide a variety of services to individuals. Providers should be allowed to provide both support coordination, and fiscal support services. This will allow better quality and coordination and reduce the costs of administrative fees. 	<p>Management services across all of Minnesota's self-directed programs. National research also supports this direction to provide the strongest integrity of fiscal management.</p> <p>Stakeholders will be involved in the future discussions of when providers can provide multiple services under self-directed services.</p>
<p>9.2.6 New budget methodology to serve medically complex seniors who are vent dependent</p> <ul style="list-style-type: none"> Look beyond those who are "vent dependent" and focus on clinical needs of individuals who need the higher threshold of nursing and therapy services; calculate the total costs when determining which setting is the lesser cost of comparison purposes; reconsider current policies that pay for only limited licensed nurse time in customized living Supportive of this provision 	<p>DHS appreciates the support of stakeholders in the development of budgets to support medically complex seniors who are vent dependent. DHS will continue to explore strategies to provide resources to support community living for individuals with all levels and types of long term care needs as part of the reform demonstration. This proposal may be expanded as additional populations are identified. DHS will continue to work with providers and other stakeholders to redesign services and services components while ensuring accountability and cost effectiveness.</p>
<p>9.2.6 Threshold for accessing residential services</p> <ul style="list-style-type: none"> Consider how to assist private pay residents who have lived in a housing-with-services setting for a long time prior to waiver eligibility 	<p>The term "residential services" here refers to services provided in settings in which housing and services are integrally combined in congregate settings. Ideally, the wide range of types of housing with services settings will continue to be able to serve individuals with a wide variety of needs.</p> <p>Other strategies, both current and proposed, are intended to better assist consumers in long-term care decision-making. These strategies rely on collaboration with housing with services providers and other partners to ensure consumers receive useful information and assistance to understand:</p> <ul style="list-style-type: none"> Community alternatives and the comparative costs of these alternatives The availability of decision support and community services planning Changes they can expect in their housing and services as a result of spend down to Medical Assistance Long term care eligibility under Medical Assistance, including level of care Consumer responsibilities and rights related to services contracting, leases,

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	<p>discharges, and non-renewal of leases</p> <ul style="list-style-type: none"> • Provider responsibility for discharge planning • Other resources that can assist the individual in making a transition to other housing if their lease is not renewed upon spend down to Medical Assistance
<p>9.2.6 Provider Standards</p> <ul style="list-style-type: none"> • Recognized need for articulating professional standards is a strength of the proposal. • Language in this section indicates a movement towards specific criteria for specific diagnosis which is inconsistent with stated objectives • can provide training and technical assistance in this area • What recommendations are being considered for recommendations on new licensing and quality outcome system for 2013 legislative? • Rule 40 work is briefly mentioned, but no mention of positive behavioral supports; can more info about Rule 40 Advisory Committee be included? 	<p><i>Provider standards</i> for waiver services are in the process of moving towards a single set of (health, safety and rights) standards. Optional provider certifications for mental health, autism and other expertise will be developed to help individuals select the most appropriate provider.</p> <p><i>Licensing and Quality Outcomes:</i> DHS plans to bring additional licensing standards under Chapter 245D to meet the Legislature’s directive to establish a single set of standards for services for people with disabilities. DHS will also bring forward a request for the funding of Chapter 245D licenses. The new licensure will address part of the plan to eliminate county/tribal contracts with HCBS waiver providers as required by Minnesota’s corrective action plan with the federal government. Additional recommendations by the State Quality Council will address more comprehensive quality outcome strategies and measures.</p> <p><i>Rule 40:</i> Information on the Rule 40 Advisory Committee is available on the DHS website (provide link). The work of this committee will establish practice standards for person centered positive approaches, prohibitions on restraint and seclusion, emergency criteria, training, technical assistance, oversight, reporting and monitoring that will be incorporated into the work on provider standards, as well as in a rule for those provisions that are best specified in more detail through the administrative rule process. The committee recommendations are expected to be complete this fall, so that they inform legislative proposals for provider standards, and the administrative hearing process on the new rule will commence this winter.</p>
<p>9.2.7 Rate Methodologies</p> <ul style="list-style-type: none"> • The customized living tool has not resulted in fair and consistent pricing across the state. As DHS develops rate methodology for disability waivers, include adequate testing and evaluation of the methodologies and use this to inform changes to the EW CL tool. 	<p>The Disability Waivers Rate System is currently in a research phase of gathering and analyzing data to evaluate and shape payment rate methodologies for disability waivers. The Customized Living Tool is one of the many ways we are gathering data. DHS is committed to a system that produces equitable and consistent payments, and will include the customized living tool and related values in its research.</p>

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<p>9.2.8 Redesign Case Management</p> <ul style="list-style-type: none"> • A long list of problems and solutions are identified; is there any more information about priorities or data to set priorities? • We agree that it will be an improvement to separate administrative functions from services • Urge DHS to consider important case management function played by nurses and other health care professionals; in customized living services the on-site RN plays the primary day-to-day cm role (i.e. coordinating/communicating med changes, side effects, etc. with physician) and yet there is no reimbursement • We support the consolidation of service coordination but are concerned that not one person can do everything; for example, staff the cm waiver services may not be the right person to provide health care coordination 	<p>The 2010 Legislature required DHS to establish a work group to make recommendations to redesign the case management system. The report submitted in Feb.2011 recommended changes to the case management system. DHS has taken steps to begin implementation with separating the administrative functions of case management from the service of case management. There are several other recommendations that will take time to implement and DHS is reengaging the work group to continue the work of implementing the recommendations.</p> <p>DHS appreciates the work that RNs and other health professionals do to provide case management-like services and will consider that work in the redesign of case management.</p> <p>DHS understands that there are many issues that need to be considered in the redesign of case management one of which the coordination between LTSS case managers and health care coordination.</p>
<p>9.2.9 Crisis Intervention and Protection of Vulnerable Adults</p> <ul style="list-style-type: none"> • How will “expanding crisis services to people with disabilities and seniors living in the community” intersect with current mental health crisis teams? • Articulate the need for Positive Behavioral Support (PBS) for people with a history of challenging behavior to avert the need for crisis services, and the need for providers to receive additional training 	<p>Stakeholders that include counties, providers, family members, advocates and state employees have recommended that community-based crisis services be readily available at the local level. Services must focus on prevention and include coordination of existing services from both mental health and developmental disabilities so as to create both cost effective as well as locally available resources.</p> <p>The use of Positive Behavioral Support (PBS) strategies have been the foundation for supporting persons with developmental disabilities with challenging behaviors for over the last 25 years. State policy incorporates this important philosophy and it is expected to expand to other populations (Brain Injury, Mental Health and Aging).</p>
<p>9.2.9 Statewide, centralized system for Reports of Vulnerable Adult Maltreatment</p> <ul style="list-style-type: none"> • Strongly supports the proposal to create a statewide, centralized system for reports of vulnerable adult maltreatment; have been advocating for this for a number of years. • Build off the work that is already underway with the Vulnerable Adult Justice Project; look at ways to address financial exploitation • This proposal needs county input • Support streamlining the current CEP system 	<p>DHS appreciates the comments in support of the Centralization of the Common Entry Point.</p> <p>DHS has been working collaboratively with the Vulnerable Adult Justice Project (VAJP) on centralization of the Common Entry Point since 2008.</p> <p>In 2009, with support from the VAJP, legislation was passed to grant authority to the Commissioner of Human Services to seek Federal Funds to Establish the Common Entry Point (245A.655). Representatives from Aging and Adult</p>

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<ul style="list-style-type: none"> • Supportive; will reduce variability and enhance effective responses • Supportive of centralized CEP and increased training for professionals 	<p>Services consulted with Counties/MACSSA at this time. DHS Aging and Adult Services staff and the project manager for the centralization of the common entry point understand the necessity to obtain input from MN Counties and Tribes and will continue to seek county input on this this legislative proposal.</p> <p>The centralization of the Common Entry Point will enable the commissioner to track critical steps in the investigation process and maintain data to evaluate manage and plan for preventive measures for not only financial exploitation but also abuse and neglect.</p>
<p>9.2.10 Money Follows the Person</p> <ul style="list-style-type: none"> • Adult Day Services are a key service for people returning home from a nursing home 	<p>People discharged to the community under MFP will have access to the full Medical Assistance benefit set. Depending on individual needs, the elderly waiver and any of the disability waivers may be appropriate means to provide services. Service planning will take into account the needs of the individuals who are transitioning to the community.</p>
<p>9.5 Intensive Residential Treatment Services</p> <ul style="list-style-type: none"> • Support integrating primary and behavioral treatment within this setting and to establish standards for what would be included • Agree that addressing an individual’s medical needs while residing in an IRTS facility has challenges; we support DHS in developing a proposal for improved integration of medical and behavioral health services for medically complex patients 	<p>DHS welcomes the support of stakeholders as it explores development of integrated models of care in these intensive settings for people with complex needs.</p>
<p>9.6 Children Under 21 in Residential “IMD” Facilities</p> <ul style="list-style-type: none"> • We share the concerns expressed in the description of this issue on pages 103 and 104 and urge DHS, in consultation with stakeholders, to develop some solutions to this issue as soon as possible • We seek to understand [the need for this] as children under 21 in an IMD facility are eligible for Medicaid and can be seen on an out-patient basis now for any medical needs that may arise 	<p>The waiver would remove major obstacles to both necessary care, in that a child diagnosed with diabetes or leukemia could not be treated for those conditions until discharged from a psychiatric hospital, and to the kind of integrated care which is rapidly becoming industry standard, in that children receiving psychiatric treatment in an IMD also are not allowed reimbursement for dental care, immunizations, or care for routine childhood illnesses such as ear infections. While all of these services may be reimbursed as outpatient benefits, access is often crippled by the severity of mental health symptoms among children receiving the residential level of care.</p> <p>Additionally, while the IMD exclusion explicitly applies to psychiatric hospitals, it also applies to children’s Psychiatric Residential Treatment Facilities, or PRTFs. This type of non-hospital setting is designed for the treatment of children who continue to need a secure, supervised environment,</p>

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Comments	DHS Response
	<p>but not at a hospital level of intensity or medical staffing. Numerous stakeholder groups have encouraged DHS to pursue the addition of this level of care to the children’s mental health continuum of services, but Minnesota has not been able to develop the PRTF level of care, despite having at least some capable and willing providers, largely because of the children’s exception to the IMD exclusion.</p>
<p>10 Evaluation</p> <ul style="list-style-type: none"> The evaluation design section could be strengthened if there are individual designs for each part of the Section 1115 Waiver Proposal but with an overall design offered; for example, providing an outline of sample numbers, targets and comparisons, and how samples will be drawn would contribute to the collection of data and outcome measures that are more closely matched with the envisioned reforms for each of the initiatives Are there any specific evaluation questions regarding people with developmental disabilities? Increased community integration is mentioned throughout the design and should be a primary indicator in the evaluation What are the data sources for personal level outcomes? <p>Evaluation design focuses on process without addressing how to measure client outcomes</p>	<p>The overall design intended with the evaluation is an impact assessment focusing on program outcomes. For example major program outcomes to be studied include utilization trends, hospitalizations and emergency department visits. The impact assessment will examine changes in major outcomes between a baseline period before the proposed waiver reform efforts and an implementation period after the revised waiver services have been implemented. The evaluation plan refers to a study sample but that term is used as a means for defining all program participants impacted by the program change, including people with developmental disabilities. It was not intended to convey that a representative sample would be drawn for measurement of major program outcomes. Representative samples may be appropriate for additional secondary analysis that may involve additional data collection efforts such as personal experience surveys for example. Secondary analysis activities are still under development.</p> <p>MnCHOICES will be the primary data source for measuring community integration and may be supplemented with other data collection efforts, such as the personal experience survey.</p> <p>The impact assessment will also examine health and functioning status of program participants following the implementation period. Data sources for person level outcomes analysis include Nursing facility, Minimum Data Set (MDS), Return to Community data system standardized assessments, MnCHOICES, encounter data for dual-eligibles and Medicaid claims data.</p>
<p>Waiver Process – Over-arching Comments</p> <ul style="list-style-type: none"> Would like to see fiscal analysis associated with each proposal Please separate reform components that require CMS approval from those that do not Additional opportunities are needed for stakeholder involvement in recommending more specific changes to proposals Include counties extensively and proportionately as proposals are further 	<p>Attachment O includes the fiscal analysis for those items requiring waiver approval under this document.</p> <p>Many of the comments in this section have been addressed elsewhere in this document.</p> <p>Most changes to the Medicaid program require federal authority, but requests</p>

Attachment K: DHS Response to Reform 2020 Public Comments

Comments	DHS Response
<p>developed; role of counties and other entities unclear</p> <ul style="list-style-type: none"> • Two commenters urge DHS to ensure budget neutrality not just with state budget but <i>across the system</i> • We support overall policy direction contained in this proposal • Coverage and eligibility for mental health treatment and supports is hugely important because it is often the only place to turn since private insurance is inadequate • Previous changes to MA have been significantly detrimental to people with mental illness, specifically: <ul style="list-style-type: none"> ○ NFLOC will result in thousands of people with mental illness no longer able to receive CADI services ○ PCA changes meant that many people, esp. children, were no longer eligible or drastically cut hours ○ CADI reduced funding for people with “low needs” and that hurt many people with mental illness whose needs are not well understood/assessed (NAMI) • One commenter supports development of a waiver specifically for children and adults with mental illness • The value/vision, emphasis on functional impairment rather than disability categories, focus on outcomes rather than process, and promotion of person-centered planning are all strengths of the proposal • Reform shouldn’t be limited to people with high costs/complex service systems • Proposal does not go far enough in addressing empowering personal support systems • There is not enough specificity about person-centered planning; many people say they do it but their practices are far from current “best practices.” Is MnCHOICES consistent with best practices? • One commenter lists many ways in which their organization, members and practice model can assist with MA Reform effort • One commenter applauds DHS for undertaking such a broad reform effort • Plan to include consumer input was not always clear • Breakthroughs/innovations were not always clear • Context about market environment, current delivery system/capacity not always included • More detail needed about : service/product description, how to access, usability features, performance specs, cost controls/budget neutrality • Describe test team process; is it the Partners Panel? 	<p>for federal authority can be made in a variety of ways. Some requests are routine and others, like a Section 1115 waiver, require significant negotiation with CMS. DHS has included a chart at Attachment J to communicate what federal authority is being requested under this waiver proposal. We hope that this is sufficient to clarify which reform components require CMS approval at this time.</p> <p>There have been difficult budget decisions by the legislature, which have affected people with disabilities and older adults. We would like to clarify that the analysis of the NF LOC change does not identify the statement that thousands of people with mental illness no longer receive CADI services. There are 501 people currently receiving CADI who will no longer be eligible and the impact on people with a mental illness is less than what you might have expected given the percentage of participation in the program.</p> <p>We appreciate that words like independent and community may mean different things to people. In the context of this proposal, independence reflects the goal to support people in having meaningful lives, with choice and inclusion in their communities. It is acknowledged that we are all interdependent.</p> <p>The new waiver authorities requested in this document are not intended to replace the PMAP+ waiver. This waiver should be viewed as separate from the PMAP+ waiver.</p> <p>DHS is not seeking authority to limit or prohibit using managed care organizations and/or county-based purchasing for Medicaid.</p>

Attachment K: DHS Response to Reform 2020 Public Comments

Comments	DHS Response
<ul style="list-style-type: none"> • External review of design specs and method to certify that service is ready for release is not obvious • More data about projections is needed. There for some things but not all • Business case should be included • Not enough detail about provider standards • One commenter listed terms that need definition: <ul style="list-style-type: none"> ○ Technology and assistive technology (terms seem to be used interchangeably) ○ Person-centered planning/plans; other types of plans are also mentioned—be specific and consistent ○ DD, intellectual disability and mental retardation (page 79) are all used. Pick on consistent term (not MR) ○ No definition of “most integrated setting” ○ Personal care assistants, personal care attendants and personal assistants is terminology with a 50 year history. If we are changing the terms there must be an information campaign to inform people—people will continue to use the term PCA; maybe CFSS is just a term for CMS and won’t be used in MN? Needs clarification ○ Service coordination, case management and variations on those terms are used throughout the document; help the reader know which is what • More information needed about the role of counties in the reform efforts; metro counties are ready to participate with DHS to implement Reform 2020 • Supportive of efforts to integrate care, develop linkages with health care homes, and focus on transitions • Concern about spending additional state and federal dollars. • Without modernizing our current IT infrastructure, including MMIS, the reforms in this proposal will be greatly hindered. • More information is needed about what parts of the system will be simplified, and how this will occur • We support overall direction and values of the proposal • Doesn’t like the word “independence” in title as no one is truly “independent” and suggests “interdependence”. • Have to grapple with the meaning of “community” • Submittal focuses on system change not the benefits to individuals; what do people stand to gain/lose? (Another commenter made a similar 	

Attachment K: DHS Response to Reform 2020 Public Comments

Comments	DHS Response
<p>comment and sent a re-write of the submittal summary in a tone that is about people)</p> <ul style="list-style-type: none"> • DHS staff should plan to fix all issues identified by consumers • Concerned about managed care, specifically about DHS not getting info regarding services and outcomes • Need more specificity about how reform impacts managed care and MCOs; does this replace the existing PMAP+ waiver? Describe how it will change; does DHS’s authority to deliver services thru health plans and county-based entities come from existing PMAP+ waiver? Please provide a summary comparison of how each of these proposals with intersect with PMAP+ waiver. • Is DHS seeking authority with CMS that will limit or prohibit using MCOs and/or county-based purchasing for Medicaid? • We support the theme of enhanced care coordination services • Be clearer on the goals of the waivers—full set of objectives and timelines, and budgets • We have a concern that DHS is compromising some of the success we’ve had by pursuing new initiatives that will impact services that are already successful; specifically, case management reform and implementation of direct provider contracting threatens MSHO • Be clearer on how proposed activities impact fee-for-service, managed care • One commenter believes palliative care services should be included in reform as they are high quality, cost-effective care services • We affirm the integration of primary care and mental health services • Lack of affordable housing could capsize the plan • One commenter believes that its members’ knowledge and experience in managing care delivery can be crucial in developing strategies to reduce costs for long term care services; suggests DHS consult and solicit input from providers re: new models of payment or service delivery to achieve best outcomes 	<p>DHS appreciates the knowledge and experience of all Medicaid providers and stakeholders, including managed care organizations. DHS looks forward to continuing to work with stakeholders to thoughtfully implement proposed reforms.</p>

Attachment K: DHS Response to Reform 2020 Public Comments

Comments	DHS Response
<p data-bbox="176 235 1047 267"><i>Consumer Concern Regarding Medicaid Eligibility</i></p> <ul data-bbox="176 269 1047 459" style="list-style-type: none"><li data-bbox="176 269 1047 459">• Consumer has very high medical, transportation, and living expenses due to chronic illness, but does not qualify for Medicaid or any other public assistance, finding it very difficult to meet needs on current, limited income	<p data-bbox="1050 235 1919 459">DHS responded directly to this consumer.</p>

Attachment M: Comparison of Current PCA Program to Proposed Community First Services and Supports

Will there be a change?	Current PCA	Community First Services and Supports (CFSS)
Eligibility <i>(no changes)</i>	<ul style="list-style-type: none"> Eligible for Medical Assistance (includes people who receive waiver services and who qualify for MA under special income standards)¹ Any age Have an assessed need for assistance with at least one activity of daily living (ADL), or, be physically aggressive towards one's self or other or be destructive of property that requires the immediate intervention of another person ("Level One Behavior" per Minnesota Statute). 	<ul style="list-style-type: none"> Eligible for Medical Assistance, (including people who receive waiver services and qualify for MA under special income standards)² Any age Have an assessed need for assistance with at least one activity of daily living (ADL), or, be physically aggressive towards one's self or other or be destructive of property that requires the immediate intervention of another person ("Level One Behavior" per Minnesota Statute).
Relationship to waivers <i>(no change in access to service; change on an administrative level)</i>	<ul style="list-style-type: none"> State plan service (you don't need to be on a waiver to access) People on waivers can access PCA 	<ul style="list-style-type: none"> State plan service (you don't need to be on a waiver to access) People on waivers can access all the same services as the services offered through CFSS³
Services allowed <i>(more flexibility in how services can be used, more things covered)</i>	<ul style="list-style-type: none"> Assistance with activities of daily living (bathing, dressing, eating, transferring, toileting, mobility, grooming, positioning) or instrumental activities of daily living (e.g. cooking, cleaning, laundry, shopping). 	<ul style="list-style-type: none"> Same services as currently available under PCA, <i>plus</i>, Individuals can access <ul style="list-style-type: none"> Skills acquisition Assistive technology Environmental modifications Transition supports
Needs determination <i>(no change)</i>	<ul style="list-style-type: none"> Needs are assessed and participant is assigned a home care rating NOT based on institutional level of care 	<ul style="list-style-type: none"> Needs are assessed and participant is assigned a home care rating NOT based on institutional level of care
Daily minutes of coverage <i>(minimum level of minutes raised)</i>	Determined by current PCA home care ratings <ul style="list-style-type: none"> Current lowest amount is 30 minutes (two units) for people with an "LT" home care rating 	Determined by current PCA home care ratings with one exception: <ul style="list-style-type: none"> Lowest amount will be 75 minutes (three units) with additional time for identified behaviors and/or complex health-related needs. On average the lowest daily amount is anticipated to be 90 minutes.

¹ Described in special eligibility rules available under 42 CFR §435.217

² Ditto.

³ To simplify administration of the 1915(c) and 1115 waivers CFSS will be accounted for as separate programs. This will not be visible to participants and will be managed on a state level.

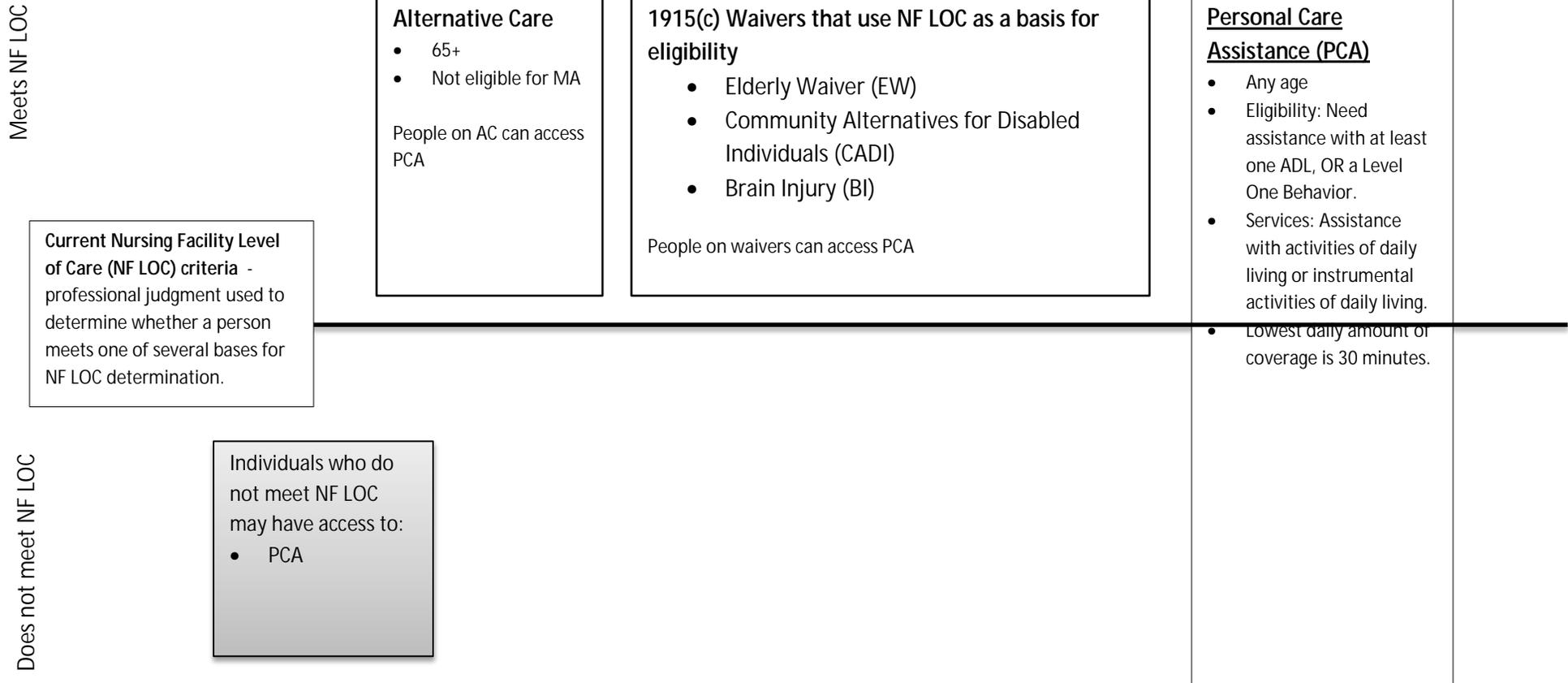
Attachment M: Comparison of Current PCA Program to Proposed Community First Services and Supports

Will there be a change?	Current PCA	Community First Services and Supports (CFSS)
Provider standards <i>(changes)</i>	There are currently licensing and other requirements in place for both PCA agencies and direct service providers. A complete listing is available in the Minnesota HealthCare Program Providers manual.	<ul style="list-style-type: none"> Provider standards will be changing across all home and community-based services with a goal of consistency with other HCBS standards. Details of CFSS provider standards will be determined over the next several months with the soon-to-be formed Development and Implementation Council. Standards for financial management entities will build off what has been used for certification of fiscal support entities that support self-direction in the HCBS waivers and will be further delineated in consultation with the Development and Implementation Council. All staff providing CFSS will be required to meet certain standards, including background checks, certain core training prior to employment and on-going training. There will be additional training and certification available for people who wish to specialize and have more experience working with certain people (e.g. people with mental illness or complex health conditions.)
Self-directed options (service models) <i>(CDCS will remain; PCA Choice, Consumer Support Grants and Family Support Grants will end as models— individuals will continue to be eligible under CFSS delivered through one of the new models)</i>	<p>People who are on waivers have the option of Consumer-Directed Community Services (CDCS). Under CDCS the participant can develop a plan for delivery of all their waiver services, including personal support services, and purchase them through a fiscal support entity which manages employer-related tasks (fiscal management entity model).</p> <p>Other self-direction options for personal support services are:</p> <ul style="list-style-type: none"> PCA Choice – participant works with an agency but can select, train and terminate the person delivering the service Consumer Support Grant – Participant receives and controls a budget Family Support Grant – Families caring for a child with a disability receive and control a budget 	<p>Individuals will have a choice of models. The specific service models will be developed in collaboration with the Development and Implementation Council.</p> <p>Broadly, there will be three options:</p> <ul style="list-style-type: none"> Agency provider model – Participant is actively involved in the selection and dismissal of their direct care worker while the agency is the employer. Financial Management entity model⁴ – Participant has complete control over whom they select and dismiss but the FME provides employer-related services such as processing timesheets and payroll, managing taxes and insurance, paying invoices, tracking budget funds and expenditures and providing reports to the person and the State. Participant/Employer model – Participant takes on all the employer responsibilities. FME are available to them to provide some assistance.

07/27/2012

⁴ In an initiative that is related to the switch from PCA to CFSS, DHS will be changing the fiscal management entity structure in order to make the system more efficient to manage and better organized for quality management. An RFP will be issued and a limited number of FMEs will be selected. Participants in CFSS will have at least two FMEs to choose from.

Current HCBS System: Interaction of Nursing Facility Level of Care, HCBS Waivers, and PCA



Future HCBS System: Interaction of Nursing Facility Level of Care, HCBS Waivers, and CFSS

Meets NF LOC

Proposed Nursing Facility Level of Care (NF LOC) criteria -

- Functional, OR
- Clinical, OR
- Cognitive /behavioral, OR
- Frailty/vulnerability

Alternative Care

- 65+
- Not eligible for MA

People on AC can access the same services that are offered through CFSS.

1915(c) Waivers that use NF LOC as a basis for eligibility

- Elderly Waiver (EW)
- Community Alternatives for Disabled Individuals (CADI)
- Brain Injury (BI)

People on waivers can access the same services that are offered through CFSS.

1115 Demonstration
Community First Services and Supports (CFSS)

Replaces current PCA program. Provides additional flexibility in services; raises minimum service amounts.

- Any age
- Eligibility (no change): assistance with at least one ADL, OR a Level One Behavior.
- Same services as currently available under PCA, **plus**, individuals can access:
 - Skills acquisition
 - Assistive Technology
 - Environmental modifications
 - Transition supports
- Lowest amount will be 75 minutes (three units) with additional time for identified behaviors and/or complex health-related needs. On average the lowest daily amount is anticipated to be 90 minutes.

Does not meet NF LOC

Individuals who do not meet NF LOC may have access to:

- ECS, or
- CFSS

Essential Community Supports (ECS)

MA Ineligible Seniors:

- 65+
- Not eligible for MA
- Have an assessed need for an ECS service

1115 Demonstration

Transition Group:

- Any age
- Have an assessed need for an ECS service
- Losing waiver services as a result of NF LOC implementation

**Minnesota
Medical Assistance
Fiscal Analysis of
Summary of Waiver Items**

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	Waiver Total
Accountable Care Organizations						
Net MA Costs						\$0
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	\$0	\$0	\$0	\$0	\$0	\$0
State share	\$0	\$0	\$0	\$0	\$0	\$0
PCA Redesign / Waiver Request for Limits on K and I Options						
Net MA Costs	-\$39,757,597	-\$169,113,446	-\$184,987,613	-\$201,700,526	-\$219,003,258	-\$237,740,038
Federal share % (calculated) *	55.65%	55.64%	55.62%	55.60%	55.59%	55.59%
Federal share	-\$22,123,772	-\$94,099,436	-\$102,881,607	-\$112,142,330	-\$121,752,390	-\$132,170,970
State share	-\$17,633,825	-\$75,014,011	-\$82,106,006	-\$89,558,195	-\$97,250,868	-\$105,569,068
* Most effects are in Option K projections, with a 56% federal share.						
Anoka IMD Waiver						
Net MA Costs	-\$1,802,233	-\$1,989,665	-\$2,188,010	-\$2,397,802	-\$2,619,598	-\$10,997,309
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	-\$901,117	-\$994,833	-\$1,094,005	-\$1,198,901	-\$1,309,799	-\$5,498,654
State share	-\$901,117	-\$994,833	-\$1,094,005	-\$1,198,901	-\$1,309,799	-\$5,498,654
Expand Access to Transition Services						
Net MA Costs	\$1,135,492	-\$194,970	-\$3,004,294	-\$5,975,470	-\$9,119,722	-\$17,158,964
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	\$567,746	-\$97,485	-\$1,502,147	-\$2,987,735	-\$4,559,861	-\$8,579,482
State share	\$567,746	-\$97,485	-\$1,502,147	-\$2,987,735	-\$4,559,861	-\$8,579,482
Employment Supports						
Net MA Costs	\$163,000	-\$202,231	-\$780,005	-\$943,695	-\$1,033,620	-\$2,796,552
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	\$81,500	-\$101,116	-\$390,003	-\$471,848	-\$516,810	-\$1,398,276
State share	\$81,500	-\$101,116	-\$390,003	-\$471,848	-\$516,810	-\$1,398,276
PATH CTI Pilot						
Net MA Costs	\$73,800	\$354,074	\$406,519	\$336,032	\$261,090	\$1,431,515
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	\$36,900	\$177,037	\$203,259	\$168,016	\$130,545	\$715,757
State share	\$36,900	\$177,037	\$203,259	\$168,016	\$130,545	\$715,757
Housing Stabilization						
Net MA Costs	\$1,230,000	\$10,503,199	\$9,629,676	\$7,586,207	\$7,116,105	\$36,065,188
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	\$615,000	\$5,251,600	\$4,814,838	\$3,793,104	\$3,558,053	\$18,032,594
State share	\$615,000	\$5,251,600	\$4,814,838	\$3,793,104	\$3,558,053	\$18,032,594
Asset Test for Adults						
Net MA Costs	-\$4,151,373	-\$6,027,472	-\$6,453,609	-\$6,741,012	-\$7,012,675	-\$30,386,141
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	-\$2,075,686	-\$3,013,736	-\$3,226,805	-\$3,370,506	-\$3,506,337	-\$15,193,070
State share	-\$2,075,686	-\$3,013,736	-\$3,226,805	-\$3,370,506	-\$3,506,337	-\$15,193,070

Residence Requirement for MinnesotaCare Adults

Net MA Costs	-\$1,018,446	-\$126,445	\$0	\$0	\$0	-\$1,144,891
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share	-\$509,223	-\$63,222	\$0	\$0	\$0	-\$572,445
State share	-\$509,223	-\$63,222	\$0	\$0	\$0	-\$572,445

MA Total Fiscal Effects

Net MA Costs	-\$44,127,358	-\$166,796,956	-\$187,377,337	-\$209,836,265	-\$231,411,678	-\$262,727,192
Federal share	-\$24,308,652	-\$92,941,190	-\$104,076,469	-\$116,210,200	-\$127,956,600	-\$144,664,547
State share	-\$19,818,705	-\$73,855,765	-\$83,300,868	-\$93,626,065	-\$103,455,078	-\$118,062,645

**Proposal: Replace PCA State Plan Option with "K" & "I" Options
Without Waiver
Without Limitations for Which Waiver Approval is Requested**

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
1 Current FFS PCA Forecast with 7/1/12 After Session						
Recipients	19,873	20,954	22,128	23,367	24,676	26,057
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$475,282,668	\$514,714,056	\$559,749,888	\$609,037,488	\$662,402,544	\$720,423,936
% Waiver PCA FFS StatePlan Recipients						
State Plan Recipients	4,591	4,840	5,112	5,398	5,700	6,019
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$109,790,296	\$118,898,947	\$129,302,224	\$140,687,660	\$153,014,988	\$166,417,929
% State Plan Only FFS Recipients						
State Plan Recipients	15,282	16,114	17,016	17,969	18,976	20,038
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$365,492,372	\$395,815,109	\$430,447,664	\$468,349,828	\$509,387,556	\$554,006,007
Phase-out	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$91,373,093	\$395,815,109	\$430,447,664	\$468,349,828	\$509,387,556	\$554,006,007
2 PCA Forecast-Managed Care						
Recipients(Estimate)	6,867	6,255	6,834	7,215	7,619	8,046
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$164,232,350	\$153,659,632	\$172,882,375	\$188,040,702	\$204,528,111	\$222,461,136
% State Plan PCA/Waiver Recipients-Managed Care						
State Plan Recipients	4,189	3,816	4,169	4,401	4,648	4,908
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$100,181,734	\$93,732,376	\$105,458,249	\$114,704,828	\$124,762,148	\$135,701,293
% State Plan PCA ONLY Recipients-Managed Care						
State Plan Recipients	2,678	2,440	2,665	2,814	2,971	3,138
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$64,050,617	\$59,927,256	\$67,424,126	\$73,335,874	\$79,765,963	\$86,759,843
Phase-out	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$16,012,654	\$59,927,256	\$67,424,126	\$73,335,874	\$79,765,963	\$86,759,843
Destination Programs						
3 Added Recipients of K-option due to Expanded Eligibility						
Children under 21 Eligible for K but not TEFRA/Spouses	907	907	907	907	907	907
Disabled Adults	255	255	255	255	255	255
Elders at 300% SSI	290	290	290	290	290	290
Increase Caseload Total	1,452	1,452	1,452	1,452	1,452	1,452
Avg. Mo. Cost Per Recipient (Base PCA +30% with no budget limits)	\$2,591	\$2,661	\$2,740	\$2,824	\$2,908	\$2,995
Total LTC Costs	\$45,136,731	\$46,356,172	\$47,732,398	\$49,195,727	\$50,659,056	\$52,174,646
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$11,284,183	\$46,356,172	\$47,732,398	\$49,195,727	\$50,659,056	\$52,174,646

**Proposal: Replace PCA State Plan Option with "K" & "I" Options
Without Waiver
Without Limitations for Which Waiver Approval is Requested**

	SFY 2014 SFY 2014	SFY 2015 SFY 2015	SFY 2016 SFY 2016	SFY 2017 SFY 2017	SFY 2018 SFY 2018	SFY 2019 SFY 2019
4 Basic Care Costs for additional recipients						
Children under 21 Eligible for K but not TEFRA/Spouses	\$ 376.78	\$ 384.87	\$ 466.92	\$ 444.36	\$ 444.36	\$ 444.36
Disabled Adults	\$ 912.07	\$ 960.51	\$ 1,198.98	\$ 1,163.92	\$ 1,163.92	\$ 1,163.92
Elders at 300% SSI	\$ 771.67	\$ 825.54	\$ 1,041.76	\$ 1,011.29	\$ 1,011.29	\$ 1,011.29
Total Basic Care Costs	\$9,574,780	\$9,998,594	\$12,373,225	\$11,914,415	\$11,914,415	\$11,914,415
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$2,393,695	\$9,998,594	\$12,373,225	\$11,914,415	\$11,914,415	\$11,914,415
5 % of Waiver FFS PCA Recipients to "I Option"	2.95%	2.95%	2.95%	2.95%	2.95%	2.95%
Average Monthly CADI Recipients Not Meeting NF LOC	538	555	623	694	724	755
Percent of CADI Recipients Accessing "I Option"	33%	33%	33%	33%	33%	33%
Percent Additional of CADI Recipients Accessing "I Option"	24%	24%	24%	24%	24%	24%
Number of CADI Recipients Accessing "I Option"	296	305	344	385	402	420
Adjustment to Average Monthly CADI Cost	71%	71%	71%	71%	71%	100%
Substitution of other waiver services	0%	0%	0%	0%	0%	0%
Avg. Mo. Cost Per Recipient	\$2,029	\$2,163	\$2,271	\$2,384	\$2,503	\$3,713
Total Costs	\$7,198,790	\$7,927,109	\$9,381,835	\$11,009,375	\$12,071,025	\$18,693,020
Already in State Plan PCA Forecast	(\$4,322,782)	(\$4,754,640)	(\$5,605,113)	(\$6,556,049)	(\$7,179,798)	(\$11,105,998)
Net Cost	\$2,876,007	\$3,172,469	\$3,776,722	\$4,453,326	\$4,891,226	\$7,587,022
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$719,002	\$3,172,469	\$3,776,722	\$4,453,326	\$4,891,226	\$7,587,022
6 % of State Plan PCA FFS Recipients to "K Option" (Non-waiver)	91%	91%	91%	91%	91%	91%
Recipients	13,907	14,663	15,485	16,352	17,268	18,234
Adjustment to Avg. Monthly Cost	106%	106%	106%	106%	106%	106%
Avg. Mo. Cost Per Recipient (Adj. base +30% with no budget limits)	\$2,745	\$2,819	\$2,903	\$2,992	\$3,081	\$3,173
Total Costs	\$458,094,165	\$496,033,484	\$539,433,827	\$587,101,954	\$638,433,163	\$694,294,082
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$114,523,541	\$496,033,484	\$539,433,827	\$587,101,954	\$638,433,163	\$694,294,082
7 % of State Plan PCA FFS Recipients to "I Option" (Non-waiver)	9%	9%	9%	9%	9%	9%
Recipients	1,375.41	1,450.23	1,531.48	1,617.23	1,707.83	1,803.40
Adjustment to Avg. Monthly Cost	0.40	0.40	0.40	0.40	0.40	0.40
Avg. Mo. Cost Per Recipient	\$797	\$819	\$843	\$869	\$895	\$922
Total Costs	\$13,157,725	\$14,249,344	\$15,496,116	\$16,860,594	\$18,337,952	\$19,944,216
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$3,289,431	\$14,249,344	\$15,496,116	\$16,860,594	\$18,337,952	\$19,944,216
8 % of State Plan CSG Recipients to "K" Option	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%
Average Monthly Recipients	1,872	2,021	2,183	2,357	2,546	2,750
Adjustment to Avg. Monthly Cost	0.934	0.934	0.934	0.934	0.934	0.934
Avg. Mo. Cost Per Recipient (Adj. base +30% with no budget limits)	\$ 2,420	\$ 2,485	\$ 2,559	\$ 2,638	\$ 2,716	\$ 2,797
Total Costs	\$ 54,348,225	\$ 60,281,852	\$ 67,032,385	\$ 74,605,654	\$ 82,988,765	\$ 92,315,918
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$ 13,587,056	\$ 60,281,852	\$ 67,032,385	\$ 74,605,654	\$ 82,988,765	\$ 92,315,918
9 % of State Plan CSG Recipients to "I" Option	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Average Monthly Recipients	29	31	33	36	39	42
Adjustment to Avg. Monthly Cost	1.20	1.20	1.20	1.20	1.20	1.20
Avg. Mo. Cost Per Recipient	\$ 2,179	\$ 2,302	\$ 2,371	\$ 2,443	\$ 2,515	\$ 2,592
Total Costs	\$ 745,286	\$ 850,119	\$ 945,824	\$ 1,052,384	\$ 1,170,323	\$ 1,302,636
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 186,322	\$ 850,119	\$ 945,824	\$ 1,052,384	\$ 1,170,323	\$ 1,302,636

**Proposal: Replace PCA State Plan Option with "K" & "I" Options
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	SFY 2014 SFY 2014	SFY 2015 SFY 2015	SFY 2016 SFY 2016	SFY 2017 SFY 2017	SFY 2018 SFY 2018	SFY 2019 SFY 2019
10 % of Waiver MC Recipients to "I Option" Due to NFLOC	13.3%	13.3%	13.3%	13.3%	13.3%	13.3%
Average Monthly EW Recipients not meeting LOC	3,123	2,913	3,030	3,151	3,277	3,408
Percent of EW Recipients Accessing "I Option"	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%
Percent of Additional EW Recipients Accessing "I Option"	28.0%	28.0%	28.0%	28.0%	28.0%	28.0%
Number of EW Recipients Accessing "I Option"	1,854	1,729	1,798	1,870	1,945	2,023
Adjustment to EW Avg. Monthly Cost	60%	60%	60%	60%	60%	60%
Substitution of other waiver services	0%	0%	0%	0%	0%	0%
Avg. Mo. Cost Per Recipient	\$744	\$825	\$850	\$876	\$902	\$929
Total Costs	\$16,556,232	\$17,127,110	\$18,346,560	\$19,652,835	\$21,052,117	\$22,551,028
Already in Forecast	-\$8,745,373	-\$9,046,923	-\$9,691,064	-\$10,381,068	-\$11,120,200	-\$11,911,958
Net Cost	\$7,810,859	\$8,080,187	\$8,655,496	\$9,271,767	\$9,931,917	\$10,639,070
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 1,952,715	\$ 8,080,187	\$ 8,655,496	\$ 9,271,767	\$ 9,931,917	\$ 10,639,070
11 % of State Plan MC Recipients to "K Option" Nonwaiver	89%	89%	89%	89%	89%	89%
Average Monthly Recipients	2,384	2,171	2,372	2,504	2,645	2,793
Adjustment to Avg. Monthly Cost	1.05	1.05	1.05	1.05	1.05	1.05
Avg. Mo. Cost Per Recipient (Adj. base +30% with no budget limits)	\$2,732	\$2,806	\$2,889	\$2,978	\$3,066	\$3,158
Total Costs	\$ 78,148,387	\$ 73,111,891	\$ 82,249,236	\$ 89,486,585	\$ 97,315,636	\$ 105,844,842
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$ 19,537,097	\$ 73,111,891	\$ 82,249,236	\$ 89,486,585	\$ 97,315,636	\$ 105,844,842
12 % of State Plan MC Recipients to "I Option" Nonwaiver	11%	11%	11%	11%	11%	11%
Average Monthly Recipients	295	268	293	310	327	345
Adjustment to Avg. Monthly Cost	0.56	0.56	0.56	0.56	0.56	0.56
Avg. Mo. Cost Per Recipient	\$1,115	\$1,145	\$1,179	\$1,215	\$1,252	\$1,289
Total Costs	\$3,941,995	\$3,688,223	\$4,149,618	\$4,513,456	\$4,909,196	\$5,339,635
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 985,499	\$ 3,688,223	\$ 4,149,618	\$ 4,513,456	\$ 4,909,196	\$ 5,339,635
13 Care Coordination/Other for Complex Needs						
% of State Plan PCA and CSG Recipients meeting LOC	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%
Average Monthly Recipients	2,325	2,414	2,565	2,715	2,875	3,044
% of Recipients Involved in Demonstation	30%	35%	40%	45%	50%	50%
Estimated Recipients in Demonstation	697	845	1,026	1,222	1,437	1,522
Avg. Mo. Cost Per Recipient	\$175	\$175	\$175	\$175	\$175	\$175
Total Costs	\$1,464,582	\$1,773,963	\$2,154,693	\$2,565,958	\$3,018,469	\$3,195,680
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 366,146	\$ 1,773,963	\$ 2,154,693	\$ 2,565,958	\$ 3,018,469	\$ 3,195,680

**Proposal: Replace PCA State Plan Option with "K" & "I" Options
Without Waiver
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	SFY 2014 SFY 2014	SFY 2015 SFY 2015	SFY 2016 SFY 2016	SFY 2017 SFY 2017	SFY 2018 SFY 2018	SFY 2019 SFY 2019
14 Buying Up Benefit for LT Group (current ltd. PCA benefit) by four units per day or 30 to 90 minutes per day plus 30% without waiver K Option increase						
% Of State PCA Recipients with LT Rating	7.40%	7.40%	7.40%	7.40%	7.40%	7.40%
% of LT Recipients Affected	100%	100%	100%	100%	100%	100%
Total LT Recipients Affected	1,131	1,192	1,259	1,330	1,404	1,483
Increase to Average Monthly Costs	\$686	\$686	\$686	\$686	\$686	\$686
Total Costs	\$9,302,725	\$9,808,751	\$10,358,311	\$10,938,297	\$11,551,052	\$12,197,510
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$2,325,681	\$9,808,751	\$10,358,311	\$10,938,297	\$11,551,052	\$12,197,510

15 Waiver NFLOC-Transition Group to I Option (Without waiver there is no medical necessity threshold, and this group continues to grow and has a higher benefit.)						
MA EW Recipients	1,270	1,184	1,232	1,281	1,332	1,385
CADI Recipients	231	239	268	299	311	325
Total Recipients	1,501	1,423	1,500	1,579	1,644	1,710
#REF!	\$900	\$900	\$900	\$900	\$900	\$900
Total Costs	\$16,209,492	\$15,368,110	\$16,195,485	\$17,057,890	\$17,750,066	\$18,469,874
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$4,052,373	\$15,368,110	\$16,195,485	\$17,057,890	\$17,750,066	\$18,469,874

Without Waiver Projections

Total Change with 50% Federal Share	\$121,330,929	\$512,923,374	\$561,618,969	\$609,375,492	\$661,077,084	\$719,158,397
Federal share	\$60,665,465	\$256,461,687	\$280,809,484	\$304,687,746	\$330,538,542	\$359,579,199
State share	\$60,665,465	\$256,461,687	\$280,809,484	\$304,687,746	\$330,538,542	\$359,579,199
Total Change with 56% Federal Share	\$161,257,558	\$685,592,149	\$746,806,156	\$811,328,217	\$880,947,671	\$956,826,998
Federal share	\$90,304,233	\$383,931,603	\$418,211,448	\$454,343,802	\$493,330,696	\$535,823,119
State share	\$70,953,326	\$301,660,546	\$328,594,709	\$356,984,416	\$387,616,975	\$421,003,879
Grand Total Change	\$282,588,487	\$1,198,515,523	\$1,308,425,125	\$1,420,703,709	\$1,542,024,755	\$1,675,985,395
Federal share	\$150,969,697	\$640,393,291	\$699,020,932	\$759,031,548	\$823,869,238	\$895,402,318
State share	\$131,618,790	\$558,122,233	\$609,404,193	\$661,672,162	\$718,155,517	\$780,583,078

**Proposal: Replace PCA State Plan Option with "K" & "I" Options
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	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
1 Current FFS PCA Forecast with 7/1/12 After Session						
Recipients	19,873	20,954	22,128	23,367	24,676	26,057
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$475,282,668	\$514,714,056	\$559,749,888	\$609,037,488	\$662,402,544	\$720,423,936
% Waiver PCA FFS StatePlan Recipients	23.1%	23.1%	23.1%	23.1%	23.1%	23.1%
State Plan Recipients	4,591	4,840	5,112	5,398	5,700	6,019
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$109,790,296	\$118,898,947	\$129,302,224	\$140,687,660	\$153,014,988	\$166,417,929
% State Plan Only FFS Recipients	76.9%	76.9%	76.9%	76.9%	76.9%	76.9%
State Plan Recipients	15,282	16,114	17,016	17,969	18,976	20,038
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$365,492,372	\$395,815,109	\$430,447,664	\$468,349,828	\$509,387,556	\$554,006,007
Phase-out	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$91,373,093	\$395,815,109	\$430,447,664	\$468,349,828	\$509,387,556	\$554,006,007
2 PCA Forecast-Managed Care						
Recipients(Estimate)	6,867	6,255	6,834	7,215	7,619	8,046
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$164,232,350	\$153,659,632	\$172,882,375	\$188,040,702	\$204,528,111	\$222,461,136
% State Plan PCA/ Waiver Recipients-Managed Care	61%	61%	61%	61%	61%	61%
State Plan Recipients	4,189	3,816	4,169	4,401	4,648	4,908
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$100,181,734	\$93,732,376	\$105,458,249	\$114,704,828	\$124,762,148	\$135,701,293
% State Plan PCA ONLY Recipients-Managed Care	39%	39%	39%	39%	39%	39%
State Plan Recipients	2,678	2,440	2,665	2,814	2,971	3,138
Avg. Mo. Cost Per Recipient	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total Costs	\$64,050,617	\$59,927,256	\$67,424,126	\$73,335,874	\$79,765,963	\$86,759,843
Phase-out	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$16,012,654	\$59,927,256	\$67,424,126	\$73,335,874	\$79,765,963	\$86,759,843
Destination Programs						
3 Added Recipients of K-option due to Expanded Eligibility						
Children under 21 Eligible for K but not TEFRA/Spouses	907	907	907	907	907	907
Disabled Adults	255	255	255	255	255	255
Elders at 300% SSI	290	290	290	290	290	290
Increase Caseload Total	1,452	1,452	1,452	1,452	1,452	1,452
Avg. Mo. Cost Per Recipient (with budget limits, base PCA cost)	\$1,993	\$2,047	\$2,108	\$2,172	\$2,237	\$2,304
Total LTC Costs	\$34,719,222	\$35,659,934	\$36,722,589	\$37,837,506	\$38,969,844	\$40,137,023
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$8,679,806	\$35,659,934	\$36,722,589	\$37,837,506	\$38,969,844	\$40,137,023

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	SFY 2014 SFY 2014	SFY 2015 SFY 2015	SFY 2016 SFY 2016	SFY 2017 SFY 2017	SFY 2018 SFY 2018	SFY 2019 SFY 2019
4 Basic Care Costs for additional recipients						
Children under 21 Eligible for K but not TEFRA/Spouses	\$ 376.78	\$ 384.87	\$ 466.92	\$ 444.36	\$ 444.36	\$ 444.36
Disabled Adults	\$ 912.07	\$ 960.51	\$ 1,198.98	\$ 1,163.92	\$ 1,163.92	\$ 1,163.92
Elders at 300% SSI	\$ 771.67	\$ 825.54	\$ 1,041.76	\$ 1,011.29	\$ 1,011.29	\$ 1,011.29
Total Basic Care Costs	\$9,574,780	\$9,998,594	\$12,373,225	\$11,914,415	\$11,914,415	\$11,914,415
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$2,393,695	\$9,998,594	\$12,373,225	\$11,914,415	\$11,914,415	\$11,914,415
5 % of Waiver FFS PCA Recipients to "I Option"	2.95%	2.95%	2.95%	2.95%	2.95%	2.95%
Average Monthly CADI Recipients Not Meeting NF LOC	538	555	623	694	724	755
Percent of CADI Recipients Accessing "I Option"	33%	33%	33%	33%	33%	33%
Percent Additional of CADI Recipients Accessing "I Option"	24%	24%	24%	24%	24%	24%
Number of CADI Recipients Accessing "I Option"	296	305	344	385	402	420
Adjustment to Average Monthly CADI Cost	71%	71%	71%	71%	71%	100%
Substitution of other waiver services	0%	0%	0%	0%	0%	0%
Avg. Mo. Cost Per Recipient	\$2,029	\$2,163	\$2,271	\$2,384	\$2,503	\$3,713
Total Costs	\$7,198,790	\$7,927,109	\$9,381,835	\$11,009,375	\$12,071,025	\$18,693,020
Already in State Plan PCA Forecast	(\$4,322,782)	(\$4,754,640)	(\$5,605,113)	(\$6,556,049)	(\$7,179,798)	(\$11,105,998)
Net Cost	\$2,876,007	\$3,172,469	\$3,776,722	\$4,453,326	\$4,891,226	\$7,587,022
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$719,002	\$3,172,469	\$3,776,722	\$4,453,326	\$4,891,226	\$7,587,022
6 % of State Plan PCA FFS Recipients to "K Option" (Non-waiver)	91%	91%	91%	91%	91%	91%
Recipients	13,907	14,663	15,485	16,352	17,268	18,234
Adjustment to Avg. Monthly Cost	106%	106%	106%	106%	106%	106%
Avg. Mo. Cost Per Recipient (Adj. PCA base, with budget limits)	\$2,111	\$2,168	\$2,233	\$2,301	\$2,370	\$2,441
Total Costs	\$352,290,266	\$381,483,006	\$414,934,804	\$451,511,229	\$491,102,433	\$534,122,866
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$88,072,567	\$381,483,006	\$414,934,804	\$451,511,229	\$491,102,433	\$534,122,866
7 % of State Plan PCA FFS Recipients to "I Option" (Non-waiver)	9%	9%	9%	9%	9%	9%
Recipients	1,375.41	1,450.23	1,531.48	1,617.23	1,707.83	1,803.40
Adjustment to Avg. Monthly Cost	0.40	0.40	0.40	0.40	0.40	0.40
Avg. Mo. Cost Per Recipient	\$797	\$819	\$843	\$869	\$895	\$922
Total Costs	\$13,157,725	\$14,249,344	\$15,496,116	\$16,860,594	\$18,337,952	\$19,944,216
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$3,289,431	\$14,249,344	\$15,496,116	\$16,860,594	\$18,337,952	\$19,944,216
8 % of State Plan CSG Recipients to "K" Option	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%
Average Monthly Recipients	1,872	2,021	2,183	2,357	2,546	2,750
Adjustment to Avg. Monthly Cost	0.934	0.934	0.934	0.934	0.934	0.934
Avg. Mo. Cost Per Recipient (Adj. PCA base, with budget limits)	\$ 1,861	\$ 1,912	\$ 1,969	\$ 2,029	\$ 2,089	\$ 2,152
Total Costs	\$ 41,804,714	\$ 46,372,398	\$ 51,570,901	\$ 57,380,836	\$ 63,839,707	\$ 71,016,987
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$ 10,451,178	\$ 46,372,398	\$ 51,570,901	\$ 57,380,836	\$ 63,839,707	\$ 71,016,987
9 % of State Plan CSG Recipients to "I" Option	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Average Monthly Recipients	29	31	33	36	39	42
Adjustment to Avg. Monthly Cost	1.20	1.20	1.20	1.20	1.20	1.20
Avg. Mo. Cost Per Recipient	\$ 2,179	\$ 2,302	\$ 2,371	\$ 2,443	\$ 2,515	\$ 2,592
Total Costs	\$ 745,286	\$ 850,119	\$ 945,824	\$ 1,052,384	\$ 1,170,323	\$ 1,302,636
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 186,322	\$ 850,119	\$ 945,824	\$ 1,052,384	\$ 1,170,323	\$ 1,302,636

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10 % of Waiver MC Recipients to "I Option" Due to NFLOC	13.3%	13.3%	13.3%	13.3%	13.3%	13.3%
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Percent of EW Recipients Accessing "I Option"	31.4%	31.4%	31.4%	31.4%	31.4%	31.4%
Percent of Additional EW Recipients Accessing "I Option"	28.0%	28.0%	28.0%	28.0%	28.0%	28.0%
Number of EW Recipients Accessing "I Option"	1,854	1,729	1,798	1,870	1,945	2,023
Adjustment to EW Avg. Monthly Cost	60%	60%	60%	60%	60%	60%
Substitution of other waiver services	0%	0%	0%	0%	0%	0%
Avg. Mo. Cost Per Recipient	\$744	\$825	\$850	\$876	\$902	\$929
Total Costs	\$16,556,232	\$17,127,110	\$18,346,560	\$19,652,835	\$21,052,117	\$22,551,028
Already in Forecast	-\$8,745,373	-\$9,046,923	-\$9,691,064	-\$10,381,068	-\$11,120,200	-\$11,911,958
Net Cost	\$7,810,859	\$8,080,187	\$8,655,496	\$9,271,767	\$9,931,917	\$10,639,070
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 1,952,715	\$ 8,080,187	\$ 8,655,496	\$ 9,271,767	\$ 9,931,917	\$ 10,639,070
11 % of State Plan MC Recipients to "K Option" Nonwaiver	89%	89%	89%	89%	89%	89%
Average Monthly Recipients	2,384	2,171	2,372	2,504	2,645	2,793
Adjustment to Avg. Monthly Cost	1.05	1.05	1.05	1.05	1.05	1.05
Avg. Mo. Cost Per Recipient (Adj. PCA base, with budget limits)	\$2,102	\$2,159	\$2,223	\$2,290	\$2,359	\$2,430
Total Costs	\$ 60,111,824	\$ 56,242,030	\$ 63,277,880	\$ 68,826,084	\$ 74,860,755	\$ 81,424,546
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$ 15,027,956	\$ 56,242,030	\$ 63,277,880	\$ 68,826,084	\$ 74,860,755	\$ 81,424,546
12 % of State Plan MC Recipients to "I Option" Nonwaiver	11%	11%	11%	11%	11%	11%
Average Monthly Recipients	295	268	293	310	327	345
Adjustment to Avg. Monthly Cost	0.56	0.56	0.56	0.56	0.56	0.56
Avg. Mo. Cost Per Recipient	\$1,115	\$1,145	\$1,179	\$1,215	\$1,252	\$1,289
Total Costs	\$3,941,995	\$3,688,223	\$4,149,618	\$4,513,456	\$4,909,196	\$5,339,635
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 985,499	\$ 3,688,223	\$ 4,149,618	\$ 4,513,456	\$ 4,909,196	\$ 5,339,635
13 Care Coordination/Other for Complex Needs						
% of State Plan PCA and CSG Recipients meeting LOC	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%
Average Monthly Recipients	2,325	2,414	2,565	2,715	2,875	3,044
% of Recipients Involved in Demonstration	30%	35%	40%	45%	50%	50%
Estimated Recipients in Demonstration	697	845	1,026	1,222	1,437	1,522
Avg. Mo. Cost Per Recipient	\$175	\$175	\$175	\$175	\$175	\$175
Total Costs	\$1,464,582	\$1,773,963	\$2,154,693	\$2,565,958	\$3,018,469	\$3,195,680
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$ 366,146	\$ 1,773,963	\$ 2,154,693	\$ 2,565,958	\$ 3,018,469	\$ 3,195,680

**Proposal: Replace PCA State Plan Option with "K" & "I" Options
With Waiver
With Limitations for Which Waiver Approval is Requested**

	SFY 2014 SFY 2014	SFY 2015 SFY 2015	SFY 2016 SFY 2016	SFY 2017 SFY 2017	SFY 2018 SFY 2018	SFY 2019 SFY 2019
14 Buying Up Benefit for LT Group (current Ltd. PCA benefit) to by four units per day or 30 to 90 minutes per day in K Option						
% Of State PCA Recipients with LT Rating	7.40%	7.40%	7.40%	7.40%	7.40%	7.40%
% of LT Recipients Affected	100%	100%	100%	100%	100%	100%
Total LT Recipients Affected	1,131	1,192	1,259	1,330	1,404	1,483
Increase to Average Monthly Costs	\$475	\$475	\$475	\$475	\$475	\$475
Total Costs	\$6,439,304	\$6,789,573	\$7,169,976	\$7,571,440	\$7,995,586	\$8,443,061
Phase-in	25%	100%	100%	100%	100%	100%
Change with 56% federal share	\$1,609,826	\$6,789,573	\$7,169,976	\$7,571,440	\$7,995,586	\$8,443,061
15 Waiver NFLOC-Transition Group (With waiver this is a grandfathered group that does not meet a medical necessity threshold, with a limited benefit and with attrition.)						
MA EW Recipients with Attrition @ 20%/Year	1,270	947	758	606	485	388
CADI Recipients with Attrition @ 10%/Year	231	215	193	174	157	141
Total Recipients	1,501	1,162	951	780	642	529
Total Costs	0	\$380	\$380	\$380	\$380	\$380
Phase-in	25%	100%	100%	100%	100%	100%
Change with 50% federal share	\$1,711,002	\$5,299,874	\$4,337,880	\$3,558,486	\$2,926,153	\$2,412,351

With Waiver Projections

Total Change with 50% Federal Share	\$118,989,558	\$502,855,137	\$549,761,363	\$595,876,088	\$646,253,171	\$703,100,874
Federal share	\$59,494,779	\$251,427,569	\$274,880,682	\$297,938,044	\$323,126,585	\$351,550,437
State share	\$59,494,779	\$251,427,569	\$274,880,682	\$297,938,044	\$323,126,585	\$351,550,437
Total Change with 56% Federal Share	\$123,841,333	\$526,546,940	\$573,676,149	\$623,127,096	\$676,768,325	\$735,144,484
Federal share	\$69,351,146	\$294,866,286	\$321,258,643	\$348,951,173	\$378,990,262	\$411,680,911
State share	\$54,490,186	\$231,680,653	\$252,417,505	\$274,175,922	\$297,778,063	\$323,463,573
Grand Total Change	\$242,830,890	\$1,029,402,077	\$1,123,437,512	\$1,219,003,184	\$1,323,021,496	\$1,438,245,357
Federal share	\$128,845,925	\$546,293,855	\$596,139,325	\$646,889,218	\$702,116,848	\$763,231,348
State share	\$113,984,965	\$483,108,222	\$527,298,187	\$572,113,966	\$620,904,649	\$675,014,010

Without Waiver Projections

Grand Total Change	\$282,588,487	\$1,198,515,523	\$1,308,425,125	\$1,420,703,709	\$1,542,024,755	\$1,675,985,395
Federal share	\$150,969,697	\$640,393,291	\$699,020,932	\$759,031,548	\$823,869,238	\$895,402,318
State share	\$131,618,790	\$558,122,233	\$609,404,193	\$661,672,162	\$718,155,517	\$780,583,078

Difference with Waiver

Grand Total Change	-\$39,757,597	-\$169,113,446	-\$184,987,613	-\$201,700,526	-\$219,003,258	-\$237,740,038
Federal share	-\$22,123,772	-\$94,099,436	-\$102,881,607	-\$112,142,330	-\$121,752,390	-\$132,170,970
State share	-\$17,633,825	-\$75,014,011	-\$82,106,006	-\$89,558,195	-\$97,250,868	-\$105,569,068

Minnesota
MEDICAL ASSISTANCE
 Fiscal Analysis of the
Nursing Facility Return to Community Intervention
Counseling & Assessments

	FY 2014	FY 2015	FY 2016
Cost of assessment and counseling services	\$3,132,001	\$4,346,000	\$4,345,730
Federal share %	50.00%	50.00%	50.00%
Federal share	\$1,566,001	\$2,173,000	\$2,172,865
State share	\$1,566,001	\$2,173,000	\$2,172,865
Projected impact on NF recipients of expanded assessment and counseling: Avg. Monthly Recip.	-60	-140	-220
Average monthly cost	\$3,912	\$3,960	\$4,079
Total MA Cost	(2,816,640)	(6,652,800)	(10,768,560)
Federal share %	50.00%	50.00%	50.00%
Federal share	(1,408,320)	(3,326,400)	(5,384,280)
State share	(1,408,320)	(3,326,400)	(5,384,280)
Proportion served by Eld. Waiver	80.00%		
Average MA EW recipients	48	112	176
Average monthly cost	\$1,245	\$1,380	\$1,422
Total MA Cost	716,959	1,855,262	3,003,264
Federal share %	50.00%	50.00%	50.00%
Federal share	358,479	927,631	1,501,632
State share	358,479	927,631	1,501,632
Proportion served by CADI Waiver	5.00%		
Average MA EW recipients	3	7	11
Average monthly cost	\$2,866	\$3,054	\$3,146
Total MA Cost	103,172	256,569	415,272
Federal share %	50.00%	50.00%	50.00%
Federal share	51,586	128,284	207,636
State share	51,586	128,284	207,636
Proportion served by Alt. Care	5.00%		
Average AC recipients	3	7	11
Average monthly cost	\$861	\$883	\$909
Total AC Cost	\$30,996	\$74,172	\$119,988

Fiscal Summary

	FY 2014	FY 2015	FY 2016
Total MA Cost	\$1,135,492	-\$194,970	-\$3,004,294
Federal share %	50.00%	50.00%	50.00%
Federal share	\$567,746	-\$97,485	-\$1,502,147
State share	\$567,746	-\$97,485	-\$1,502,147
Total AC Cost	\$30,996	\$74,172	\$119,988

Minnesota
Medical assistance
Fiscal Analysis of
Employment Supports and Projected Effects

Employment Supports	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	Waiver Total
Unique Enrollees			1,840	1,920	1,920	1,920	
Enrollee months			8,000	9,600	9,600	9,600	
Average monthly payments			\$40.45	\$49.78	\$49.78	\$49.78	
Payments for service			\$323,570	\$477,888	\$477,888	\$477,888	\$1,757,234
Federal share %			50.00%	50.00%	50.00%	50.00%	
Federal share			\$161,785	\$238,944	\$238,944	\$238,944	
State share			\$161,785	\$238,944	\$238,944	\$238,944	
Projected Effect of Delaying Onset of Disability-Based Eligibility							
Enrollee months affected			1,160	2,301	2,304	2,304	
Average monthly difference in capitation payment			-\$596.38	-\$620.12	-\$692.09	-\$732.43	
Difference in non-disabled capitation payments			-\$691,801	-\$1,426,893	-\$1,594,583	-\$1,687,508	-\$5,400,786
Federal share %			50.00%	50.00%	50.00%	50.00%	
Federal share			-\$345,901	-\$713,447	-\$797,292	-\$843,754	
State share			-\$345,901	-\$713,447	-\$797,292	-\$843,754	
Projected Administrative Costs of Demonstration							
Administrative costs		\$163,000	\$166,000	\$169,000	\$173,000	\$176,000	\$847,000
Federal share %		50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share		\$81,500	\$83,000	\$84,500	\$86,500	\$88,000	
State share		\$81,500	\$83,000	\$84,500	\$86,500	\$88,000	
Total Fiscal Effects of Demonstration							
Administrative costs		\$163,000	-\$202,231	-\$780,005	-\$943,695	-\$1,033,620	-\$2,796,552
Federal share %		50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share		\$81,500	-\$101,116	-\$390,003	-\$471,848	-\$516,810	
State share		\$81,500	-\$101,116	-\$390,003	-\$471,848	-\$516,810	

**Minnesota
PATH CTI Pilot
Effective January 1, 2014**

Projected Fiscal Effects on Minnesota's Medicaid Program

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
1 PATH CTI Pilot					
1 FY ending target Recipients per month (9 month service period)	20.0	45.0	60.0	60.0	60.0
Avg. Monthly Recipients	5.0	32.5	52.5	60.0	60.0
Avg. Monthly Cost per Recipient	\$820.00	\$820.00	\$820.00	\$820.00	\$820.00
Total Annual cost	\$49,200	\$319,800	\$516,600	\$590,400	\$590,400
Federal share @ 50%	\$24,600	\$159,900	\$258,300	\$295,200	\$295,200
Non-federal share	\$24,600	\$159,900	\$258,300	\$295,200	\$295,200
2 Projected Voluntary County Participation @ 50% of #1					
FY ending target Recipients per month (9 month service period)	10	22.5	30	30	30
Avg. Monthly Recipients	2.5	16.3	26.3	30.0	30.0
Avg. Monthly Cost per Recipient	\$820.00	\$820.00	\$820.00	\$820.00	\$820.00
Total Annual cost	\$24,600	\$159,900	\$258,300	\$295,200	\$295,200
Federal share @ 50%	\$12,300	\$79,950	\$129,150	\$147,600	\$147,600
Non-federal share	\$12,300	\$79,950	\$129,150	\$147,600	\$147,600
3 Baseline medical costs for recipient months					
Number of recipient months					
PATH/CTI	60	390	630	720	720
County	30	195	315	360	360
Total	90	585	945	1,080	1,080
Projected monthly cost per person (Using projected cost for GA homeless)					
	\$2,092	\$2,127	\$2,183	\$2,246	\$2,313
Projected baseline medical costs	188,280	1,244,295	2,062,935	2,425,680	2,498,040
4 Projected months of 25% savings (9-month lag)					
Number of months with savings					
PATH/CTI	0	157.5	450	652.5	720
County	0	78.75	225	326.25	360
Total	0	236	675	979	1,080
Projected monthly cost per person times 25%	\$523.00	\$531.75	\$545.75	\$561.50	\$578.25
Projected cost impact	\$0	-\$125,626	-\$368,381	-\$549,568	-\$624,510
Federal share @ 50%	\$0	-\$62,813	-\$184,191	-\$274,784	-\$312,255
Non-federal share	\$0	-\$62,813	-\$184,191	-\$274,784	-\$312,255
5 Net cost of waiver					
	\$73,800	\$354,074	\$406,519	\$336,032	\$261,090
Federal share @ 50%	\$36,900	\$177,037	\$203,259	\$168,016	\$130,545
Non-federal share	\$36,900	\$177,037	\$203,259	\$168,016	\$130,545

Minnesota
Medical assistance
Fiscal Analysis of
Housing Stabilization Services and Projected Effects

Housing Stabilization Services	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	Waiver Total
Average participants		405	2,250	2,895	3,000	3,000	
Participant months		4,860	27,000	34,740	36,000	36,000	
Average monthly payments		\$600.00	\$600.00	\$600.00	\$600.00	\$600.00	
Total payments by service date		\$2,916,000	\$16,200,000	\$20,844,000	\$21,600,000	\$21,600,000	
Total payments by payment date		\$1,230,000	\$14,826,000	\$20,304,000	\$21,600,000	\$21,600,000	\$79,560,000
Federal share %		50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share		\$615,000	\$7,413,000	\$10,152,000	\$10,800,000	\$10,800,000	\$39,780,000
State share		\$615,000	\$7,413,000	\$10,152,000	\$10,800,000	\$10,800,000	\$39,780,000
 Projected Effect on Medical Costs							
Baseline medical payments for participant months		\$5,775,068	\$35,044,358	\$52,891,457	\$57,265,758	\$58,983,526	
Baseline cost per participant month		\$1,188	\$1,298	\$1,522	\$1,591	\$1,638	
Projected cost impact by service date		\$0	-\$5,194,423	-\$11,180,840	-\$14,104,917	-\$14,527,962	
Projected cost impact by payment date		\$0	-\$4,322,801	-\$10,674,324	-\$14,013,793	-\$14,483,895	-\$43,494,812
Federal share %		50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share		\$0	-\$2,161,400	-\$5,337,162	-\$7,006,896	-\$7,241,947	-\$21,747,406
State share		\$0	-\$2,161,400	-\$5,337,162	-\$7,006,896	-\$7,241,947	-\$21,747,406
 MA Net Fiscal Effects							
Net MA Costs		\$1,230,000	\$10,503,199	\$9,629,676	\$7,586,207	\$7,116,105	\$36,065,188
Federal share %		50.00%	50.00%	50.00%	50.00%	50.00%	
Federal share		\$615,000	\$5,251,600	\$4,814,838	\$3,793,104	\$3,558,053	\$18,032,594
State share		\$615,000	\$5,251,600	\$4,814,838	\$3,793,104	\$3,558,053	\$18,032,594

Minnesota
Medical Assistance
Fiscal Analysis of
Asset Test at \$10,000 / \$20,000 for Adults with No Children

Based on February 2012 forecast.

Assumes effective for services beginning October 2012.

Base Forecast	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Avg Monthly Enrollment						
Up to 75% FPG	87,348	98,193	109,778	110,876	111,985	113,104
Over 75% to 133% FPG		18,332	43,279	43,712	44,149	44,590
% Effect on Avg. Mo. Enrollment						
Up to 75% FPG	-0.32%	-0.32%	-0.32%	-0.32%	-0.32%	-0.32%
Over 75% to 133% FPG	-0.64%	-0.64%	-0.64%	-0.64%	-0.64%	-0.64%
Phase-in for October 2012	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Effect on Avg. Mo. Enrollment						
Up to 75% FPG	-210	-314	-351	-355	-358	-362
Over 75% to 133% FPG	0	-117	-277	-280	-283	-285
Average monthly enrollees	-210	-432	-628	-635	-641	-647
Average monthly payment						
Up to 75% FPG	835.79	853.84	881.51	906.23	933.41	961.42
Over 75% to 133% FPG		610.29	617.06	634.36	653.39	672.99
Effect on Payments						
Monthly pmts.: Up to 75% FPG	(2,102,524)	(3,219,492)	(3,715,969)	(3,858,383)	(4,013,876)	(4,175,636)
Monthly pmts.: Over 75% to 133% FPG	-	(859,226)	(2,050,990)	(2,129,594)	(2,215,416)	(2,304,697)
Perf. pmts.: Up to 75% FPG		(72,655)	(260,513)	(302,721)	(329,729)	(343,017)
Perf. pmts.: Over 75% to 133% FPG		-	-	(162,911)	(181,990)	(189,325)
Total payments (incl HMO perf pmt)	(2,102,524)	(4,151,373)	(6,027,472)	(6,453,609)	(6,741,012)	(7,012,675)
Federal share %	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
Federal share	(1,051,262)	(2,075,686)	(3,013,736)	(3,226,805)	(3,370,506)	(3,506,337)
State share	(1,051,262)	(2,075,686)	(3,013,736)	(3,226,805)	(3,370,506)	(3,506,337)

Minnesota
MinnesotaCare
Fiscal Analysis of
Reinstating Residency Requirement for MnCare Adults

Based on February 2012 forecast.

Assumes effective for services beginning October 2012.

Fiscal effects are limited to coverage in the waiver period ending December 31, 2013.

	FY 2013	FY 2014	FY 2015	FY 2016
Average monthly enrollees	(480)	(480)	-	
Average monthly payment	485.48	514.61	545.48	
Phase-in	50.00%	50.00%	50.00%	
Total payments (excl HMO perf pmt)	(815,606)	(988,051)	-	
HMO performance payment	-	(30,395)	(126,445)	
Total payments (incl HMO perf pmt)	(815,606)	(1,018,446)	(126,445)	
Federal share	(407,803)	(509,223)	(63,222)	
State share	(407,803)	(509,223)	(63,222)	

Proposal: Demonstration to Reform Personal Care Assistance Services

This is expenditure history and current state forecast for FFS PCA, as used in #1 of the analysis for this option. The forecast has been extended in the waiver proposal.

Minnesota
MEDICAL ASSISTANCE PROGRAM
Recipient and Cost Projections
Table B7: Personal Care Assistance*

Fiscal Year -----	Monthly Average Recipients -----	Monthly Average Payments -----	Total Annual Payments -----
ACTUAL			
1994	4,411	1,559	82,502,268
1995	5,195	1,742	108,613,727
1996	5,638	1,514	102,441,655
1997	4,992	1,512	90,577,153
1998	4,868	1,632	95,324,164
1999	5,032	1,738	104,961,604
2000	5,250	1,838	115,757,455
2001	5,362	1,991	128,089,380
2002	5,143	2,130	131,458,021
2003	5,960	2,271	162,417,045
2004	7,336	2,168	190,858,747
2005	9,238	2,168	240,381,729
2006	10,410	2,204	275,300,221
2007	11,298	2,253	305,442,337
2008	12,769	2,240	343,155,151
2009	14,808	2,264	402,364,206
2010	16,477	2,045	404,264,975
2011	17,384	2,024	422,260,288
PROJECTED			
2012	17,967	2,045	440,975,525
2013	18,774	2,077	468,008,174
2014	19,873	1,993	475,260,465
2015	20,954	2,047	514,745,537

This is the estimated expenditure history and current forecast of PCA costs included in managed care rates for elderly and for families with kids. This forecast is used, and extended, in #2 of the "Replace PCA" analysis.

Personal Care in Managed Care rates

Fiscal Year -----	Elderly Managed Care PCA = 29.90%	Fam. w Ch Managed Care PCA = 1.20%	Total Managed Care PCA
2008	93,691,117	13,203,666	0
2009	106,071,211	15,421,247	0
2010	111,273,520	17,638,690	0
2011	115,820,767	18,897,066	0
2012	116,506,827	18,225,639	0
PROJECTED			
2013	111,141,416	16,467,148	0
2014	143,752,585	20,479,765	0
2015	133,473,577	20,186,054	0

Note that the "Replace PCA" analysis does not project the elimination of all forecasted PCA expenditures, but only the "non-waiver" portion. State plan PCA expenditures for HCBSwaiver recipients are assumed to continue.

Proposal: Demonstration to Expand Access to Transition Services

Nursing facility FFS expenditure history and current forecast:

Minnesota
MEDICAL ASSISTANCE PROGRAM
 Recipient and Cost Projections
Table A1: Nursing Facilities

Fiscal Year	Monthly Average Recipients	Monthly Average Payments	Total Annual Payments
-----	-----	-----	-----
ACTUAL			
1994	30,298	1,988	722,795,012
1995	30,087	2,444	882,333,353
1996	29,688	2,369	844,101,869
1997	29,073	2,459	857,852,080
1998	28,108	2,502	844,024,852
1999	27,407	2,563	842,904,140
2000	26,419	2,674	847,658,486
2001	25,521	2,853	873,701,800
2002	24,630	3,014	890,922,425
2003	23,772	3,139	895,486,149
2004	22,998	3,308	912,866,198
2005	21,954	3,296	868,246,231
2006	21,011	3,339	841,905,805
2007	20,233	3,384	821,582,971
2008	19,468	3,479	812,796,052
2009	18,783	3,696	833,074,698
2010	18,219	3,771	824,531,917
2011	17,535	3,783	795,962,910
PROJECTED			
2012	17,038	3,831	783,337,432
2013	17,009	3,880	791,891,929
2014	16,766	3,912	787,082,926
2015	16,225	3,960	770,963,242

Paid Days and Cost Projections

Fiscal Year	Annual Paid NH Days	Average Payment per Day	Total Annual Payments
-----	-----	-----	-----
ACTUAL			
1994	9,867,837	73.25	722,795,012
1995	11,571,518	76.25	882,333,353
1996	10,619,370	79.49	844,101,869
1997	10,285,172	83.41	857,852,080
1998	9,916,663	85.11	844,024,852
1999	9,665,394	87.21	842,904,140
2000	9,385,087	90.32	847,658,486
2001	9,081,026	96.21	873,701,800
2002	8,717,182	102.20	890,922,425
2003	8,333,583	107.46	895,486,149
2004	7,973,240	114.49	912,866,198
2005	7,554,540	114.93	868,246,231
2006	7,179,690	117.26	841,905,805
2007	6,815,932	120.54	821,582,971
2008	6,525,299	124.56	812,796,052
2009	6,257,421	133.13	833,074,698
2010	6,036,892	136.58	824,531,917
2011	5,820,452	136.75	795,962,910
PROJECTED			
2012	5,596,653	139.97	783,337,432
2013	5,559,176	142.45	791,891,929
2014	5,466,854	143.97	787,082,926
2015	5,282,954	145.93	770,963,242

Elderly Waiver expenditure history and current forecast, by FFS and Managed care:

Minnesota
MEDICAL ASSISTANCE PROGRAM
Recipient and Cost Projections
Table B2: Elderly Waiver Fee For Service

Fiscal Year	Undupl. Annual Recipients	Avg. Cost per Undupl. Recipient	Total Annual Payments
-----	-----	-----	-----
ACTUAL			
1994	4,936	2,486	12,271,607
1995	6,324	2,773	17,536,807
1996	6,697	3,496	23,414,622

Attachment P: Historical Financial Data: Expand Access to Transition Services

1997	7,001	3,407	23,854,467
1998	7,293	3,927	28,641,232
1999	7,842	4,201	32,941,602
2000	9,772	4,175	40,799,821
2001	10,890	5,115	55,703,492
2002	11,912	6,086	72,497,605
2003	13,497	6,820	92,052,096
2004	14,816	7,463	110,574,887
2005	15,397	8,351	128,584,929
2006	15,630	7,147	111,706,281
2007	9,774	9,300	90,896,550
2008	8,904	9,041	80,498,665
2009	7,181	7,532	54,087,828
2010	5,035	6,864	34,557,785
2011	5,242	7,039	36,897,589
PROJECTED			
2012	5,384	6,946	37,393,956
2013	5,561	7,037	39,130,922
2014	5,600	7,445	41,692,391
2015	5,223	8,257	43,127,134

Projections of Monthly Average Service Recipients

Fiscal Year	Monthly Average Service Recipients	Monthly Cost per Recipient	Total Annual Cost Incurred
-----	-----	-----	-----
ACTUAL			
1994	3,429	351.96	14,483,091
1995	4,123	366.09	18,111,405
1996	4,600	392.95	21,692,674
1997	4,872	417.05	24,381,937
1998	5,133	473.16	29,147,287
1999	5,461	512.88	33,607,096
2000	6,701	539.95	43,419,819
2001	7,732	626.70	58,144,963
2002	8,594	715.26	73,762,556
2003	9,657	805.96	93,393,894
2004	10,976	855.61	112,691,783
2005	11,411	933.28	127,792,880
2006	8,352	1,097.87	110,028,363
2007	5,653	1,313.86	89,121,958
2008	4,642	1,398.94	77,922,580
2009	2,765	1,521.35	50,484,531
2010	1,810	1,618.68	35,156,140
2011	1,967	1,577.54	37,242,461
PROJECTED			
2012	2,024	1,512.12	36,725,473
2013	2,091	1,547.46	38,821,220
2014	2,105	1,631.76	41,226,342
2015	1,964	1,787.34	42,116,040

Minnesota
 MEDICAL ASSISTANCE PROGRAM
 Recipient and Cost Projections
Elderly Waiver Managed Care
**(These payments are included in HMO payments and so they are included in the
 Elderly & Disabled Basic Care Budget Activity)**

Fiscal Year	Undupl. Annual Recipients	Avg. Cost per Undupl. Recipient	Total Annual Payments
-----	-----	-----	-----
ACTUAL			
1997			\$19,203
1998			458,967
1999			1,172,772
2000			2,002,912
2001			3,022,096
2002			5,152,691
2003	1,137	\$4,147	4,714,670
2004	1,512	5,962	9,015,041
2005	1,833	5,901	10,816,481
2006	11,996	5,161	61,915,599
2007	15,830	8,470	134,074,646
2008	19,041	9,228	175,709,529
2009	23,006	9,863	226,918,312
2010	24,077	11,018	265,283,969
2011	25,119	10,904	273,900,665
PROJECTED			
2012	26,163	10,620	277,849,441
2013	27,190	9,577	260,400,705
2014	27,149	12,138	329,539,180
2015	25,324	11,432	289,505,156

Projections of Monthly Average Service Recipients

Fiscal Year	Monthly Average Service Recipients	Monthly Cost per Recipient	Total Annual Cost Incurred
-----	-----	-----	-----
ACTUAL			
1997	10	226.02	25,766
1998	51	743.87	458,967
1999	126	781.98	1,186,260
2000	203	821.68	2,000,795
2001	346	809.16	3,357,217
2002	559	796.13	5,342,832
2003	786	761.62	7,182,817
2004	1,019	762.56	9,328,457
2005	1,327	813.59	12,958,043
2006	5,935	961.36	68,462,065
2007	11,190	1,024.80	137,606,495
2008	13,724	1,082.82	178,323,902
2009	16,889	1,145.62	232,174,777
2010	19,012	1,167.20	266,291,405
2011	19,816	1,155.46	274,756,876
PROJECTED			
2012	20,601	1,122.19	277,419,588
2013	21,410	1,118.81	287,439,609
2014	21,377	1,206.57	309,515,796
2015	19,940	1,340.36	320,720,103

Proposal: Demonstration to Empower and Encourage Independence through Employment Supports

The difference in monthly cost achieved by delaying a disability determination is based on the difference between our expected capitation rate for MA adults with no children and MA disabled individuals enrolled in our Special Needs Basic Care capitation product.

Projected rates are as follows:

Rate trends:

	SNBC Monthly Payment / Non-Medicare	MA Adults / No Kids Monthly Payment	Difference	SNBC	MA Adults / No kids
CY 2012 Approx. pmt.	\$1,378.00	\$825.00	\$553.00		
CY 2013	1,404.44	840.98	563.46	1.92%	1.94%
CY 2014	1,455.97	871.84	584.13	3.67%	3.67%
CY 2015	1,494.72	895.04	599.68	2.66%	2.66%
CY 2016	1,569.45	939.79	629.66	5.00%	5.00%
CY 2017	1,647.93	986.78	661.14	5.00%	5.00%
CY 2018	1,730.32	1,036.12	694.20	5.00%	5.00%

Agency and stakeholder policy discussions identified transition age Medicaid recipients (ages 18-26) as a group that could benefit greatly from early benefits planning and employment planning supports. Offering Employment, Benefits Planning and Navigation benefits at an early age that focus on healthy starts can change people’s trajectories and support people to increase independence. For evaluation and quality purposes, it was determined to offer this benefit as a demonstration in phases.

Two models were used to estimate the number of participants in the Demonstration to Empower and Encourage Independence. The first, a deterministic estimate based on averages, was used to estimate potential enrollment. The second, a dynamic model,

Attachment P: Historical Financial Data: Employment Supports

used measures of central tendency and distributions to estimate attrition.

Enrollment rates were based on data from nearly three years (Jan 2007 through Sept. 2009) of the Demonstration to Maintain Independence and Employment (DMIE), which had a 26% attrition rate. The DMIE Final Evaluation Report can be found at <http://staywellstayworking.com>

Proposal:

Project for Assistance in Transition from Homelessness and Critical Time Intervention Pilot

Historical data is not available for this demonstration because it is a new service.

The cost of providing the Critical Time Intervention service was estimated by reviewing DHS statewide rates of case management costs for Mental Health Targeted Case Management.

Because of the intensive nature of the service, this rate was built up to a 15:1 caseload ratio.

The number of demonstration participants was estimated based on the amount of excess state and local funding available for this project, divided by the assumed service cost. The projections also assumed a ramp-up period for identifying and engaging with demonstration participants.

Proposal: Housing Stabilization Services Demonstration

Participant projections are based on the number of homeless State General Assistance recipients (about 1500) and an equal number of state Group Residential Housing recipients believed to be able to benefit from this service.

Baseline medical costs are based on actual current MA payments for these two groups, starting in CY 2014 at \$872 per month for the GRH group and \$2092 per month for the homeless GA group. The baseline average cost per month is blended for the two groups, based on enrollment projections which phase in the GA group more slowly.

The savings assumption is an average 25% reduction from baseline medical costs, starting 6 months after the initial enrollment in the stabilization service. A spreadsheet with the month-by-month projections is available.

The 25% savings assumption is based on a study of a Chicago project which served homeless adults:

Laura Sadowski et al.

"Effect of a Housing and Case Management Program . . ."

JAMA May 2009

The \$600 service rate picked because of provider feedback that the monthly rate under a comparable state program of \$459.85 was insufficient. The state-funded program (GRH) is currently structured as an income supplement and not a medical service, so a direct comparison was not feasible. In addition, medication management services are not provided under that program.

Historical GRH Rates

SFY	Rate
2008	\$487.13
2009	\$496.87
2010	\$459.85
2011	\$459.85
2012	\$459.85

Proposal: Asset Test at \$10,000 / \$20,000 for State Plan Adults with No Children

Projections are built on the current state forecast for MA adults with no children, currently covered under an early expansion up to 75%, with coverage assumed to rise to 133% FPG in January 2014.

Minnesota
MEDICAL ASSISTANCE PROGRAM
Recipient and Cost Projections
Table C2: Total for Adults with No kids Basic Care

Fiscal Year	Monthly Average Eligibles	Monthly Average Payments	Total Annual Payments
-----	-----	-----	-----
ACTUAL			
2011	27,841	319.86	106,865,468
PROJECTED			
2012	82,486	833.15	824,681,177
2013	87,348	792.68	830,866,694
2014 early	45,422		654,396,243
2014 mand	70,990		547,718,772
2014 total	116,412	860.53	1,202,115,015
2015	152,705	778.24	1,426,093,409

This forecast is split in the waiver projections into the lower-income, more expensive group up to 75% FPG, and the group in the further expansion up to 133% FPG.

Based loosely on asset data on our current MA parent population, we project that an asset test at \$10,000 for one person would affect less than 1% in either of the two groups, with the proportion affected being slightly higher in the group above 75% FPG.

Proposal: Reinstating Residency Requirement for MinnesotaCare Adults with no Children

Projected effects of this change are based on the current forecast for MinnesotaCare adults with no children. We currently have federal waiver funding for this group until December 31, 2013.

This is the current state forecast for that group:

MINNESOTA CARE

Enrollment and Cost Projections

Adults with No Children (Excluding Limited Benefit Set and Transitional MnCare)

Fiscal Year	Monthly Average Households Enrolled	Monthly Average Enrollees	Average Enrollees Per Household
-----	-----	-----	-----
ACTUAL			
1995	1,767	2,023	1.14
1996	5,098	5,821	1.14
1997	6,988	7,890	1.13
1998	9,108	10,208	1.12
1999	12,382	13,900	1.12
2000	16,740	18,727	1.12
2001	21,206	23,553	1.11
2002	26,245	28,966	1.10
2003	31,207	34,233	1.10
2004	17,894	19,178	1.07
2005	13,742	14,557	1.06
2006	12,540	13,249	1.06
2007	11,297	11,933	1.06
2008	21,989	23,283	1.06
2009	35,044	37,222	1.06
2010	46,600	49,380	1.06
2011	66,962	61,621	0.92
PROJECTED			
2012	39,834	42,335	1.06
2013	40,486	43,476	1.07
2014	30,163	32,620	1.08
2015	18,331	20,164	1.10

Medical Payments	Revenue from Enrollee Payments	Federal Share Under Waiver	Net Cost
-----	-----	-----	-----

(Cash Basis Costs and Revenues)

ACTUAL				
1995	\$2,438,458	\$363,637	0	\$2,074,821
1996	10,792,663	1,015,891	0	9,776,772
1997	16,677,757	1,671,958	0	15,005,799
1998	23,367,720	2,170,539	0	21,197,181
1999	37,983,279	3,178,488	0	34,804,791
2000	59,947,419	4,604,986	0	55,342,433

Attachment P: Historical Financial Data

2001	75,376,683	6,596,646	0	68,780,037
2002	109,056,487	8,235,841	0	100,820,646
2003	138,814,592	9,879,142	0	128,935,450
2004	94,564,697	1,633,937	0	92,930,760
2005	61,238,107	900,025	0	60,338,082
2006	65,690,970	838,449	0	64,852,521
2007	60,902,973	765,544	0	60,137,429
2008	98,602,536	4,300,634	0	94,301,902
2009	177,283,287	9,563,405	0	167,719,882
2010	283,463,887	12,940,800	0	270,523,087
2011	380,619,066	19,032,734	0	361,586,332
PROJECTED				
2012	231,124,904	19,850,991	80,958,686	130,315,227
2013	259,151,986	19,649,524	112,769,802	126,732,660
2014	255,643,066	17,579,331	93,382,127	144,681,608
2015	144,491,071	15,040,588	10,742,220	118,708,262

This forecast assumes federal coverage of this group ends with January 2014. Projections for the waiver are only for the period of federal coverage.

The residency requirement is projected to make about 1.1% of enrollees ineligible. This projection is based on the number of MinnesotaCare denials from the period when a durational residency requirement applied to state-funded MinnesotaCare.

Proposal: Anoka Metro Regional Treatment Center Demonstration**Projection Assumptions:**

- Total Pt Days = Budget ADC (110) x 365 days
- 76.8% of ADC has MA as primary insurance
 - Analysis assumes new community based services eliminate Do Not Meet Criteria Patient Days
- Per Diem Rate assumes 3.5% inflation

AMRTC as provider	Year 1	Year 2	Year 3	Year 4	Year 5
Total Pt Days	40,150	40,150	40,150	40,150	40,150
MA Primary (76.8%)	38,143	38,143	38,143	38,143	38,143
% of MA Patient Days not meeting hospital level of care criteria	25%	20%	15%	10%	5%
Net MA Days Payable	28,607	30,514	32,421	34,328	36,235
Per Diem Rate (inflated 3.5% per year)	\$ 1,020	\$ 1,056	\$ 1,093	\$ 1,131	\$ 1,170
Total MA Revenue	\$ 29,179,013	\$ 32,213,630	\$ 35,424,926	\$ 38,821,551	\$ 42,412,545
50% Fed Share	\$ 14,589,506	\$ 16,106,815	\$ 17,712,463	\$ 19,410,776	\$ 21,206,272

Historical - Notes:

- *MA patient days not tracked separately prior to SFY2010
- **Based on percent for all payors

Historical

AMRTC	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012
Total Pt Days	58,521	47,771	41,713	40,143	39,595
Medical Assistance (MA)*	n/a	n/a	29,189	31,013	31,061
% of MA Patient Days not meeting hospital level of care criteria**	n/a	n/a	25%	25%	25%
Net MA Days Payable			21,892	23,260	23,296
Per Diem Rate	640	670	\$ 785	\$ 982	\$ 1,038
Total possible MA Revenue			\$ 17,185,024	\$ 22,841,075	\$ 24,180,989
50% Fed Share	-	-	\$ 8,592,512	\$ 11,420,537	\$ 12,090,494

Attachment Q: Copy of published State Register notice for second comment period

Department of Human Services

Health Care Administration

Request for Comments on *Reform 2020* Section 1115 Medicaid Waiver

DHS is announcing a second 30-day comment period on the *Reform 2020* Section 1115 Medicaid waiver request. This second 30-day comment period provides an opportunity for public comment on the fiscal analysis and historical expenditure data. The comment period is from September 24, 2012 to October 24, 2012.

The 2011 Minnesota Legislature directed the Department of Human Services (DHS) to develop a proposal to reform the Medical Assistance Program. Goals of the reform include: community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs.

DHS held an initial 30-day comment period on the *Reform 2020* Section 1115 Medicaid waiver request from June 18-July 17, 2012. All comments submitted during the June 18-July 17, 2012 comment period remain part of the public record for this waiver and will be submitted to the federal Centers for Medicare & Medicaid Services (CMS) for further consideration.

This second 30-day comment period provides an opportunity for public comment on the new fiscal information provided. The fiscal analysis of those components of the reform initiative requiring federal approval is set out at Attachment O of the *Reform 2020* waiver request. Historical financial data is set out at Attachment P of the *Reform 2020* waiver request.

After the conclusion of the comment period ending October 24, 2012, DHS will seek federal authority for the *Reform 2020* waiver request.

A copy of the waiver request is posted at www.dhs.state.mn.us/Reform2020

To request a paper copy of the waiver request, please contact Quitina Cook at (651) 431-2191.

Written comments on the fiscal analysis of the *Reform 2020* waiver proposal may be submitted via postal mail to the address below or via email to: Reform2020Comments@state.mn.us. DHS would like to be able to provide copies of comments received in a format that is accessible for persons with disabilities. Therefore, please submit comments in Microsoft Word format or incorporated within the email text. If you would also like to provide a signed copy of the comment letter, you may submit a second copy in .pdf format or mail it to the address below.

Comments must be received by October 24, 2012.

Scott Leitz
Interim Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

Attachment R: Comments and DHS Responses from the Second Comment Period: September 24-October 24, 2012

Comment: A parent of a young adult with disabilities expresses concern that the needs of people with profound physical and cognitive disabilities may get lost in Reform 2020 efforts to reduce costs and alleviate tax burdens, and may be overshadowed by the needs and interests of different advocacy groups. The writer states that low reimbursement rates for personal care providers contribute to the challenges of finding consistent qualified staff and is concerned that a higher rate is paid to the provider agency than actually goes to the direct care worker.

DHS Response: *DHS recognizes that the long term care services and supports system must support needs related to a wide range of physical, mental and behavioral health and aging-related conditions. The goal of Reform 2020 is not to reduce costs or tax burdens. Rather, the goal is to build a person-centered and flexible system that is sustainable so that it will be available to those who need it well into the future.*

The emphasis on self-direction in the new Community First Services and Supports program (the program that will replace PCA) is designed to give individuals more flexibility in choosing, hiring and paying their direct care workers and in managing their own service budget.

Comment: The parent of a young adult with Asperger's tells the story of what has happened with her child. She expresses concern that her son, and others like him, fall through the cracks. He is disabled under the Social Security standards but does not meet Minnesota Medicaid criteria for receiving independent living skills services or help becoming self-sufficient enough to move off Social Security. She expresses concern that the lack of services means many end up in the criminal justice system.

DHS Response: *DHS appreciates the writer sharing her personal story which illustrates the challenges we face and how a lack of service, the wrong service, or a poorly timed service can result in personal tragedy.*

DHS recognizes the important role that home and community-based services play in supporting people to live in the community and pursue their own goals. Part of the intention of Reform 2020 is to provide lower-intensity services to more people, earlier, in the belief that this kind of support will be sufficient for some people and will prevent or delay the use of more intense services later. Examples are the Community First Services and Supports, with the ability to provide this to people who don't qualify for waiver services, and the employment initiative. We want to find efficient, effective ways to provide services so that they will continue to be available to people in the future.

Comment: The Minnesota Consortium for Citizens with Disabilities (MN CCD) supports the overall goals and direction of *Reform 2020*. They are supportive of the changes that were made after the first public comment period. Specifically,

- Moving Intensive Care Coordination demonstration out of school setting
- Changing eligibility groups for employment services demonstration
- Removing age limits for Autism Spectrum Disorder services (not part of 1115 waiver request)

The Consortium continues to have concerns that were expressed during the earlier comment period. They appreciate DHS' responsiveness and involvement of stakeholders in the process.

DHS Response: *DHS appreciates the support of our partners.*

Comment: The Minnesota Disability Law Center supports the availability of the *Reform 2020* fiscal analysis for public review and comment and supports DHS pursuing the 1915(k) option. It supports many of the changes made after the first comment period. It opposes the use of any funds from the enhanced federal match for anything other than services under the new CFSS program and restoring services that have been cut in previous years.

It opposes the Demonstration of Innovative Approaches to Intensive Care Coordination, citing the lack of available data on Medicaid funding levels through schools by district. It is concerned that this demonstration will fail just as previous interagency collaboration efforts have. It contends that schools need training in positive behavior supports, as opposed to more coordination.

DHS Response: *DHS appreciates the recognition that the agency is trying to make the Reform 2020 fiscal analysis fully available to our stakeholders and regret that there is still confusion about the analysis. We will revise some of our public documents to offer clarification. The funds generated by the enhanced 6% FFP on the services that meet the 1915(k) criteria is dedicated to services under the CFSS program, but will not be sufficient to cover the full cost of the following:*

- *Increasing the minutes allowed under the lowest assessed functional need category for PCA services*
- *Covering additional people that we anticipate will come on to the program*

Changes to eligibility or access criteria will require additional dollars, over and above what is outlined in the waiver request. The Demonstration of Innovative Approaches to Intensive Care Coordination will test innovative approaches that are designed locally, through community agencies and local education and county partners. It is intended to reduce the number of coordinators, fill gaps when there are no coordinators where needed, and navigate between systems to support the child and their family. The demonstration will inform future work on the cost of care and integrated delivery models. This will be designed and evaluated through the Implementation Council.

Scott Leitz
Minnesota Department of Human Services
PO Box 64998
St. Paul, Minnesota 55164

RE: 2020 Reform for Waivers

Wednesday, October 10, 2012

Mr. Scott Leitz,

I am involved both personally and professionally in the lives of people with disabilities. My letter to you is personal. My son [REDACTED] is [REDACTED]. He has spastic quadriplegic cerebral palsy, profound mental retardation, and a mixed seizure disorder.

[REDACTED] is totally dependent on another person or two other people in all of his activities of daily living and all of his instrumental activities of daily living. [REDACTED] weighs 189 pounds and he is 5'7" tall. He uses a wheelchair for mobility. He sleeps in an electric "sleep safe" bed. He has and requires the use of a ceiling lift, and adapted bathing equipment. He requires the use of adapted transportation to leave his home, and he has a wheelchair adaptation to our van. [REDACTED] is diapered, fed, groomed, toileted, repositioned, and transferred. He is dependent on another person to provide all of these cares. [REDACTED] though 18 years old, can never be left home alone. He requires 24 hour 1:1 supervision at all times.

I believe in advocacy for all people who have disabilities, including autism and mental health diagnoses. However, my concern is that people like my son get lost in the advocacy and lobby for Autism spectrum disorders and mental health diagnoses.

[REDACTED] cannot walk, talk, toilet himself, or feed himself. Without 1:1 assistance 24-hours per day; he would die. I hope that statement alone emphasizes a difference in level of care and care needs. Please do not lose sight in these debates and discussions of the increased need and cost of care to keep a person with profound physical and cognitive disabilities alive, healthy, and living in the community, with their families if they choose, and out of institutional settings such as nursing facilities.

I realize that it is difficult for all families and supporters and providers for differing disabilities to provide care. Reform 2020 is meant to reduce costs and alleviate tax burdens while still providing care. People like my son with quadriplegia with or without the cognitive disabilities are already left with inconsistent, unreliable, unprofessional personal care staff in many cases. It is extremely difficult to find good personal support staff due to the low rate of pay per hour and the lack of any benefits. Personal Care provision is a job that some people will just outright refuse to do because they have an aversion to performing the toileting part of personal cares. If anything, my son's care providers should receive a pay increase, not continual pay cuts. Rates of pay to agencies are \$15.60 per hour, while the direct care provider is paid \$8.00-\$12.00 maximum without any health care benefits.

I am a stakeholder in the community of people with severe to profound physical and cognitive disabilities, and I ask for you and your colleagues to remember people like my son in your decision-making. It is my hope that MN Choices and any Consumer Directed Budget Methodology changes will reflect the difficulty of care and high needs of my son and people with disabilities similar to his.

Sincerely,

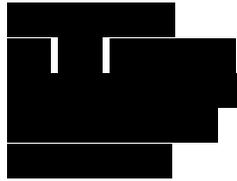
[REDACTED]

[REDACTED]

From: [REDACTED]
Sent: Thursday, October 04, 2012 2:16 PM
To: *DHS_Reform2020Comments
Subject: ASD
Attachments: +I_am_a_Public_Health_Nurse_and_mother_of_a[1].docx

Attached is the story of my son that has ASD. There was not enough waivers to go around and he could not get one. We were repeatedly told there was not enough money to provide him with services. This is his story and what happened to one young person that "feel through the cracks".

April 28th 2012



To whom this may concern:

I am a Public Health Nurse and the mother of a son with Asperger's. I read the article in the West Central Tribune on April 19, 2012 and appreciate the efforts made by the Counties and Commissioner [REDACTED] [REDACTED] to fill the gaps in services to disabled people because they do not "fit the mold". Our son is one of those individuals that fell through the cracks after graduating from high school. He is not severely disabled physically but people with Asperger's have disabilities that leave them just as "vulnerable."

The courts assigned my husband and me to be his legal guardians after he turned 18 years old. The guardianship papers read that he is an "incapacitated person" that "lacks sufficient understanding or capacity to make or communicate responsible decisions" and "demonstrated behavioral deficits evidencing inability to meet his needs for medical care, nutrition, clothing, shelter, or safety." Our son also meets the strict guidelines to receive Social Security Benefits related to his mental health needs. So why doesn't he meet the criteria to receive any type of service after graduating high school that could teach independent living skills and to enable him to go off social security? This could be accomplished in a day program just for Asperger kids that have special needs apart from other disabled individuals. This would also allow them to live at home while preparing them for their future.

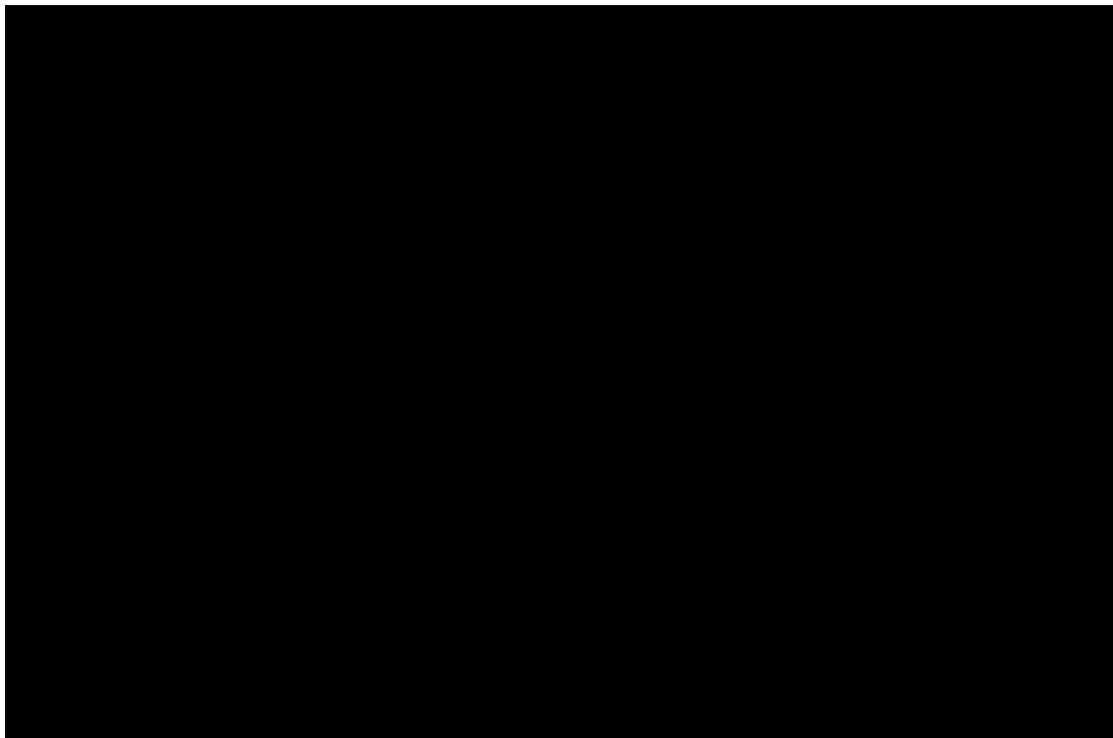
These kids do not need to be in a group home like the majority of the those offered today for long term care of the seriously disabled, who will most likely spend the rest of their lives in that type of care setting. The Commissioner and counties are right on when they voice concern to the state about filling a gap in services for people with disabilities.

Young people with Asperger's are not prepared to live independently after high school, but with some guidance and a little extra help they can learn the skills needed to be productive hard working individuals in our community. High school does not teach these kids the social skills they need or prepare them for the job market. People with Asperger's tend to be immature in relation to their peers and need time to "catch up" mentally. With the growing rate of kids diagnosed with Aspergers today, (1 out of 88) it is time to make the needed changes in our health care services and meet the needs of this growing population.

Recently I had a discussion with a Medical Doctor from [REDACTED] regarding the issues these kids face. He stated he was asked by a group of community leaders, "why the facility near the [REDACTED] was not filled to capacity, when it was first built?" And they wanted to know, "where are all the people with mental health needs ending up?" Sadly, he reported many are "filling our prisons". [REDACTED], who oversees the [REDACTED] county public health and family services department, states that counties are "ramping up" efforts to bring "mental health professionals into the jail to provide treatment," however, "jail is not a therapeutic setting", and makes a good point in saying "that's not what our jails are intended to do" but also added the fact that there are "no other place for them to go."

Governor Dayton signed a law protecting vulnerable adults the same day I read the article about counties "ramping up" efforts to bring mental health professionals into the jail. The new bill signed makes intentional abuse and neglect of vulnerable adults a felony. The abuse or neglect includes depriving a vulnerable adult of food, shelter, supervision, clothing or health care. Great bodily harm would carry up to 10 years in prison, up to \$10,000 fine or both, while substantial bodily harm would bring five years in prison and/or up to \$5,000 in fines. How many vulnerable adults do you think are filling our prisons today?

I know for sure one is; and that is my son. Prior to his incarceration he had no criminal history. He was active in Special Olympics all through high school and served as team captain in basketball and track. He was proud of his gold medals from state tournaments and we were very proud of him. He attended a school in [REDACTED], MN for kids with autism. He did not mind the hour bus ride to school and back each day because he had found a place that he belonged. His grades went from failing to A's and B's and when I asked him what made the difference, he stated, "They know how to teach me mom." His self esteem soared and his goals became lofty. He had found a purpose for his life and he wanted to be a security guard.



This is a picture of our son. He is number [REDACTED]. His name is [REDACTED].

After [REDACTED] graduated from high school we were sickened to discover there were no services to help him in his continued growth and development. Other kids his age were working or went to college. He did not have the skills to work nor was he prepared to go to College. My husband and I were faced with some difficult decisions. Does one of us quit our job? And stay home and ensure our son's safety? We looked into PCA services. He was able to do most of his own personal cares with reminders and some supervision so he did not fit the criteria for that program.

With reservations and considerable worry we gave into allowing our son to live in a small apartment. One that had security doors that locked and was close enough to our home that we could check on him frequently. His greatest trial during that time was the lack of structure in his day to day living. It was overwhelming to all of us, but there was no perfect answer to our situation. [REDACTED] was a good kid and if we could keep him away from trouble he should be fine. We helped [REDACTED] with his grocery shopping and laundry. [REDACTED] did not have a driver's license. He needed more than what we could provide, but we did the best we could for him. We just prayed no one would take advantage of him. Asperger kids have a difficult time differentiating good from bad when it comes to people. They are so trusting. They think "everyone" is their friend.

On the 23rd of April 2011, our son introduced us to his "new friend." We needed to be [REDACTED] eyes and ears when it came to signs of trouble in his life. So we immediately told his friend (whom we thought was higher functioning than [REDACTED]) that we were [REDACTED] guardians. We told him what that meant and that we were responsible for helping our son make good decisions. His friend [REDACTED] said he understood. We thought he seemed genuine in his friendship to [REDACTED]. We learned later this new friend had a long criminal history and that he told our son upon meeting us, not to tell us his "real" last name. Within in a two week time period our nightmare began to unfold. The first thing we noticed was [REDACTED] wrote on Facebook that he got a new apartment (with no mention of our son); he began wearing our son's shoes and clothes and when I asked [REDACTED] about this he said "they share everything." I asked what [REDACTED] shared with him and he had no reply. [REDACTED] began asking for more money than usual. [REDACTED] shaved our son's hair off and pierced his ears and told [REDACTED] they were "brothers now", we asked [REDACTED] to leave [REDACTED] apartment, but every time we returned he was there. He somehow convinced our son that he was "going to take care of him." The TV and X Box went missing and it was not long after that our keys to our son's apartment disappeared. We realized this total stranger had taken over not only our son's life but his apartment as well. We could no longer "drop in" unexpectedly without our keys. It happened so fast. This kid had some kind of hold on our son and we did not know why. We later learned he had been threatening [REDACTED] with a gun. [REDACTED] father came to our house and said his son stole his gun. All we knew was that we needed help and decided to call the police. It wasn't soon enough because that day we heard on the radio that our son had been arrested. It was May 3rd 2011.

I was in shock. Our son's picture was on the news that night. I will never forget the broad cast as they described our son as a man. He's not a man! He is a child in a man's body. He looked so young, even though he was nineteen years old. At that moment we knew our lives, our son's life, and the lives of many other people had been critically altered.

Although [REDACTED] was found guilty to nearly all of the crimes, our son was sentenced to 36 months in prison as an accomplice. His mental health issues were irrelevant to the court system. It did not matter that this was his first time in serious trouble, he was found guilty by association. And that is not the only thing, to makes matters worse it was the same judge that sentenced him to prison that had signed the guardianship papers stating our son was a vulnerable adult.

All I could think of was how wrong this all seemed. The judge asked before he sentenced our son to prison if anyone had any other ideas as to where he could be sent besides prison and no one could think of any other place. There is nowhere for vulnerable adults to go if they get into trouble? They do not belong in prison. They are vulnerable, gullible, naïve, and incapable of taking care of themselves. They do not have criminal minds. I pleaded with the prosecuting attorney, [REDACTED] and stated that "[REDACTED] does not belong in prison". It did not matter; there was "no other place for him to go."

I faxed the guardianship papers to the prison before our son arrived to serve his time. It was all I could do to help [REDACTED]. I hoped someone would read them and care about our son's safety. The case manager for [REDACTED] at the prison called me after he arrived and said, "In the history of the prison they have only had possibly two other cases of a vulnerable adult being sentenced to prison." I'm guessing there have been many prisoners that were vulnerable but did not have the documentation to prove it. She went on to say, "He doesn't belong here", and stated "what he needs is independent living skills, not a prison. They placed him by the guards' desk in a cell by himself so that they could keep an eye on him. The case manager told me upon our next conversation she would transfer him to a minimum security if at all possible and told me that [REDACTED] was doing alright. She said the older prisoners were watching after him and making sure no one "messed with him." I thanked her from the bottom of my heart. She cared.

We visit [REDACTED] weekly and try to keep his spirits up. They started him on an antidepressant this last week. He tells us stories about what it's like in prison. He described it as hell. He said that every morning when he wakes up he waits for the guard to come to his cell and tell him to pack his stuff because he was going home and that there had been a mistake. He reassures us that he is doing fine when he sees the worry on our faces. We listen to his stories about the other prisoners he has met, a boy who is serving a life sentence for killing his whole family, another person that hit his mother in the head with a hatchet and killed her, the rapist, the chimo's (child molesters) that no one likes. He has told us that there are bi-sexual people there too, but not to worry, he is getting use to them starting at him when he is in the shower. And he told us that every time we visit him he is strip searched before he can go back to his cell, but he does not want us to stop coming to see him. He has been given a nick name too, they call him Smiley.

I can't help wondering what our son will be like when he gets out of prison. Will he be the same sweet person? Will he be hardened and uncaring and someone we do not know any more? Will he be emotionally distraught? Or suffer from some post traumatic stress? I know one thing for sure; he will never be the same person that left.

Through this experience I will continue to be an advocate for my son. Although physically I cannot be there to protect him, and God knows I would have taken his place in a heartbeat, I can be there in prayer and in words through letters. And there is one more thing I can do for my son, and that is to be a voice for him and others like him that are "falling through the cracks." I can tell his story for him and hope that someone will listen and his time will not be served in vain. I hope that maybe, just maybe, God did have his hand in this horrific event and something good will come out of it for those still suffering in our prisons with mental illnesses and disabilities ... and better yet maybe, just maybe someone will listen and help to make changes in our health care system to provide services to the vulnerable adults in our communities that are "falling through the cracks" so they do not end up in jail. Too many times after high school these kids end up on the streets unsupervised and that makes them easy targets for those looking to manipulate and take advantage of other people more vulnerable. To me "those people" who take advantage of vulnerable adults are the "real criminals."



**The MN Consortium for Citizens
with Disabilities**
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www.mnccd.org

To: MN State Medicaid Director

From: The MN Consortium for Citizens with Disabilities (MN-CCD)

Re: Public Comments on the Reform 2020 Section 1115 Waiver Proposal (Second Round)

Date: October, 2012

On behalf of the Minnesota Consortium for Citizens with Disabilities (MN-CCD), a state-wide, cross disability public policy coalition, we thank you for the opportunity to submit a second round of public comments on the Reform 2020 Section 1115 Waiver Proposal.

We appreciate the changes that DHS made to their Section 1115 Waiver Proposal in response to the public comments that we and many other organizations and individuals submitted. We were particularly pleased to see some of the specific changes around the nature of school districts' involvement in the Demonstration for Intensive Service Coordination for Children. Additional changes that we feel strengthen the Section 1115 Waiver Proposal include the changes in eligibility groups for the employment supports initiative as well as the removal of age limits in conjunction with the Autism services section of the proposal (although we understand that the latter section does not require federal authority and will be discussed extensively in the newly formed Autism Spectrum work group).

While there are certainly pieces of the proposal that we continue to have concerns about, we identified those specific concerns at length in the initial public comments we submitted this past summer (available as an attachment to the proposal) and therefore we will not review them again here. Additionally, despite these areas of concern, we have overall been encouraged by the MN Department of Human Services' willingness to discuss issues of concern with stakeholders throughout the entire Section 1115 Waiver Proposal creation process. There has been strong stakeholder involvement since the very first stages of work on this proposal began.

In summary, we continue to remain in agreement with the Section 1115 Waiver Proposal's vision for achieving better health outcomes, simplifying programmatic administration and access, ensuring the long term sustainability of the Medicaid program, increasing the flexibility and responsiveness of the LTSS system, and supporting Minnesotans to have a meaningful life at all stages according to their own desires. These proposal goals align well with the three founding principles that guide MN-CCD in our disability policy advocacy work: access to needed services, empowerment and choice, and quality of care. We look forward to CMS's feedback on the proposal, and to continuing our work with DHS on the critical and significant implementation and operational decisions that will have to be made as we move forward.

Thank you again for the opportunity to comment.

Steve Larson and Chris Bell, 2012 MN-CCD Co-chairs



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October 24, 2012

Scott Leitz
Interim Medicaid Director
Minnesota Department of Human Services
P.O. 64998
St. Paul, MN 55164-0983

**RE: Comments on September 24 Version of
“Reform 2020: Pathways to Independence,
Section 1115 Waiver Proposal”**

Dear Mr. Leitz:

Thank you for the opportunity to comment on the changes the Department of Human Services (DHS) made to its June 18, 2012 version of the above-named 1115 waiver request. Our office is Minnesota’s designated Protection and Advocacy (P&A) System which represents children and adults across Minnesota with significant, often lifelong, disabilities, including mental illnesses, physical disabilities, brain injuries and intellectual and developmental disabilities. These comments relate to the changes made in Minnesota’s Reform 2020 1115 waiver request provided to the public September 24, 2012. We also submitted comments on the June 18 version of Reform 2020 and urge DHS to make additional changes as recommended.

I. SUPPORT

A. Availability of Fiscal Analysis

We appreciate the additional information on Minnesota’s fiscal assumptions and analysis for the changes and 1115 waivers requested. However, we still do not have enough information to understand some points we believe are important to persons with disabilities and will continue to request clarification.

B. CFSS

1. As stated in our comments on the June 18 Draft Reform 2020 version, we are in strong support of reforming and modernizing Minnesota’s PCA services program using the 1915k Community First Choice federal

authority, under the title Community First Services and Supports (CFSS), for a number of reasons which we will not repeat here.

II. OPPOSE

A. Community First Services and Supports (CFSS) Fiscal Issues

While we strongly support Minnesota's effort to both move to the 1915k state plan option and obtain an 1115 waiver using 1915i in order to continue current eligibility for PCA services, we strongly oppose the use of any of the additional 6 percent federal match for anything other than changes to the new CFSS program to restore eligibility for those who need cuing and supervision (42 C.F.R. § 441.500) to accomplish activities of daily living (ADL) and instrumental activities of daily living (IADL), to cover the projected caseload increase, to increase the payment rate due to added responsibilities such as teaching and skill development and to raise the minimum amount of service from 30 minutes to 75 minutes. Because of the harsh and discriminatory 2009 cuts primarily affecting persons with mental illnesses, brain injuries and intellectual and developmental disabilities, any additional federal financial participation is needed to restore this program and eliminate the unfair treatment of persons who need cuing and supervision to accomplish essential activities in their homes and communities.

It appears that funding generated under CFSS, 1915k is projected to be used for a demonstration on Intensive Care Coordination for Children and for Essential Community Supports needs due to the Nursing Facility Level of Care (NF/LOC) changes adopted in 2009 (also the subject of an 1115 waiver request in February 2012). We oppose the use of CFSS-generated funds for purposes other than necessary changes to the PCA/CFSS program.

B. Demonstration of Innovative Approaches to Intensive Care Coordination for Children with Complex Services

We oppose the use of any the 1915k additional funds for the Demonstration of Innovative Approaches to Intensive Care Coordination for Children with Complex Needs.

We continue to oppose this demonstration program despite changes made in the September version of Reform 2020 for the following reasons:

1. No data has been provided on the amount of Medicaid funding schools are currently providing through the Medical Assistance (MA) program by district. We think this essential to analyze this information in order to predict whether there would be any interest in such coordination from school districts.

2. Our state spent many years working on interagency collaboration (IIIP), including DHS, health care and education for children. After an enormous amount of effort, untold hours in meetings and travel, many legislative adjustments, this effort has been terminated. It is important to learn from this experience and not repeat the same failed practices under a new name.
3. As stated in our earlier comments, we often find that school resources are not robust enough to meet the complex needs of children in school, much less in other environments. Many districts are in need of significant training on positive behavior supports because they are still resorting to the use of prone restraint in school for children as young as five years old.

We urge the Intensive Care Coordination Demonstration request be withdrawn. Instead, we think that improvements in intensive care service coordination for children should proceed with the other reform efforts, including case management, health care coordination, state innovation model initiative, health home and health care home efforts. Minnesota is awash in proposals to coordinate and manage health care and other services for persons with complex needs. We think that another coordination project to develop and manage in addition to the multiple efforts already occurring is excessive duplication. As stated above, we firmly oppose the use of any additional CFSS related federal financial participation for anything other than restoring eligibility in order to end the serious discrimination against persons with mental illnesses and other behavioral issues in the newly-designed PCA program called CFSS.

C. Essential Community Supports (ECS) Program for “Transition Group”

Is this item listed in order to cover the cost of providing ECS to those who lose HCBS waiver eligibility due to the Nursing Facility Level of Care (NF/LOC) change? We oppose use of 1915k additional federal matching funds for this purpose. We think all 1915k increased funds are needed to make changes in our PCA program to eliminate discriminatory provisions which are contrary to 1915k requirements. The costs for alternative services were included in the NF/LOC 1115 waiver and should not be paid for with funds needed to correct discriminatory practices in the current PCA program.

We appreciate numerous other changes as described in the September Reform 2020 proposal, including eligibility for and emphasis on competitive employment for the Employment Supports demonstration and the change in eligibility (elimination of the functional assessment), change in the 18-year-old age requirement and the addition of Community Living Assistance services for the Housing Stabilization Services demonstration.

Scott Leitz
October 24, 2012
Page 4

In sum, thank you for the opportunity to comment. We appreciate all of the public meetings and information provided by DHS as the 1115 proposal has been developed.

Sincerely,

/s/

Anne L. Henry
Attorney

ALH:nb

Attachment L

Public Comments on *Reform 2020* Received by DHS

This appendix includes copies of the public comments received by DHS regarding the *Reform 2020* Section 1115 Medicaid waiver proposal during the comment period June 18-July 17, 2012. Portions of some comments have been redacted to protect private information. Some comments have also been mechanically scanned with Optical Character Recognition (OCR) software where it was necessary to convert the document to a format that is readable to people with disabilities. While providing very good results, the software may not always have recognized all of the words in all of the documents.



Seeing Strengths. Creating Options. Restoring Health.

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July 17, 2012

David Godfrey, Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164

RE: Reform 2020 Comments

Dear Mr. Godfrey:

Thank you for the opportunity to comment briefly on the Reform 2020 Section 1115 Medicaid Waiver request. Thank you, too, for the opportunities the Department of Human Services has provided to the public over the past several months to participate in the process. The goals of the Reform are laudable.

Guild Incorporated, a not-for-profit, community mental health agency, provides an array of evidenced-based community treatment and support services, crisis stabilization, residential treatment, employment services, and supportive housing for adults living with serious mental illness and all its' complexities – seeing strengths, creating options and restoring health.

Services are provided in vivo, where and when needed (e.g., on the street, at one's home, during a doctor's appointment, etc.) Services include intensive case management, assertive community treatment, illness management recovery, integrated dual disorder treatment, supported employment, crisis stabilization, supportive housing, and care coordination. Social determinants of health as well as physical and mental health conditions are addressed simultaneously. Just over 1600 individuals are served over the course of a year.

First, we wish to underscore the importance and value of ensuring that individuals and families have access to on-going, evidence and community-based mental health services as they learn to live with, and successfully manage, chronic health conditions such as schizophrenia, schizoaffective disorder, major depression and other serious mental illnesses. Access to community services is key to the Reform goals of improved health and reduced reliance on institutional care.

We are hopeful that MnCHOICES is being designed such that it is effective in identifying the needs of individuals who have psychiatric disabilities, in addition to other disabilities. Certainly we welcome reductions in administrative complexity and simplification of the system wherever possible, as long as the unique needs of those who have psychiatric disabilities are incorporated into the tools that are used.

We support the policy direction of providing services "earlier in order to prevent or delay the demand for higher cost services." Accordingly, there is value in assuring that quality services are accessible to those who do not meet a level of institutional care.

We support pursuing the 1915(i) option to address gaps in service levels for those living with mental illness of a serious and serious and persistent nature. We need to do anything we can to offer services and supports before people need institutional care. Steps to improve the structure and viability of the current adult mental health rehabilitative services need to be explored - perhaps there is value in incorporating the rehabilitative services into the 1915(i).

To "empower and encourage work", the evidence-based Individual Placement Support model should be expanded and pursued through the 1915(i). Let's align our services to achieve 75% employment among those who have serious mental illness, rather than the current 15-25% employment rate.

We support the inclusion of Housing Stabilization Services in the demonstration projects. Safe, stable housing is at the foundation of health.

At Guild, we know, and have demonstrated, that when people, even those who have most disabling and complex conditions, have access to on-going, high quality, person-centered community mental health services and supports; health can be maintained, homelessness prevented, and disruptive, high-cost health services such as emergency department visits and hospital admissions used only when absolutely necessary.

Thank you for your attention to these brief comments. Please be in contact with us if we can be of assistance in furthering the goals of Reform 2020.

Sincerely,

A handwritten signature in black ink, appearing to read "Grace Tangjerd Schmitt". The signature is fluid and cursive, with a large initial "G" and "S".

Grace Tangjerd Schmitt
President

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 17, 2012 8:18 PM
To: *DHS_Reform2020Comments
Subject: Medical Assistance (MA) proposal; The needs of autistic adults.
Attachments: White Paper Final Draft.docx

I'm a mother of a teenage boy with an ASD. He's fifteen. For the past three years I've struggled to maintain or get services my son needs so he can become a successful and contributing member of society. His services started to be slowly stripped away from him when he turned 12. My son is on the cusp of adulthood and I worry about what kind of difficulties he'll face once he turns 18. There are little to no services for autistic adults, and I see the needs of adults are not addressed in the waiver request. I feel this is an issue that is being severely overlooked.

I understand the concerns of addressing autism in individuals at a young age. But these same individuals will someday grow up to become adults. Isn't it important that these individuals have the services they need to be successful? We're only setting them up for failure if they don't have anything to help them transition into adulthood and maintain a positive course with positive outcomes.

I feel it's equally imperative that adults already on the autistic spectrum have the services they need. This includes job training and placement, educational and housing opportunities, and social skills development. Autistic adults need these services now. Young autistics will need these services in the future when they become adults. It's important and crucial that the state of Minnesota do something now to ensure the future of people with an ASD.

I'd like to conclude with the fact I'm also a graduate of [REDACTED] with a Bachelor's of Science in Social Work. Spring quarter of my junior year I wrote a white paper on the needs of services for autistic adults that I sent to Senator Al Franken. I've attached the paper here. I hope you take the time to read it and consider the importance of services for autistic adults, now and those to come.

Thank you for your time.

Sincerely,

[REDACTED]

AUTISTIC ADULT SOCIAL SERVICES ASSISTANCE

**A WHITE PAPER FOR MINNESOTA SENATOR AL FRANKEN
UNITED STATES OF AMERICA SENATE**

AUGUST 5, 2011

I. INTRODUCTION

Autism is a developmental disability that affects people of all ages, gender, race, ethnicity, and socioeconomic background. While autism is often thought of as a children's disability, the fact is that the disability does not cease to exist on an 18th birthday. There is currently a significant number of adults who have been diagnosed as autistic, and an ever increasing number of adolescents who are aging into adulthood each day (IAN, 2009). This population is severely overlooked when it comes to providing services that will help them become productive and successful members within our society. While policymakers on every level are working hard to meet the needs of autistic children, little to no effort is being made to meet the needs of autistic adults resulting in an unequal amount of care for a critical group of vulnerable citizens. Most specifically, young autistic adults who age out of high school are in serious need of services that will help them make the transition into adulthood. At this pivotal time in their lives, services that have been proven to help them maintain the skills they developed during their school years, enabling them to maneuver through society as they get older, are not available.

I am writing to you today as a constituent and mother of an autistic teenage boy who will soon begin his transition into adulthood. Like all citizens in the United States, autistic adults have a right to participate in society. They cannot do that, however, without the necessary services to help them achieve this. It is my hope that you will see the importance of this issue and understand the level of urgency needed to modify our service resources.

II. ABSTRACT

For over a decade autism has been viewed as a children's disability and is approached as such despite the fact it knows no age, race, gender, ethnicity, religious affiliation, or socioeconomic status, and that many autistic youth become autistic adults. Focus is placed on a variety of therapies, treatments, and developmental strategies to help autistic children. While this must continue, it is equally important to put this same kind of focus towards autistic adults. Services are not available or are very limited to autistic adults who need care after age 18. Care over the lifespan of an autistic person costs up to \$3.2 million dollars (CDC, 2010). "Unless a concerted effort on the part of parents, professionals, employers, and society at large is made to correct these shortcomings, the costs can only be expected to grow in the coming years" (New York Center for Autism, 2009).

III. EXAMINATION

A. CURRENT POLICY SHORTFALLS

Surveys and studies conducted by Think Tanks (New York Center for Autism, 2009), research institutes (SFARI, 2011), and universities alike have found the rates of services for autistic adults of varying ages to be severely lacking. A recent study done at Washington University of St. Louis, Missouri (Feb. 2011) and corresponding article published in the February issue of *Arch Pediatric and Adolescent Medicine* (2011) take a close look at services available to autistic adults during their first few years post high school graduation. The study

found a large discrepancy in rates which show 39.1 percent of young autistic adults do not receive the services they need to increase their ability to become productive and successful members of society. Looking at medical diagnostics and care, mental health, case management, and speech therapy as being the services most needed, the below chart reflects the discrepancy between services for high school and post graduation autistic youth.

	Medical	Mental Health	Case Management	Speech Therapy
High School	46.9%	46.2%	63.6%	74.6%
Post Graduation	23.5%	35%	41.9%	9.1%

The sharp contrast in these figures shows a sharp decline in services once young autistic adults leave high school, and highlights that not enough focus is placed on their many important needs (Arch Pediatric Adolescent Medicine, 2011).

Autism is seen as a children’s disability with current statistics provided by the Center for Disease Control and Prevention estimating that an average of 1 in 110 children within the United States have an autistic spectrum disorder (CDC, 2011). Most of the focus has been placed on meeting the needs of children such as prevention, early intervention, and locating a cause. Emphasis has also been placed on various forms of therapies to help children develop skills that were affected by the onset of the disability. While these initiatives are critical, this has left the needs of autistic adults severely neglected.

Aside from the need for medical, mental health, case management, and speech therapy services, autistic adults also need services in job training and employment, housing, independent living skills, support and social skills groups, and educational opportunities (New York Center for Autism, 2009). There is a lack of understanding that autistic adults have the potential for employment and can become contributing members of their community when the appropriate support systems are available (New York Center for Autism, 2009).

B. MISUNDERSTANDINGS ADDRESSED

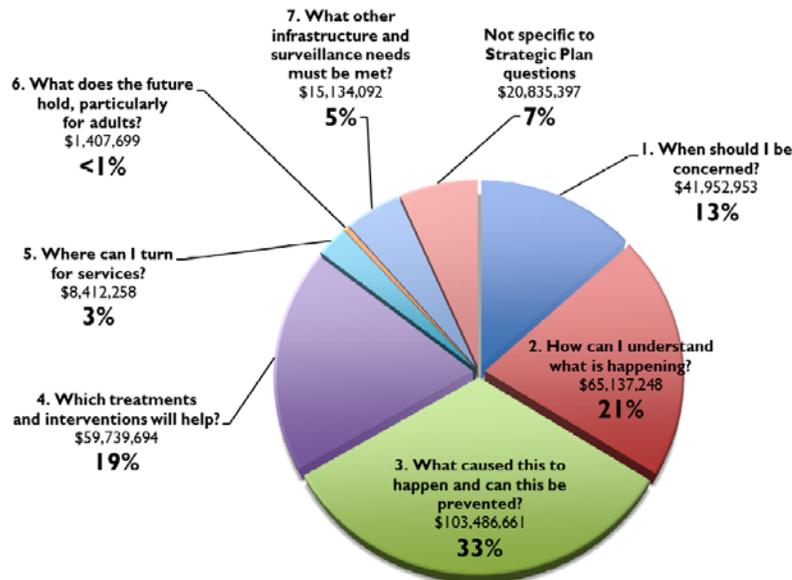
Although autism is known on a global level, there is ignorance surrounding the disability. Many people believe that autism has become an epidemic because the numbers of people diagnosed with the disability have increased over the last ten to twelve years from 1 in 10,000 to 1 in 110 (CDC, 2010). “Researchers believe this is due to a greater recognition, with changes in diagnostic practice associated with more trained diagnosticians; broadening of diagnostic criteria to include a spectrum of disorder; a greater willingness by parents and educationalists to accept the label; and better recording systems, among other factors.” (Taylor 2006).

There was also a widely held belief that autistic adults did not exist. In recent years, two studies have been conducted in England that refutes this claim. One was done in 2007 by the National Health Services (NHS, 2009, Time, 2009) and another recently in 2011 at the University of Leicester (Arch Gen Psychiatry, 2011, Science Daily, 2011). Both found that autism appears to be just as common amongst adults as it does children. It was discovered that roughly 1 in 100 adults in England are autistic. The findings are consistent with the rates of diagnosed children found in Japan, Canada, and New Jersey, where the prevalence of autism amongst children is the highest, 1 in 94 (Star-Ledger, 2007, Time, 2009). Given these statistics, it is reasonable to believe that the numbers of autistic adults in this country are similar. Furthermore, according to preliminary findings by the Interactive Autism Network (IAN, 2009),

a project of the Kenny Krieger Institute, it was discovered that the ages of participants who shared personal information for an online research project and identified themselves as autistic varied from eighteen up to sixty-two (IAN, 2009). As I have stated throughout this document, and as represented in the above data, autistic adults do exist and their numbers will increase as more adolescents grow into adulthood.

C. PROPOSED POLICY REFORMATION

With the passing of the Combating Autism Act (CAA) in 2007, The Interagency Autism Coordinating Committee (IACC), a Federal advisory committee that coordinates all efforts within the Department of Health and Human Services (HHS) concerning autism spectrum disorder was formed (IACC, 2009). This committee receives funding from both Federal agencies and private organizations. Every year the IACC establishes a Strategic Plan that apportions this funding for autism research to be done in this country. The graph below demonstrates a breakdown of this funding and highlights what can only be described as a clear fundamental bias in a matter of importance in autism research.



Graph provided by 2009 IACC Autism Spectrum Disorder Research Portfolio Analysis Report

To date, a combined total of seventy-three percent of funding has been put toward gaining understanding, locating the cause, prevention and early interventions, and treatments of autism, with an extremely small amount – only one percent - going towards “what the future holds, particularly for adults” (IACC, 2010). This is outrageous and not acceptable. The allocation of funds needs to be adjusted so more research can be done to identify the needs of autistic adults and provide necessary services, as well as the development of new programs and the sustainment of any current ones for autistic adults of all ages. Funding for the IACC is received from both federal and private sources (IACC, 2011), as such it is essential that this funding continue, but the focus for this money must shift if autistic adults ever hope to find a place within society.

Recently, the Combating Autism Reauthorization Act (CARA) was presented before Congress. On September 7th, 2011, the Senate HELP Committee is scheduled to discuss CARA. It is imperative this Act continue. Without it, the IACC will cease to continue. But most

importantly, funding allocated towards autism research will cease as well. I urge you to support the Combating Autism Reauthorization Act so necessary research can continue. I also request that you make a stand for autistic adults and insist that more funding be allocated towards services that will help adults currently on the spectrum and those growing into adulthood become productive and successful members of society.

The number of young autistic adults making their way into adulthood is growing, adding to the already present population. The fact that there are adults of varying ages who are autistic needs to be acknowledged and services need to be available for them to utilize. This is both for young adults to help them transition successfully from high school into adulthood, and for those already on the spectrum. If this is not done now, present autistic adults will continue to find themselves without critical services. Young autistic adults aging into adulthood will experience the same outcome. As a result, both will flounder in a society that failed to provide them with the means to reach their full potential and have a positive future.

There are agencies and organizations at the local and national level that already work to provide the necessary services needed by autistic adults. Two located in the Twin Cities are Fraser Center and Lifeworks Services, Inc. Fraser Center in Minneapolis is considered by many in the Twin Cities to be the premier organization for autism services. Fraser provides autistic adults with “residential living options” (Fraser, 2011), and “home & community supports that assists people with maintaining physical and behavioral health, family well-being, increasing independent living skills and participating in the community” (Fraser, 2011). There is also an organization in St. Paul called Lifeworks Services Inc. that works with autistic and many other disabled individuals to provide career development. As of 2009, approximately 299 businesses throughout the Twin Cities have partnered with Lifeworks. The result is 662 individuals overall have earned \$4.1 million in income with the average wage of \$8.32 an hour (Lifeworks, 2011).

On the national level, organizations such as Advancing Futures for Adults with Autism (AFAA) are working to bring attention to the need for services for autistic adults. New strategies need to be implemented because “[t]he potential of young adults and adults (14 years of age and older) with autism to become employed and engaged citizens of the U.S. is not so much limited by their disability itself but, rather, by the failures of the system charged with supporting them” (AFAA, 2011). To further stress the urgency of this matter, AFAA hosted a Congressional briefing in Washington, DC on July 15th, 2010. Federal legislators, national policymakers and advocates for [autistic adults] – including [adult autistic self-advocates] – came together to discuss “priorities for action in the public and private sectors that address the increasing and unmet demand for effective services for adolescents and adults with the disorder” (AFAA, 2011).

Organizations like these are vital in guaranteeing the success of autistic adults. It would be imperative that IACC form a collaboration with AFAA to further prevent the economic cost of our country’s systematic failure of its most vulnerable citizens. It would also be beneficial if the IACC studied organizations like Fraser Center and Lifeworks and use them as models to develop additional federally funded programs and services that will help autistic adults of all ages become productive and successful members of society.

D. LONG-TERM RESULTS

Companies such as Best Buy, Cargill, and 3M have autistic adults in their employment and see the benefits of doing so. The Best Buy webteam Vice President, Cindy Hoker, is convinced

“that this group is one of the most untapped pools of talent we have.” Autistic adults can be taught the skills needed to succeed in the workplace (East Valley Tribune, 2011). Therefore, it is imperative that services are provided so autistic adults have the chance to participate in these opportunities.

Autistic adults of all ages have a right to “participate in the economic, political, and cultural life of society” (NASW, 2006). They have a right to find their place in the work force, and take advantage of college or vocational training. They have a right to have a place to live, whether it is on their own or in an assisted living facility. Participation in society allows autistic adults the opportunity to live their lives to the fullest. This goes hand in hand with the rights and responsibilities that not only adults with an autism spectrum disorder have to the community, but with what we the community have to these individuals in return. All “[people] have a right and responsibility to participate in society and to work together toward the common good” (NASW, 2006). We can help autistic adults achieve their right to participate in society by guaranteeing services are available for them once they mature into adulthood, and continue to be available to them as they age. It is just as important to guarantee that services are available for already existing autistic adults who have the “fundamental right to things necessary for human decency” (NASW, 2006).

E. CONCLUSION

Autism is not going away. There are autistic adolescents growing into autistic adults. My own son will soon begin the transition into what will be one of the most critical times in his life. He has dreams and goals for himself. I have great concern my son will not be able to meet them due to the lack of services for adults and an even greater lack of funding and research into what the future holds for him and others autistic individuals transitioning into adulthood.

This concern also reaches out to the autistic adults already present in our society. They have a right and responsibility to participate and become productive and successful members. Providing services for these individuals have never been more important or necessary than they are today. It is time the needs of autistic adults stop being overlooked and start being taken into consideration. Today’s autistic children will become tomorrow’s autistic adults. If the needs are not met now, what will happen to future generations when they mature into adulthood and discover the services they need are not there? We cannot afford to fail these individuals, for it will be more costly to them as well as our country if we do not act.

F. APPENDICES

APPENDIX A- AUTHOR(S)

[REDACTED]

APPENDIX B- REFERENCES CITED

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July 17, 2012

David Godfrey, Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

Re: Comments on Autism section of the Reform 2020 Section 1115 Medicaid Waiver Proposal

By email with attached word document and signed pdf to:
Reform2020Comments@state.mn.us

Dear Mr. Godfrey:

I am submitting the following comments as permitted during the public comment period for this proposed waiver. These are my written comments regarding the concerns of the Lovaas Institute Midwest about this proposal.

Background: For the purpose of introducing these comments, I am a licensed psychologist with 25 years of experience as a Licensed Psychologist in Minnesota. I am also a Board Certified Behavior Analyst. I have been employed by a county social services department, a community mental health center, and two universities in Minnesota, as well as serving on three state task forces. I have consulted widely for children and adults with severe disabilities, school districts, and private service agencies across Minnesota. I have incorporated two nonprofits to serve Minnesotans with autism, and I have served as the chairperson of two other statewide nonprofit agencies. I am presently employed as the Executive Director of Clinical Services at the Lovaas Institute Midwest, where we provide intensive early intervention services to children with autism.

My comments will:

- 1) reinforce the need for a 1915(i) waiver to prevent Minnesota from creating a waiting list that would hamper early intervention,**
- 2) provide support for extending the age of coverage of the 1915(i) waiver to 12 years, and**
- 3) address the extent to which Applied Behavior Analysis can assist in resolving concerns regarding the section on Autism Services in the proposed waiver.**

1) It is critical to fashion an autism services funding stream that will not result in a waiting list for early intervention services.

When the state of Wisconsin transitioned its Katie Beckett coverage of ABA for autism to a 1915(c) waiver, the waiting list increased to over one year. This effectively eliminated the opportunity for early intervention for many children, and particularly those from disadvantages populations, because of the following facts.

In a recent CDC study of factors associated with age of diagnosis of autism, the CDC reports the following:

- The average age of diagnosis of autism is 5.7 years.
- The average age of diagnosis in children with IQs over 70 is 6.6 years.
- The average age of diagnosis in children whose mothers were teenagers at birth is 6.6 years.
- The average age of diagnosis in children whose mothers had less than 12 years of school is 6.3 years.

- 27% of the children with autism had not been diagnosed by the age of 8.

These studies suggest that economically disadvantaged children are unlikely to be diagnosed with autism until after they reach first grade. While studies contradict each other over whether the age of diagnosis of minority children is older than other children, what is consistently found are that less minority children are ever diagnosed with autism. This suggests that the age data is severely confounded by the lack of reliable evaluation services for minority children. One study found that rural children are also diagnosed later (at the average age of 8.1 years).

Therefore age-caps are likely to discriminate against disadvantaged children.

Others claim that the older age of diagnosis in general is due to the failure to diagnose young children who are “high-functioning” or have Asperger’s disorder, and that this is somehow a trivial problem. However, the ABA studies show that both “low-” and “high-functioning” children are equally likely to recover from intensive early intervention. Further, the cost to society of “high-functioning” adults with autism is estimated at an average of \$2 million per person.

Therefore it is imperative that society cover the costs of timely early identification and early intervention for all children, regardless of IQ.

Section 1 References

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2) If the evidence in Early Intensive Behavioral Intervention is used as a guide, then the age cap for the 1915(i) autism waiver should be 12 years.

The cost effectiveness of Early Intensive Behavioral Intervention (EIBI) for autism is well documented (I have a full bibliography available on request). Much of the research emphasizes the need to treat the children at as young an age as possible, and this is certainly an important aspect of effective treatment. However, the following list of several hundred references also reports the clinically important impact of Applied Behavior Analysis (ABA) with children who are specifically *above* the age of seven. Several articles of note are highlighted that report the effectiveness of EIBI/ABA that was delivered to children who *started* treatment even up to the age of seven, and then continued treatment for up to five more years, until they were over the age of ten, if still medically necessary.

For a child starting treatment at any age, the average length of intensive ABA treatment would be expected to be 3 years, and the range of medically necessary treatment durations has been shown to be from 18 months to 5 years. Therefore, system-wide, maximum cost effectiveness will be achieved when a competent authorization process involves evaluation of the child’s response to treatment and prognosis every six months, as was done in these studies. When applying such standards, the children would not automatically continue treatment indefinitely. Instead the intensity and duration would be tailored to each child’s optimum effectiveness, by periodically evaluating each child’s individual response to

treatment, and thereby dramatically control costs by providing time-limited ABA for only so long as is medically necessary.

The range of age cut-offs in evidence-based EIBI studies were established for the purpose of controlled research, and were based upon a number of factors, such as available funding. They weren't meant to imply that autism was untreatable after those ages. Throughout the EIBI literature, the published range of such age cut-offs, for the purpose of research, was 48 to 84 months for the maximum age to *begin* receiving treatment, and then the subsequent duration of treatment was one to five years.

Therefore the age of *completion* of these children's intensive treatment was up to 12 years of age.

After several groupings of these studies are summarized below, this paper then summarizes the research on the focused treatment of behavior disorders with children who suffer from autism in the ages of five to 21.

The following studies reported age cut-offs for *initiating* intensive treatment up to the age of seven years (84 months).

Eikeseth and colleagues, in 2007, used the following cut-off:

"All referrals who met the following criteria were admitted to the study: (a) a diagnosis of childhood autism... (b) chronological age between 4 and 7 years at the start of treatment, (c) a deviation IQ of 50 or above... and (d) no medical conditions... that could interfere with treatment." (page 266).

"The largest gain was in IQ; the behavioral treatment group showed an increase of 25 points (from 62 to 87) compared to 7 points (from 65 to 72) in the eclectic treatment group." (page 269).

"in the behavioral treatment group, all correlations among intake age and outcome measures and changes were nonsignificant, with $r(12)$ ranging from $-.40$ to $.46$. Thus, age was not reliably associated with outcome or amount of change for this group." (page 273).

Eikeseth, S., Smith, T., Jahr, E., & Eldevik, S. (2007). Outcome for children with autism who began intensive behavioral treatment between ages 4 and 7: A comparison controlled study. Behavior Modification, 31, 264-278.

Mudford and colleagues, in 2001, reported the following cut-off:

"By the age of 4 years, 71% of the sample had started EIBI. At the ages of 5, 6 and 7 years, the corresponding cumulative figures were 91%, 97% and 100%." (page 177).

Mudford, O.C., Martin, N.T., Eikeseth, S., & Bibby, P. (2001). Parent-managed behavioral treatment for preschool children with autism: Some characteristics of UK programs. Research in Developmental Disabilities, 22, 173-182.

These additional studies reported effective treatment of children who *completed* their treatment after the age of five.

Sallows and Graupner, in 2005, reported the following data for children who ranged up to the age of 8.5 years of age at the conclusion of treatment:

"Following 2 to 4 years of treatment, 11 of 23 children (48%) achieved Full Scale IQs in the average range, with IQ increases from 55 to 104, as well as increases in language and adaptive areas comparable to data from the UCLA project. At age 7, these rapid learners were succeeding in regular first or second grade classes, demonstrated generally average academic abilities, spoke fluently, and had peers with whom they played regularly." (page 433).

Sallows, G.O., & Graupner, T.D. (2005). Intensive Behavioral Treatment for Children With Autism: Four-Year Outcome and Predictors. American Journal on Mental Retardation, 110, 417-438.

Love, Carr and colleagues, in 2009, reported the following average ages of treatment in a comprehensive survey of nationwide ABA practices:

“Seventy-four percent (n = 153) of respondents reported that the *average* age of the children they served was between 2 and 5 (33% reported serving children who were 4-years old), and 26% (n = 55) reported an *average* client age of 6 or greater.” (page 177).

Love, J.R., Carr, J.E., Almason, S.M., Petursdottir, A.I. (2009). Early and intensive behavioral intervention for autism: A survey of clinical practices. Research in Autism Spectrum Disorders, 3, 421-428.

These additional studies reported meta-analyses of ABA treatment of school-aged children with autism, up to and including the age of 15.

Bellini and colleagues, in 2007, reported the following age ranges of 155 children who benefited from ABA social skills training:

“21 studies involved preschool-age children, 23 involved elementary age children, and 5 studies involved secondary-age students.” (page 158).

Bellini, S., Peters, J.K., Benner, L., & Hopf, A. (2007). A meta-analysis of school-based social skills interventions for children with autism spectrum disorders. Remedial and Special Education, 28, 153-162.

Reichow and Volkmar, in 2010, reported on 31 studies of children, aged four to fifteen, who benefited from ABA social skills training:

“The school-age category had the highest participant total of the three age categories (N = 291).” (page 156).

“Within the last 8 years, 66 studies with strong or acceptable methodological rigor have been conducted and published. These studies have been conducted using over 500 participants, and have evaluated interventions with different delivery agents, methods, target skills, and settings. Collectively, the results of this synthesis show there is much supporting evidence for the treatment of social deficits in autism.” (page 161).

Reichow, B. & Volkmar, F.R. (2010). Social Skills Interventions for Individuals with Autism: Evaluation for Evidence-Based Practices within a Best Evidence Synthesis Framework. Journal of Autism and Developmental Disorders. 40, 149-166.

Brosnan and Healy, in 2011, reported on 18 studies of children aged three to 18, who received effective ABA treatment to reduce or eliminate severe aggressive behavior:

“All of the studies reported decreases in challenging behavior attributed to the intervention. Of the studies included, seven reported total or near elimination of aggression of at least one individual during intervention in at least one condition.” (page 443).

“only four of the studies conducted follow-up assessments. However, each of these studies reported that treatment gains were maintained.” (page 443).

Brosnan, J., & Healy, O. (2011). A review of behavioral interventions for the treatment of aggression in individuals with developmental disabilities. Research in Developmental Disabilities. 32, 437-446.

3) I believe that the science of Applied Behavior Analysis and the practice of Behavior Therapy offer solutions for resolving the public concerns regarding the autism services section.

I applaud the DHS intent, which I quote from page 15 here:

“A new program to deliver early intervention services to support Medicaid eligible children ages 0-7 who have a diagnosis of Autism Spectrum Disorder (ASD). The primary goal of the program is to provide high quality, medically necessary, evidence-based therapeutic and behavior intervention treatments and associated services, such as respite, that are coordinated with other medical – and educational – services. Other goals of the program will be to make a smooth and effective transition into school programs and/or other community services, and demonstrate measurable gains and achievement of identified goals.”

“With this waiver request, Minnesota seeks to move the service delivery system to a model that will better integrate medical, behavioral and long-term care services in patient-centered models of care, promote robust primary care, improve care coordination, and better align payment incentives to foster best practices. In addition, Minnesota proposes to modify existing long –term care services and supports to provide additional flexibility to match the right services with participants’ needs, at the right time.”

ABA and behavior therapy offers objective evaluation methods that can ensure that the cost of early intervention is covered as wisely as possible, regardless of the child’s age, diagnosis, or intake functioning level.

State-mandated prior authorization practices should not just be meaningless bureaucracy. ABA practitioners provide therapeutic treatment for children to accomplish important improvements in their behavior and then transition them to independence. We use scientifically established principles to evaluate each child’s response to treatment and prescribe the optimum form of behavior therapy for them. We then make customized requests for authorization of whatever further treatment might be necessary.

The intensity that we request is the level that is necessary to do the job. As such, the intensity varies dramatically across children. Some children have simple needs and others have complex needs. Each child’s response to treatment is objectively evaluated every six months over the course of an average of three years of treatment. If less clinical supervision and treatment can accomplish the treatment goals, then we identify that level and reduce treatment accordingly.

These accountability practices do increase the amount of clinical supervision that each child receives, but they also result in the effectiveness that is sought by the consumers, and the ability to screen out ineffective treatment in the most timely manner possible.

In the end, the overall cost is reduced because each child reaches their best outcomes in the fastest manner possible, and children who don’t benefit are transitioned as quickly as possible.

Is Applied Behavior Analysis (ABA) a cost-effective treatment for autism?

In the past, it was common that affected children would be placed into a state hospital, and their families would be advised to forget them. They were told that their children were incapable of learning language and social attachment. The poor parents of some of those children were further mistreated when they were told that they had caused their children’s autism. And all of this was done without any research whatsoever to support these practices.

Yet America is the home of innovation and industry, and at the University of Minnesota, the leading psychologist B.F. Skinner reasoned that the developing science of behavior could be applied to solve human problems. What other purpose for science could there be?

Following his lead, researchers at several hundred universities pursued the science of Applied Behavior Analysis (ABA). Behavior analysts began to venture into the darkest wards of state hospitals and found that they could make profound changes in the behavior of children who suffered from schizophrenia, mental retardation, and autism.

In the 1960’s, ABA researchers found that these children could learn and become independent, and their research formed a basis for the deinstitutionalization of state hospitals. Researchers found that they

could teach the blind to be independent, the deaf to talk, and the handicapped to recuperate. They found that much of the severe behavior disorders were caused by the very fact that those children were warehoused – 60 children kept in a day room with little care and nothing to do, resorted to rocking and self-injury much like zoo animals. However when the families were empowered to nurture their children in their own homes, they did indeed respond to their families' love and showed more healthy development. These gains strengthened families. The parents formed the Association for Retarded Children and the National Society for Autistic Children, to advocate for family-based ABA treatment of their children, and for local inclusive communities.

However, good intentions and family nurturing were not enough. In the 80's and 90's, most children were still segregated in special education programs and by their teenage years, because of the dangers and severe behavior disruptions, were headed for community group homes. The typical family living with a child with a severe behavior disorder found themselves isolated and preoccupied with their child's daily needs. The disruptive children were not welcomed at church, at school, or even at family Thanksgiving dinners. Further, the children were serious financial burdens on school districts, costing an average of \$18,790 per year (according to the GAO) and went onto life-long community group home living, costing an average of \$68,908 per year (according to the federal Center for Medicaid Services), overall costing more than \$3,200,000 per child over their lifetimes (according to a Harvard study).

So did the ABA fail and go away? Certainly not. Now the science was applied to solving these next problems.

ABA Researchers in school special education programs found how to teach the young children to participate meaningfully in regular classes, and how to socialize with their regular peers. They also found how to develop transitional skills to train the adolescents in meaningful work in actual community jobs. Their studies showed the cost effectiveness of these approaches. They also found methods for training the regular schoolteachers to use the behavior analysis procedures.

ABA researchers also began studying how to provide intensive early intervention in the homes of families, to prevent the development of these severe behavior disorders. Once again, they found that the families could be empowered to provide the necessary behavior therapy in their own homes. Under the intensive supervision of these university centers, the parents were able to eliminate severe behavior problems such as sleep disorders, eating disorders, self-injury, destruction, and aggression in 90 percent of the children. Simultaneously the researchers found how to train the parents to foster normal social interactions and language in their children.

With one form of ABA, Early Intensive Behavioral Intervention (EIBI), a good number of the children improved enough in all areas of their lives that, by first grade, they had attained normal IQs, lost their diagnoses, and were able to learn without special education in the regular classrooms. Follow-up studies showed that 90% of these children were able to go on to live productive, independent lives as tax-paying citizens, rather than as tax-spending wards of the state.

Up until the early 90's, the research on EIBI had been conducted in relatively few university centers, with funding from the National Institutes of Mental Health. It was fairly obscure. However it was then that the internet began to foster social networking and Catherine Maurice published a book on the recovery of her children. Her book was substantiated by an independent university study, and families began clamoring for help. Simultaneously, autism began growing from what had been considered a low incidence disorder, into a much more widespread problem.

This was a new and unusual treatment – most professionals still believed that children were born and lived with the same disorder until their deaths, and they preferred to counsel families from the safe distance of their leather couches. So community funding for intensive home-based treatment was hard to find.

And sufficient funding was needed to do the job correctly. This is intensive early intervention, designed to dramatically alter the family's natural lifestyle into a therapeutic lifestyle for three years. As such it is dynamic family therapy, and requires many hours of direct behavior therapy for the child, direct family

therapy for the parents, and ongoing behavioral assessment, analysis and clinical supervision of the many individualized treatment changes made along the way. If the critical mass of intensity is not delivered, then the results are neither widespread nor sustained, and the funds are largely wasted. So the natural inclination to parcel out the services is very clearly penny-wise yet pound-foolish.

Therefore the families began going to their school districts for funding. They had a right to IEP funding, but there was little leeway in the school district budgets, especially for the smaller districts, and this treatment went way beyond previous expenditures, and it was home-based, after all. Further, in the vanguard of this treatment, there were very few professionals who understood the therapy and were available to the schools for expertise. In due process hearings, families were able to show the effectiveness of the approach and win the needed funding. However most schools provided only minimal services, which made nowhere near the impact of the intensive programming.

So families turned to health insurance and government Medicaid funds. Pennsylvania, Wisconsin, and California established dedicated EIBI programs. Here in Minnesota, the families succeeded in lobbying for a statewide task force on autism in 1997. The cost-effectiveness data showed that the EIBI was warranted. However, the vested, traditional care providers, the “competition,” claimed that the research wasn’t yet substantial enough to warrant a programmatic investment in early intervention, and the state did not implement the recommendations, though when individual families pursued Medicaid coverage in hearings, they won.

The ABA research continued to blossom and by 2001, numerous independent panels and state commissions were finding that the results were indeed bona-fide and that the treatment was being accepted as the community standard of care. These bodies included the Surgeon General of the United States, the American Psychological Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, the National Research Council, the New York Department of Health, and the California Department of Developmental Services, to name a few. ABA and EIBI behavior therapy for autism could no longer be considered investigative, and had clearly reached the mainstream of autism treatment.

There was no alternative. Traditional mental health services were not faring so well. The Minnesota Department of Health 1998 report on children’s mental health, the Minnesota Department of Human Services Citizen’s League 2001 report on children’s mental health, and Blue Cross Blue Shield’s 2002 report on Minnesota’s mental health system all found services to be in disarray. The Citizen’s League reported:

“More than ten years after its passage, the mission of the Children’s Mental Health Act remains utterly unfulfilled. The mental health services a child receives, and the degree to which those services are coordinated and easily obtainable, depends largely on what county the child lives in and the persistence of parents and family members. Education, prevention and early intervention efforts range from limited to virtually nonexistent. No one is held accountable when a child’s mental health needs go unmet — and Minnesota’s children are suffering the consequences.”

All of these reports called for increased access to intensive, family-based services; increased personnel training resources; increased accountability, and increased early intervention. The families were calling for all of these solutions as well.

On the strength of the evidence, the families succeeded in lobbying for a law in 2001 that provided for a dedicated autism program whereby Medicaid would have covered ABA treatment. The law laid out the parameters of effective treatment, and it also included numerous cost controlling mechanisms. The law would have allowed the state to coordinate and manage the services that were directly targeted to autism.

Though the law was not set to be implemented until 2007, families continued to win Medicaid coverage in individual hearings, and the Attorney General forged a settlement with the insurance companies to not automatically deny coverage. ABA providers negotiated agreements for coverage with the state Medicaid program, and also began to be certified by the state CTSS program. Blue Cross Blue Shield took the lead in enabling children to benefit from intensive ABA therapy.

In 2004, Minnesota initiated a new Systems Change Grant to improve service quality in the children's mental health system of care and to improve outcomes for children and families. The state's independent consultant once again found that ABA was an effective treatment:

"Two treatment families demonstrated Best Support. Intensive Behavioral Treatment was successful in three (3) studies, beating alternative treatments in two (2) of those, and beating a no-treatment control in one (1). Likewise, Intensive Communication Training was also successful in three (3) studies, beating alternative treatments in two (2) of those, and beating a no-treatment control in one (1) study..."

"These results are quite promising in terms of effect size, although it should be noted that the outcome variables for these studies mainly involved reductions in the frequency of —autistic behaviors or increases in social communication or other forms of social exchange (e.g., turn taking). None of these studies claimed that children were —autism free following the intervention programs. Nevertheless, these findings represent an extraordinary improvement over the evidence base for interventions for autistic spectrum disorders in the previous Biennial Report..."

"The shape of the profile suggests that all successful treatments for autistic spectrum disorders involve teaching communication skills and modeling of appropriate communication or other behaviors. Other strategies include training in non-verbal communication (social skills), teaching parents and teachers to praise desired behaviors, and the setting of goals paired with the intensive rehearsal and reinforcement of behaviors consistent with those goals (i.e., discrete trial training)."

Chorpita, B.F. & Daleiden, E.L. (2007). *2007 Biennial report: Effective psychosocial interventions for youth with behavioral and emotional needs*. Child and Adolescent Mental Health Division, Honolulu: Hawaii Department of Health (pp. 16-19).

However this promise has not yet been fully implemented.

In 2007, the state rescinded the autism law without public notice or hearing. The state also began suspending authorization of coverage for some children, and delaying certification of new providers for others. Some providers responded by curtailing treatment to the level that the state would agree to authorize – others served families who advocated for the full intensity that their children needed. Some providers were certified only on condition that they provide less intensity than others.

In a subsequent hearing sought by families, the state presented the issue as being about which specific components of EIBI were to be covered – the direct child behavior therapy and/or the behavior analysis and clinical supervision. The state claimed that federal rules prevented the coverage of the components. But as evidence, the state provided a letter from the federal government that said something entirely different. The federal letter stated that it required additional information before it could add the autism program to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) section of Minnesota's state plan as a rehabilitative benefit. The federal government explained the problem this way:

"autism is a disorder which is developmental in nature and routinely requires treatment similar to that provided to individuals who have mental retardation..."

"Habilitation services are typically provided for the purpose of helping persons maintain or acquire new functional abilities while rehabilitative services are provided to restore a lost function."

This opinion was and is unjustified by the evidence that many children with autism have in fact lost their functioning, and that many others never had "mental retardation" and never will. Instead the ABA behavior therapy does in fact restore some children to normal functioning and others to near-normal levels of functioning. There is no credible scientific evidence to the contrary.

In the numerous hearings and mediation meetings since then, we've offered solutions for better management of autism. Yet the state has continued to provide only generic coverage – even when the generic coverage is more costly.

What are the problems that the 1915(i) waiver should correct with Applied Behavior Analysis?

Currently the state manages all treatment as if it were the same, managing specialized, intensive, daily ABA therapy for autism in the same way as weekly psychotherapy for depression. This prevents the state from customizing coverage guidelines for intensive treatment, or for who should be receiving it.

The state has no system for scaling the payment rates to the level of intensity. Instead it is one payment rate no matter how many hours are being delivered.

The state doesn't account for all of the other expenditures being made for the same children. In addition to CTSS, children are also receiving drug therapy, speech therapy, occupational therapy, psychotherapy, social work, foster care, day care, special transportation, in-home care, medical care, nutritional services, special education services, hospitalization, and psychiatric care. The data presented by the state doesn't even include these costs, but a child who accesses these services easily costs over \$50,000 per year.

The state doesn't ensure timely access to the most cost-effective early intervention.

The state doesn't cover the increased hourly cost of transitioning the children to less expensive services.

The state's intensive services for rural and disadvantaged families are almost non-existent.

The state doesn't ensure that specialized Board Certified Behavior Analysts are available to deliver these services.

The state removes the incentive for private health insurance companies to cover the same treatment.

Without cost controls, intensive services are offered to children of any age or disability, regardless of the evidence base, and the treatment services are extended in some cases for many years beyond their utility.

Without cost controls, therapy programs that do not have evidence to support them are funded at equal levels with evidence-based programs.

What are the funding solutions for ABA for autism?

There are several mechanisms for establishing a Medicaid fund for ABA therapy. One is to fund it through a 1915(c) waiver, but such programs don't cover the most cost-effective timely early intervention (the current waiting list for habilitative services in Wisconsin is 14 months – delaying the treatment of the average child until they are already in school). The 1915(i) waiver or the EPSDT rehabilitation program ("Medical Assistance") is much more timely and customizable to the child's needs. A dedicated Medicaid autism program would also allow for coordination and management of benefits. The Medicaid program also covers public school-based therapy.

Or, the state's high-risk pool (MCHA) also covers behavior therapy for autism, but requires a six-month wait. The private health insurance policies can also step up share the cost of the behavior therapy.

Without these programs, the family can (and does) pay out of their own pocket.

When these programs don't and the family can't, the cost of the child's behavioral treatment falls to the rest of society. In childhood, most of the costs go to special education, where school district spending for a student with autism is three times the cost of a regular student.

Regardless of the funding source, everyone wants a system of cost-effective management of autism services. But a system of micro-managing the service delivery is not cost-effective. This approach increases bureaucratic costs for both the state and the providers. And all we accomplish then is to produce well-organized files while each child's treatment becomes less effective.

For example, the state spends a great deal on the authorization process – paying professionals to read requests for authorization of coverage for children they have never met. But in fact, they can't realistically

afford to take the time to understand the individual needs of thousands of children every six months. So they end up wasting taxpayer money on a sham process, and possibly taking on liability for bad decisions.

Systems of value-based cost management can be much more cost-effective. The use of regulatory resources is most cost-effective when incorporating measures of quality and outcomes, as well as quantity. In the past, traditional psychotherapies haven't produced the kind of objective data that is needed to make these systems work, so the potential has been ignored. But ABA for once gives government and health plans the chance to make money-saving decisions, because it produces objective data.

Instead of micro-managing the process, let's manage the outcomes.

This focus mirrors concepts proposed by the Mayo Clinic and the Minnesota Department of Health's value-based initiative.

Medical necessity should be based upon the evidence and the community standard of care. However, when it comes to evidence, most policy makers have only relied upon one level of evidence. But actually, there are five important levels of evidence-based decision-making that result in the most helpful allocation of resources to all children:

1) Scientific Actuarial Research on Average Costs and Outcomes

The first level is the obvious one that most policy makers are aware of: the research on evidence-based treatment – children should receive the kind and level of treatment that has been proven to be most effective in meeting clinical needs. This evaluation must be ongoing, as new research indicates innovative approaches.

At this level, it is necessary to adopt research methods that are logically suited to the specificity of the population. Because the diagnosis of autism is so heterogeneous, the best understanding of potential outcomes is from within-subject designs and registries. Guidance for the optimal time limit for the length of therapy can also be identified.

2) Process Research on Service-Delivery Effectiveness and Accessibility

But, the second level is to determine the best service-delivery method for each treatment. Some methods of delivery will be much more effective than will others. Some will be much less costly than others. Some will entail much less risk than others. And some will be much more accessible than other. Some methods will enable flexible transitions along the continuum of services and some will prevent transitions. For example, will the system enable or interfere with coordination with the school districts, as the child is transitioned into their services.

But at this level an important principle, "payment reform," is also investigated. Some models of payment create disincentives for cost-effectiveness. For example, in EIBI, if payment is only made for the direct hours of one-to-one behavior therapy, and not for the behavior assessment, behavior analysis, and clinical supervision, then there is a disincentive to phase out intensity as the child responds. There is also a disincentive to provide low-intensity parent training to less affected children. The reimbursement model may also not accommodate long-distance services in rural areas. Or it may not allow for high-risk services for the dangerous children who become the highest cost children in the future.

Service delivery research also looks at accessibility in terms of the timeliness of treatment access, the continuity of care and the number of providers available for treatment. Are there enough providers recruited and retained in order to deliver care to those who need it? Does the system enable enough clinical supervision to ensure the necessary consistency of treatment in the face of turnover or other environmental challenges?

3) Value-Based Assessment and Certification of Individual Provider Agencies

However, the third level of care determination is based upon a frank realization that some provider agencies are better suited to success with certain forms of treatment than others. And

some have frankly abused the system. Therefore this level of care determination is to identify the most cost-effective provider organizations that are delivering each type of treatment.

For this purpose, it is necessary to establish standards for clearly defined providers with appropriate credentials doing clearly defined therapy.

But the service standards are not enough. The primary goal of this form of evidence is to identify the important outcome measures that can be readily evaluated across providers and then used to develop cost-effectiveness comparisons.

4) Prescriptive Assessment of Individual Children at Intake

A fourth level is to identify the optimal form of treatment, intensity, and service delivery for each individual child at intake – to prescribe this optimal treatment based upon individual measures of prognosis, such as parental involvement, age, and complicating conditions.

For this level it is necessary to require a clearly defined treatment population, and require careful documentation of each child's need and evaluation of benefits, within that population.

5) Prescriptive Assessment of Individual Children's Responsiveness to Treatment

But the maximum value is not received until the fifth level in which care-determination is based upon each individual child's responsiveness to treatment.

For this level, each child should be periodically re-assessed and referred to the optimal treatment as they show individualized patterns of response to treatment, just as every other form of medicine does. Each child will not respond the same way, and present technology does not accurately predict treatment outcomes three years hence. In our ongoing research we have found that a dynamic assessment of a child's response to treatment over time is a much better predictor than is a single static assessment at a single point in time. Therefore, in the case of early intensive home-based intervention, we have found that every six months is a cost-effective time frame for re-evaluating responsiveness to treatment and making differential referrals based upon these assessments.

How would this work to improve cost effectiveness?

To use an example, in one of the original long-term outcome studies, 16 children had been placed into state hospitals, with no hope of recovery from their symptoms, and no hope of acquiring basic language and play skills. To everyone's amazement, the children did make clinically significant progress. But what is less well known is that the study was the first of its kind to identify prognostic indicators of response to treatment. Essentially, the researchers were able to identify a matrix of response to treatment. The study compared older and younger children, in interaction with children who had high parental involvement and low parental involvement. The children who responded best were the younger children, who also had high parental involvement. Such children were then the best candidates for home-based treatment with the plain intention of training the parents to be the children's own therapists.

The other children who did not benefit from parent training were not to be "thrown away," as they had already been by society, but instead they were to be referred to other valuable treatment modalities such as center-based treatment, with other services such as medical management, respite, and social groups.

A further matrix took into account that each child could not be predicted to respond based only on the intake measures. Instead, the child's responsiveness to treatment after each six months formed the basis for further service decisions as they progressed. Some children completed treatment in 18 months, and others in three years. Some were referred to center-based care and others to normal school classrooms.

Subsequent research proved the value of that approach, and found more accurate measures of responsiveness to treatment. When replications of the approach were published in 2005, 2006, and 2007, it became clear that we could maximize the value of our limited health care dollars by focusing on real outcome measures and determining the best services for each child.

You hear that the cost can average \$100,000 in its most intense year. That is true. But what you don't hear is that the state reports that the average cost of ABA, across both high and low needs, is \$35,591 per year. When that is accounted across all children in the state, the cost is \$8 per year.

In contrast, the Harvard study estimated the lifetime cost of an untreated child at \$3.2 million. ABA reduces these costs in half. But, for the sake of argument, even if ABA only saved 10% of these costs, ABA would still save Minnesota \$137.6 million *just for the 430 children being served today*.

Today, the present cost-containment system would incorporate these concepts to determine the best treatment options for each child, and make the best possible referrals, based upon their prognostic indicators. Each child will receive their optimal treatment, and society's resources will be best conserved, if each child can benefit from the earliest possible care determinations. But it is much more than a single decision. What we have learned in this dynamic, 35-year process of treatment development is that there is an ongoing process of behavior assessment, analysis, and clinical decision making that results in the best use of scarce resources.

I and the other ABA providers are eager and willing to consult on the development of detailed outcome measures to be used to implement the above procedures.

Thank you for your attention.

Yours,

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July 16, 2012

Comments on Reform 2020: Pathways to Independence, Section 1115 Waiver Proposal

Thank you for the opportunity to comment on Minnesota’s vision for a more flexible, accountable, and responsive Medicaid program. Courage Center strongly supports the philosophical framework that has guided the formation of these proposals. As Minnesota’s largest independent, nonprofit rehabilitation and resource center, we recognize the need for dramatic – and rapid – changes that are needed to better support Minnesotans of all ages with disabilities and complex medical conditions.

Fiscal Analysis Needed

We recognize the complexity involved in determining the budgetary impact of so many (simultaneously) moving parts. However, we hope that significant time and resources can and will be devoted to determining how the proposed changes will impact expenditures between and among support programs as well as the cost-shifting that occurs both within *and* outside services provided by the Department of Human Services. While we do not yet have integrated funding across the health continuum at the individual or even program level for those with disabilities under the age of 65, we do have expenditure and encounter data that allows for this analysis. The Hennepin Health initiative (outlined on p. 20) allows for this analysis on a smaller scale. Said differently:

“It is important to find ways to make a component part of the system more effective and efficient, but it is equally important to understand how that component fits into the larger system and how actions there have consequences elsewhere. A health care reform strategy that saves money in one sector may actually produce a higher cost in another sector.”

This citation comes from a key recommendation of the Bridging the Health Continuum working group report to the Health Care Access Commission in November 2007 (<http://www.commissions.leg.state.mn.us/lchca/Bridging%20the%20Health%20Care%20Continuum.pdf>). All of the principles contained in this report are reflected in the current proposal:

- keep the client and family at the center of the system;
- Integrate and coordinate services under a single, client-centered plan;

- eliminate gaps in services and make it is easy for clients to make smooth transitions between programs, services and providers; and
- do more upstream prevention to prevent problems from developing or getting worse.

But unless we can accurately assess and evaluate the impact of these proposals, (both financial and human) how will we define success or failure?

Alternative Health Delivery and Purchasing Strategies

A number of exciting and creative changes are occurring to achieve both cost savings and improved health outcomes for the most complex and hard to serve enrollees in the Medicaid program. Thank you for consolidating them in one place.

More incentives are needed for disability service providers – particularly community-based providers who are not associated or affiliated with large, integrated health systems – to continue to serve individuals with disabilities. This is especially true for those with multiple chronic conditions and the dually eligible population. How can we better measure and financially reward the successful outcomes achieved by these organizations when savings accrue to other parts of the health system?

Understanding the patient experience within each of these strategies is just as important as the health and financial outcomes. All three prongs of this “triple aim” should be given equal weight in future policy decisions.

Accountable Care Demonstration(s)

Courage Center has provided extensive comments to DHS on the challenges and opportunities presented by provider-based delivery and financing reform, specifically to the Health Care Delivery Systems (HCDS) demonstration now underway (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_161402). It will be important to understand how DHS will implement the freedom of choice waiver requested on p. 20, and how it relates to the plan to “encourage the utilization of cost-effective care” in 2014.

Robust consumer protections exist in law and within the managed care contracts held by DHS. While we have limited outcomes data on the individual Medicaid managed care products offered by the health plans, we do have processes and procedures in place to ensure health and safety, access to care, and appeal rights, among other protections. As we expand the menu of provider-based delivery options, the same attention to detail must be considered for these emerging systems of care, especially as we look to a future where providers will be assuming higher levels of financial risk.

We must also ensure that these emerging care systems have the competency and capacity to serve complex populations. While traditional disease management programs address

large, high-incidence conditions like asthma, diabetes, and congestive heart failure, there are virtually no evidence-based protocols and defined clinical pathways for the most complex individuals within our health system. To date, DHS has excluded this population from alternatives to fee-for-service – with the Special Needs Basic Care (SNBC) being the notable exception. This must change. We must also foster increased integration of acute-and long-term care services.

The Governor’s Health Reform Task Force, and especially the Care Integration and Payment Reform Work Group, are thoughtfully addressing how we can accelerate the movement away from fee-for-service financing, while avoiding the pitfalls of both cherry-picking and adverse selection (<http://mn.gov/health-reform/images/WG-CIPR-2012-7-11-Recommendations%20DRAFT.pdf>). It is clear from the content of this proposal that an increasing number of conversations across sections and divisions within DHS are occurring. This must continue as the lines continue to blur between medical and non-medical services in our program design and financing.

We must find meaningful ways for the non-medical support service system that people with disabilities rely on to obtain and maintain their health and independence to be measured and valued by the medical service system – as well as financially compensated for the savings that these long-term services and supports generate for other parts of the health care system. Short of full capitation combining medical and long-term care services, we must continue to seek linkages, either contractual or through statute, that increase the collaboration between the medical and non-medical supports this complex population needs.

Dual Eligibles Initiative

Minnesota has long struggled to effectively finance the care of non-elderly duals within the Medicaid program. The failures of risk adjustment and a legitimate evaluation of the Minnesota Disability Health Options (MnDHO) program are well documented. Minnesota also continues to be challenged by the inadequacies of Medicare financing, which threatens the viability of the current SNBC products for the non-elderly disabled, as well as future attempts to participate in Medicare gain sharing opportunities short of full capitation.

There is currently no forum or working group within DHS for interested stakeholders within and outside DHS to have a meaningful or substantive discussion about the *holistic* needs of this complex population. There are working groups that address acute needs, or continuing care needs, but not both. While information sharing occurs to cross these lines, no forums exist to create integrated solutions that span the continuum of care. This is also true for quality and measurement efforts. While we now have a State Quality Council, it only addresses home and community-based services. There is an evaluation group that was established to look at SNBC plans and products, but it has only met once. Subsequent meetings have all been cancelled.

The modest goals of the current duals demonstration regarding the Financial Alignment Demonstration (FAD) have since been abandoned. While there is certainly a benefit to including CMS and Medicare in the contract arrangements DHS holds with health plans, and better integration of mental health services in both the senior and non-elderly disabled populations is laudable, much more aggressive reforms are being pursued elsewhere. Whether in a health plan context or in a provider-based system assuming some level of risk, we must continue to make progress to address new, integrated financing models to benefit the most complex subpopulation in the Medicaid system – and the providers who serve them. Again, the applicable recommendations coming from the Governor’s Health Reform Task Force should be seriously considered

Increased Service and Care Coordination Options

Many individuals in the Medicaid system today have no access to care coordination, case management, or comprehensive care planning due to income or categorical eligibility restrictions. It is exciting to see this as a clear need that is being addressed, especially for those without access to waived services.

A significant number of services exist today in multiple areas of the Medicaid program to assist individuals with their care planning and management of benefits and services. Many more are proposed as a part of this proposal. Some of these existing services have clear statutory definitions and established criteria regarding who can perform the service. In other cases this is not true.

While we understand the desire to allow for multiple and flexible services coordination options, and experimentation to learn what methods work best for defined populations, we strongly encourage DHS to examine the expanding body of medical literature regarding the common elements of care and service coordination that are proving to be effective. Increasingly, the data is pointing toward *complexity of conditions* (or the number of co-occurring chronic conditions) rather than a single *diagnosis* or disability type to determine what approach works best. We also should consider defining these key elements of service or care coordination regardless of purchasing strategy. We should not have one standard for fee-for-service, another for provider-based ACO-type delivery models, and yet another for health-plan based managed care products. Similarly, clear and easily understood regulations, crafted with stakeholder involvement, should define who is eligible to deliver the services. How we pay for the service(s), and how and why we will pay differently for different coordination options, also needs to be addressed.

Finally, all of these services should be able to be simply explained to the Medicaid enrollees (and/or those who are supporting them in the community) who need to make an informed choice regarding their service coordination options. Who can support me? What services will they coordinate? What information is available to me to help with this decision? How do I know who’s good at this and who isn’t? All of these questions should be anticipated and answered upon implementation.

Transforming PCA Services to CFSS

We are strongly support the transition from personal care assistance (PCA) to Community First Services and Supports (CFSS) using the 1915k Community First Choice federal authority.

We support the Department's waiver request to use Minnesota's special eligibility rules that apply to our home and community-based waivers for those who meet the level of care of an institution but would remain in the community and receive CFSS services. We strongly support the proposal to use both the 1915k option and 1915i option in order to continue serving people who do not meet Minnesota's institutional level of care criteria. With Minnesota's pending request to change the definition of nursing facility level of care, it is important to make this service available to those who have substantial impairments in functioning which jeopardize their ability to live independently in the community, but may not meet the more stringent criteria in the LOC that is proposed for the CADI and BI waivers.

We support the inclusion of service coordination for CFSS recipients that is currently unavailable for PCA services. This will allow for an assessment of needs and connection with appropriate services that may be able to treat or alleviate the functional impairment or prevent further deterioration of functional ability, reducing a need for services in the long run. It will also help recipients use their flexible dollars wisely. We have seen clients who are currently receiving PCA but with no case manager/service coordinator struggle to access services in our complex systems. At the same time we urge DHS to provide a better definition of the service coordination that will be provided and a plan for how service coordination will take place if an individual is eligible for service coordination under more than one service category, e.g. behavioral health and home care. (See also other comments on case management/care coordination/service coordination.)

We urge that the definition of dependency in Minnesota's PCA program be changed to include persons who need **prompting and cuing** to accomplish activities of daily living and health-related tasks as the program used to permit. Currently, individuals with brain injuries or mental illnesses have great needs but are not served under the current PCA program, or are served inadequately. The nature of their disabilities creates substantial functional impairments that are addressed with frequent and repeated prompting and cuing to accomplish essential tasks to remain independent in their homes. They do not meet the criteria of needing constant cueing and supervision or hands on physical assistance. We believe the current PCA eligibility criteria are discriminatory because the service is not being offered without regard to the type of disability as required by 1915k. With this more inclusive assessment of needs, clients who have extensive needs for cueing and prompting will receive the amount of services they need to remain in their own homes, rather than moving to more institutional or supported settings. The current practice of allotting the minimum 30 minutes per day for clients who do not meet the stricter criteria regarding ADL's are inadequate and simply increasing that to 90 minutes per day does not address needs on an individualized basis.

We are in strong support of the self-directed option under CFSS with an individualized budget. We urge that the budget administrative cost be carefully determined with input of stakeholders so as to provide the maximum amount to the eligible individual for services.

We strongly support the option of CFSS funding assistive technology and home modification in place of human assistance. Currently individuals with these types of needs must go on a waiver to access that funding, even though this is the only need they may have. This would eliminate the unnecessary administrative burden to access the needed funding and realize cost savings with a reduced need for human assistance. We urge DHS to work with stakeholders to gain a better understanding of how skill acquisition services differ in scope and provider skill level in comparison to hand-on, “doing for” an individual. Assisting someone to gain a skill has a higher level of complexity and staff skill level, with implications for provider standards and training requirements with increased provider costs associated with them.

Supporting Individuals with Mental Illness who are at Risk for Institutionalization Without Access to Integrated Community-Based Systems of Care

Currently, Minnesota Medical Assistance has a psychiatric rehabilitation service, called ARMHS, which has demonstrated effectiveness in reducing the risk hospitalization and institutionalization for individuals with mental illness. However the reimbursement rates for this service are not sustainable to meet the needs of the population. Rates have not been increased since 2008, while costs for providers have increased. Providers have stopped providing the service and other providers have long wait lists due to a reluctance to grow their services with the low reimbursement rates. Courage Center receives some philanthropic support which supplements the service, but does not cover the full cost. Relying on philanthropic support does not ensure a robust system of supports that are needed to further reduce the risks of more costly institutional care.

We thank you for your thoughtful consideration of these comments, and look forward to working with you as we move from the conceptual to operational stage.

John Tschida, vice president, public affairs & research
Cindy Guddal, director, community-based services

July 17, 2012

David Godfrey
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Dear Mr. Godfrey:

Thank you for the opportunity to review and provide comments on the *Reform 2020 Pathways to Independence, Section 1115 Waiver proposal* draft document. We applaud the department for the wide-reaching scope of initiatives and cross-departmental efforts that have gone into the proposed reform of Minnesota's Medical Assistance program.

These comments are submitted on behalf of Medica Health Plan State Public Programs department. Through five different programs administered by Medica's State Public Program department, we meet the health care needs of close to 140,000 Minnesotans. It is our mission to make health care affordable, accessible and a means by which our members improve their health.

Medica Health Plan has a long history of partnership with the Department of Human Services (DHS) and is particularly proud to be one of the three health plans DHS partnered with to develop the Minnesota Senior Health Options (MSHO) program. In 1995, MN was the first state to receive approval from the Health Care Financing Administration to demonstrate integration of Medicaid and Medicare in order to better serve dually eligible seniors. Since then, MN has continued to be a pioneer of innovative integration to meet the needs of dual eligibles.

The federal government, along with many state governments, has expressed interest in new service delivery approaches that address not only medical needs, but also social needs, often times through partnership of community agencies with medical providers. Medica takes pride in the fact that our State Public Programs focus very much on social service needs despite the stereotype that health plans function solely through a medical model. It is noteworthy that we partner with 27 counties to provide care coordination through county social service and/or public health departments in addition to contracting with 14 community agencies and 10 care systems to provide care coordination.

One of the reasons Medica has invested in a multi-disciplinary team approach to care coordination is that we are responsible for managing the Elderly Waiver (EW) benefits for our senior programs in addition to health care services creating an integrated system of services and supports for our members. Health Plans' ability to manage these services is a concern held by many states looking to integrate care of dual eligible's and was a sentiment voiced in the July 11th Medicare Payment Advisory Commission's (Medpac) letter regarding CMS's state demonstrations for programs serving dual eligible's¹.

¹ Medpac 2011. Letter to Centers for Medicare and Medicaid Services regarding CMS's demonstrations with states on integrated care programs for dual-eligible beneficiaries (July).

This is not a concern in MN as currently 97% of EW benefits are managed by health plans which historically having been able to manage EW benefits in a more cost-effective manner when compared to EW benefit recipients who receive their services in the fee-for-service system².

One of Medica's concerns is that several different pieces of the proposal threaten to fragment our existing MSHO care model, such as case management reform and the implementation of direct provider contracting approach to managing care for dual eligibles. Research supports the need for the integration of Medicare, Medicaid state plan funding and EW services to provide a financial base that allows for care coordination across the continuum³. It is the alignment of coordination efforts across primary care, acute care, home and community-based services, and nursing homes, with limited carve-outs that have resulted in MSHO's success.

Medica's involvement in the Preferred Integration Network (PIN) Demonstration is further testament to how Medica is committed to addressing needs above and beyond those identified in a medical model. The PIN is an integrated approach to the delivery of physical and mental health care for adults and children with mental illness or emotional disturbance while assuring coordination with needed social service supports. This demonstration has been successful as it created partnerships between Medica Health Plan, Dakota County Social Service and Medica Behavioral Health to meet the diverse needs of the specific population. We are pleased to know that the success of this demonstration has resulted in the state exploring larger-scale program development based on this model.

We appreciate DHS's ongoing efforts to evolve in the hope of MN continuing to be ranked the #1 state for long-term services and supports⁴ in addition to generally being known as a state that is innovative with health care. It is our opinion that the department's partnership with MN's non-for profit health plans is largely responsible for this success.

However, we do have concern of the department compromising some of the success we have had by pursuing initiatives that impact programs that *are* working well. We ask that DHS take careful stock of what is working well and then focus efforts to change what is *not* working well for all stakeholders including recipients.

Below you will find specific comments we have about the *Reform 2020 Pathways to Independence, Section 1115 Waiver proposal* categorized by Medica's concern and specifics of the proposal that we commend the department for pursuing and of which we are clearly in support.

² Sept., 2011 A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.

www.longtermcorecard.org

³ Malone, Morishita, Paone & Schraeder (2004) Minnesota *Senior Health Options Care Coordination Study*. Final report submitted to the Minnesota Department of Human Services (June).

⁴ DHS 2011. Minnesota Department of Human Services. *Elderly Waiver Fact Sheet (DHS-5357)*, Dec. 2011.

Medica Health Plan Supports:

- DHS's interest in pursuing the Duals Demonstration. Minnesota has been a national leader in efforts towards seamless delivery of care for dual eligible seniors. Medica supports ongoing efforts towards program development for seniors and dually eligible persons with disabilities
- DHS's interest in improving state efforts towards protection of vulnerable adults and DHS's plan, which includes consolidation of the common entry point system and increased training for community-based professionals that interface with vulnerable adults.
- Future planning towards earlier diagnosis of dementia and development of an integrated health and community service model via an Alzheimer's Health Care Home Demonstration. This is an opportune time to invest in program development to meet the needs of Minnesotans suffering with Alzheimer's disease given our demography and pervasiveness of the disease. This initiative dovetails nicely with initiatives described in the Health and Human Service's National Alzheimer's Project Act released this year.
- Medica Health Plan shares DHS's interest in pursuing evidence-based health promotion as making health care a means by which Medica members improve their health is part of our corporate mission. As a health plan, we have much experience in this area and welcome future opportunities towards collaboration to this end.
- The creation of the Community First Services and Supports (CFSS) Implementation Council. Replacing the existing Personal Care Assistance program with a new program in 17 months is a big undertaking that has the potential to greatly impact many Medica State Public Program Members. We support thoughtful implementation and request the opportunity to be part of this council.

Medica Health Plan Concerns:

- Concern that there is not more focus on further development of the MCO model in the proposal or recognition of the years of innovation that health plan have partnered with DHS to achieve. It is unclear how many of the initiatives listed will impact managed care's role in state public programs.
- The absence of budget/financing information for the proposal is concerning and prevents stakeholders from being able to provide adequate feedback related to fiscal success or caution of failure for proposed changes.
- Concern of DHS requesting a waiver from freedom of choice of providers for future ACO-like developed models. Health plans have been able to demonstrate effective coordination of care while maintaining freedom of choice. Concern of violating program participant's right to choose and DHS moving away from a person-centered delivery system towards a provider-centered delivery system.

- The stratification of populations that will be eligible for the Community First Services and Supports (CFSS), that will be created similar to 1915 (i), 1915(k) and 1915 (j) options is very confusing. A consistent criticism of MN's MA program is the complexity which leads to inequitable and inconsistent services being authorized. It is hard to see how the proposed changes are more simplistic than what we have now. Would it make better sense to transition populations into the new service category instead of overhauling everything at the same time?
- Concern about plan to "*Take case management out of waiver services and creating targeted case management*" as this has implications to health plans managing EW and our Medicare Advantage Special Needs Plan requirements. Since 93% of all EW participants are managed by health plans, we request that DHS collaborate with MCOs on planning for this including having representation at workgroups addressing this topic and consider not including EW in this initiative if pursued.

Again, Medica Health Plan thanks you for this opportunity to provide comments to this important proposal.

Sincerely,

Julie C. Faulhaber
Senior Director, State Public Programs

Comment on DHS Reform 2020

Thank you for the opportunity to comment on this important reform effort.

Lifeworks applauds the Department of Human Services for the work that has done on the Reform 2020 plan, creating a system to promote better outcomes, self direction, and the sustainability of services for people with disabilities and individuals with support needs.

Minnesota has a long history of promoting person-centered services, and it is our hope that the voices of both individuals with disabilities and individuals with support needs are heard as you design and implement the changes proposed in the reform plan.

A key component of the person-centered philosophy is choice. There are several aspects of the reform plan that have the potential to limit choice. Changing from the current FSE model to the FME model is one of the areas of concern. We support this reform limiting providers who can meet certain qualifications. We feel not only quality of services to the individuals are important, but also providers who can follow through on the regulatory policies and procedures of programs. However, on page 39 it states "allow individuals a choice between at least two entities regardless of where they live in the state". Two is not enough to provide choice, if one does not work for the individual, they will then only have one to choose from – one is not a choice. Currently Minnesota has 15 FSEs, many who have developed sophisticated systems for this service and have developed relationships with individuals and families. If current providers are able to meet the new requirements to be a FME they should be allowed to do so. In addition with the RFP process for the FME agencies, previous contractors of the State that would have undue influence on the process should be excluded.

Individuals should also be allowed choice when it comes to support coordinators. Throughout the reform proposal, we support the comments made regarding a need for less complexity and simplified coordination of services which allows individuals to receive efficient and quality services. Although many things are mentioned in a very broad view, we want to voice support over allowing providers to provide a variety of services for individuals, if elected. As a provider, we feel it is important for competition in the market which drives providers to provide innovative and quality services. It forces providers to constantly raise the status quo. We would like to ask the state to not limit choice. For example, currently there is a limitation that a provider cannot provide support planning services and fiscal support services to the same individual. We understand how this can be viewed as a financial conflict; however, it can also be viewed as better quality and coordination of services and does reduce the costs of administrative fees. Previous to this limitation, we provided a level of support planning / coordination as part of our flat fees for fiscal services. Of course, an individual could always elect to keep planning and fiscal services separate, but limiting this choice adds a level of complexity for the individual and increased cost.

To ensure sustainability of services, please design the services so that individuals are able to share services if they chose. For example, if one individual is on CDCS and another is on CFSS, they should have the choice to share staff and split the cost, allowing them to stretch their dollars. This is currently allowed in the PCA program with shared care rates, but other self directed programs are individual services and do not have provisions for shared services. Individuals should be able to share services within the same program and across programs.

With the outcomes that are promoted in the reform plan, there is a need for accessible transportation. For many individuals transportation is the barrier to employment and a meaningful role in the community. Transportation needs to be part of each service.

It is great to see the work on the common service menu as a part of the reform plan. Minnesota has been working on this for many years and it is needed. We have a very complicated system where depending on what funding source the individual has, they may or may not have access to a needed service. Also there are similar services in the different waivers with different provider requirements which adds to the complexity of the system. Often, when you have complexity you have increased costs. Some examples of services that should be streamlined and expanded to other disabilities are:

ILS Therapies – this is currently only a service for the BI waiver. Music therapy is a service that can be purchased with ILS therapies and can be a valuable service for individuals with learning needs, behavioral support needs, and autism. This service should be expanded to the other waivers.

Day Services (DTH, Adult Day, etc.) – currently individuals on the CADI and BI waiver are not able to purchase DTH service and either need to purchase pre-vocational even though they may not be able to work or the provider needs to be licensed as an Adult Day provider. There are many similarities between DTH and Adult Day, an individual should be able to purchase this service regardless of their funding and the service should not add unnecessary complexity for providers.

Personal supports – is currently an option for individuals on the DD waiver only, it should be expanded to the other waivers.

There is also a need for caregiver supports, especially respite. With more individuals living at home the need for respite has increased, especially for families of children with high medical needs or behavioral support needs. Camps and other options for respite need to be available.

Again, thank you for the opportunity to comment on this important and needed reform effort.

Lifeworks Services

July 16, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

**RE: Comments on MA Reform 2020 – Section 1115 Waiver Proposal
Housing Stabilization Services**

Dear Mr. Godfrey:

Thank you for allowing us the opportunity to offer comments in response to the Department of Human Services Medical Assistance (MA) Reform 2020 proposal, a Section 1115 waiver proposal to amend the State Medical Assistance Plan. Hearth Connection wishes to recognize DHS staff for their hard work in preparing this waiver proposal. Your DHS team members have been excellent in offering ample opportunity for public education and input and have shown a collaborative spirit in drafting this proposal. Hearth Connection wishes to offer its strong support for Section 6.2 on Housing Stabilization Services. Specifically, we wish to recognize the significant steps DHS is taking in the Reform 2020 Waiver Proposal to integrate health care services with community-based supportive housing to achieve positive outcomes in healthy recovery, improved health well-being and housing stability for persons experiencing homelessness.

I write on behalf of Hearth Connection, an innovative, data-driven nonprofit organization dedicated to ending long-term homelessness in Minnesota. As a statewide intermediary, Hearth Connection is the administrator for the Long-Term Homeless Supportive Services Fund in three regional service collaboratives. We support a network of 28 supportive housing programs in 34 Minnesota counties. Annually we serve over 1,300 individuals and distribute over \$9 million in funding for intensive support services and rental assistance. Our outcomes include empowering participants to secure housing, stay housed successfully, and improve their health, income and functioning.

Hearth Connection is committed to data collection, analysis, research, and evidence-based programmatic practices. Hearth Connection's past research, supported by the Robert Wood Johnson Foundation and The Saint Paul Foundation, helped establish supportive housing as a key component of our state's systemic approach to ending long-term homelessness. Hearth Connection's research findings documented the impact of supportive housing on housing stability, health and well-being for people with long histories of homelessness, as well as the positive effects of using scarce government resources more wisely. Our research documented and drove best practices among Minnesota nonprofit organizations serving households experiencing long-term homelessness.

General approach and background

Hearth Connection is interested in Medical Assistance for three primary reasons:

- (1) Under the Affordable Care Act, most homeless persons are Medicaid eligible based solely on their low income status;
- (2) Many homeless persons have complex physical and behavioral health conditions for which they seek care through frequent utilization of emergency medical care services (emergency rooms) and inpatient hospitalization at a significant cost to public resources; and
- (3) Capitalizing on Medical Assistance resources will be necessary to deliver adequate levels of supportive services to achieve housing stability and health recovery and to end long-term homelessness in Minnesota.

Supportive Housing (community-based affordable housing coupled with intensive support services) is an evidence-based intervention offering homeless participants access to housing and social services, including individualized goal planning and care coordination as well as enrollment in Medical Assistance and other public programs whenever possible. By combining intensive case management and housing with medical care and a primary care physician, program participants are able to achieve stability in their lives and accomplish goals related to mental, physical and chemical health as well as income and social connectedness.

Under Hearth Connection's service model, intensive case managers work with each participant to build trust and develop an individualized Community-Based Care Plan. Staff members have the professional skills to identify the participant's problems and needs as well as strengths and resources. Goals are determined by each participant. Plans include measurable goals so that participants and staff can assess progress. Care plans are updated a minimum of every six months and include crisis plans when necessary. Many plans begin with meeting immediate food, clothing, medical or shelter needs and progress to include health and wellness recovery goals.

The service model is predicated on community-based recovery; therefore, care plans take into account community-based resources that can support and foster participants' health recovery and social inclusion. Service teams are assembled so that primary providers and other community based supports work together to coordinate participant support.

Our service approach is designed specifically for people who have experienced long-term homelessness. Some essential components of this service approach include intensive case management services, harm reduction approaches, a housing first philosophy, and collaborative, mobile service teams.

Hearth Connection posits that integrating health care services and coordination with supportive housing in community-based settings will benefit Minnesota by enabling the state to better serve persons with disabilities and meet obligations under the Americans with Disabilities Act

(ADA) and the Olmstead decision. Evidence has shown that people served in the community helps to lower Medicaid costs and leads to more positive outcomes for participants.

Hearth Connection has some experience in accessing Medical Assistance resources to offer supportive services to homeless participants. Currently, Hearth Connection accesses MA-Targeted Case Management resources to cover some services delivered to participants residing in supportive housing. Medical Assistance (MA) plays a critical role in financing services and supports for many individuals needing permanent supportive housing (PSH). However, because of the complexity of the MA program, supportive housing providers and local and state government agencies are not always able to access these resources efficiently. Adding to the complexity, recent federal legislation and regulations continue to change the program. Further, Hearth Connection recognizes that even where Medicaid is used to pay for services in supportive housing, it remains just one piece in the patchwork of funding. Services in supportive housing are typically funded through an array of sources such as the State's Long-Term Homeless Supportive Services Fund, HUD's Supportive Housing Program, or local county contracts for behavioral health services. Most supportive housing providers recognize that MA funding only covers a minority fraction of the cost of delivering intensive supportive services to participants.

For the past few years, Hearth Connection and our allies in the supportive housing community have been exploring opportunities to better integrate health care services and health care systems with community-based supportive housing models. Part of this work is strengthening the nexus between MA and services needed in supportive housing. Safe and stable housing is a social determinant of health and health recovery. The research studies mentioned in the Waiver Proposal show improvement in well-being of people who are housed, along with a reduction in the use of expensive crisis emergency care and hospitals.

Hearth Connection's own research mirrors these findings. From 2000 to 2006, The Robert Wood Johnson Foundation funded an extensive study of Hearth Connection's service model, which combined service funding from the State of Minnesota with housing dollars from both federal (HUD) and state programs for people dealing with issues of long-term homelessness. The study specifically examined the impact of the supportive housing program on *participant outcomes and public costs*.

Of the 748 people in the Pilot, researchers looked at data for 518 participants, which included single adults, families and unaccompanied youth from both urban and rural areas of Minnesota. The comparison group consisted of 20,000 other Minnesotans who had indicators of homelessness in their data, 518 of which looked like the Pilot participants in their demographics and use of services. The cost study differed from previous studies in two respects. First, the breadth of services covered is larger than in many other studies. Similar studies have often tracked only a few services, such as emergency room visits and detox stays. In contrast, this study aggregated extensive data on state-funded medical and behavioral health care with criminal justice and child welfare data.

Through the collaborative effort of a third party researcher (National Center for Family Homelessness) and stakeholders at local, county and state levels, the Pilot study was released in March of 2009. Generally, the results suggested a desirable move away from costly, repetitive, and disruptive institutional services and towards necessary routine health care that improves quality of life.

Single Adults

- Use of routine outpatient mental health care and pharmaceuticals increased relative to the comparison group.
- Inpatient mental health care showed a decline, though the difference was not statically significant.
- Use and cost of emergency detox services were lower for Pilot participants.
- Prison costs for the comparison group increased while Pilot participants saw a marked decline in those costs.

Families

- Families saw decreases in use of inpatient medical care.
- Families did not experience the increase in the use of pharmaceuticals that the single adults utilized.
- The cost for outpatient mental health services increased for the Pilot families.

More extensive information on this Pilot study can be found on our website at www.hearthconnection.org.

Given what we know from research, our goal is to better align MA resources to cover a specific benefit set to offer housing stabilization services to persons experiencing homelessness (who are also disabled or experiencing chronic illnesses). Supportive housing providers have been meeting regularly with DHS staff to define these services.

COMMENTS

Hearth Connection's comments are directed to Section 6.2: the Housing Stability Services Demonstration. We appreciate the work DHS has completed in engaging and receiving input from the State's network of supportive housing programs to define this proposal. We look forward to continuing our work with DHS as the Section 1115 Waiver Proposal is refined, adopted and implemented. The following are our specific comments:

1. Hearth Connection supports the current, modified proposal regarding Housing Stabilization Services.

It is our understanding that based upon public comments already received by DHS, that Section 6.2 (Housing Stabilization Services) has been amended to include a larger array of supportive services that would be eligible for MA reimbursement. The array of services includes: outreach/in-reach, tenancy supports, service coordination, and community living assistance.

We especially appreciate the inclusion of community living assistance. It has been our experience that case managers for participants in supportive housing spend a considerable amount of time in bolstering independent living skills and assisting participants in health recovery and health care coordination. The average Hearth Connection supportive housing participant has over seven (7) years of continuous homelessness and either a mental health disability or chemical/alcohol addiction. While tenancy support and service coordination is a portion of the activities accomplished between case managers and participants, many of participants require a great deal of assistance in improving their independent living skills and navigating interpersonal relationships. Recognizing and planning for services to improve the overall well-being of the individual not only improves our ability to achieve housing stability but leads to better health outcomes as well. Allowing case managers to deliver supportive services that improve individual functioning in a community-based setting not only assists with health recovery but can be accomplished at a lower cost to the State.

2. Hearth Connection supports the current definition of eligible participants.

We believe that, in general, the definition of Target Population (p. 61 ff.) is appropriate. The Proposal as originally drafted was only extended to persons receiving Group Residential Housing (Rate II) services. The original proposal did not address the needs of the broader homeless population. Persons experiencing long-term homelessness are often burdened by mental health or chemical/alcohol addiction and have difficulty navigating the Social Security Administration's eligibility process for income support. Many of the homeless participants found in outdoor encampments or emergency shelters are only receiving General Assistance. Limiting the population to those persons receiving GRH services would be too restrictive and miss some of the most vulnerable 'street-dependent' populations.

Since the Waiver Proposal has been out for comment, however, we understand that DHS has considered significant modification to this section. We support the modifications now under consideration to include persons who are homeless, receiving General Assistance and are frequent users of high-cost medical services. This modification puts the Waiver Proposal directly in sync with the purposes of supportive housing.

Also, Hearth Connection believes the inclusion of people now in supportive housing is especially important (these people will return to homelessness without services now being provided).

Hearth Connection's only hesitation is the proposal's restriction of population eligibility to adults (ages 18 and over). Hearth Connection serves all persons experiencing long-term homelessness including unaccompanied homeless youth. Under State law, unaccompanied homeless youth (minors) are eligible to receive MA. Minnesota's homeless youth population is one of the state's fastest growing homeless subpopulations with a minority of youth having histories of long-term homelessness. Homeless youth are particularly vulnerable to physical assault, trauma, and sexual exploitation in street environments and have disproportionate rates of morbidity, mental health disabilities, and chronic illnesses (including HIV) when compared to

their housed peers. While we recognize the need to limit the population to contain costs, we would argue that the addition of eligible unaccompanied homeless youth (minors) would not significantly add to the demonstrations cost while it would make significant life-long positive changes for the youth served.

3. Hearth Connection believes this proposal adequately addresses the State goal of being 'cost neutral.'

Hearth Connection understands that any waiver proposal to the State's MA Plan must be cost neutral. DHS is aware that permanent supportive housing is a nationally recognized evidence-based model evincing positive outcomes in lowering unnecessary health care utilization and improved health outcomes for participants. Several studies have been conducted in the past two decades, including a multi-year evaluation pilot by Hearth Connection.

Supportive services delivered within community-based housing models have been proven to accomplish housing stability, improve individual functioning and reduce public costs – money now being spent for emergency and inpatient hospital care, jail, prison, shelter, detox and child welfare services. We wish to highlight the research noted on page 65 of the MA Reform 2020 Section 1115 Waiver Proposal in offering evidence of these assertions.

We understand the importance of maintaining cost neutrality in the overall Reform 2020 proposal. And we understand this proposal must either limit the population or the services available. We support the conclusion by DHS to limit the population and not the specific benefit set of services. Supportive Housing providers maintain that flexibility in designing and delivering services to participants will benefit this demonstration pilot in achieving lower costs and better outcomes.

Finally, we recognize that it is necessary to balance the rate structure with the number of households to be served in order to maintain cost neutrality. We strongly favor maintaining a rate structure that will allow providers to provide necessary services, even if it means reducing the number of Minnesotans who can be served under the Waiver. If rates decline to a point where providers cannot provide adequate services, people will not be able to maintain housing and the Waiver will be pointless.

4. Hearth Connection suggests flexibility in completing functional assessments by trained 'certified screen administrators.'

Under the current proposal, eligibility for housing stabilization services would be determined by a functional assessment administered by a trained certified screen administrator. Hearth Connection understands the importance of having an objective screening tool and mechanism to determine eligibility. However, most disability/functional screening tools are designed to be delivered in a clinical setting (an office or clinic). Many of our participants sleep outside in

encampments, in abandoned buildings or sometimes under bridges or in caves. Some homeless persons are distrustful of public systems and will not readily enter a clinic or office building.

Whatever mechanism or tool is developed, it should be flexible enough to be delivered in a variety of environments, including outdoor areas. Additionally, the trained certified screen administrators should include outreach workers and drop-in center case managers whose experience approaching and building trust with homeless persons will be critical to administering the assessment.

Hearth Connection does support the eventual integration of this functional assessment with the MNChoices Comprehensive Assessment tool if this tool can be delivered through hand held devices in a variety of settings by mobile teams.

Finally, we applaud the recognition that eligible service providers of housing stabilization services include “certified peer specialists.” (page 61)

5. Hearth Connection suggests more opportunities for coordination and involvement with housing stabilization services by accountable care organizations or health plans.

Given our work in the last few years to integrate health care systems with supportive housing, Hearth Connection has come to an appreciation of the role played by Minnesota’s Health Plans in coordinating services and incubating innovations to reduce costs. It is clear that the current proposal envisions a relationship between DHS and community-based nonprofit organizations offering supportive housing. What is not clear is how this demonstration will interface with accountable care organizations (ACO) or the Health Plans. Hearth Connection recognizes that Health Plans often enter into contractual agreements with community organizations to delivery case management services to persons experiencing mental health disabilities or chemical/alcohol addiction (including persons experiencing homelessness). Given their existing role in providing behavioral health services to homeless Minnesotans, we simply question whether the current proposal envisions the involvement or participant by Health Plans or ACOs.

Thank you again for granting us an opportunity to submit these comments. We remain enthusiastic about the proposal and appreciate the recognition that housing stabilization services are a key to better health outcomes and a potential state resources saver. We look forward to working with DHS to advance the goals of the MA Reform 2020 proposal.

Sincerely,



Richard A. Hooks Wayman
Executive Director, Hearth Connection

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

July 17, 2012

Dear Mr. Godfrey,

On behalf of Community Involvement Programs, I am submitting these comments on the draft of **Reforms 2020: Pathways to Independence**. Our organization has been providing community-based services since 1971. Because we support both people with developmental disabilities and people living with a serious mental illness, we believe we have a unique and broad perspective on Medicaid services in Minnesota. We appreciate the significant effort put forth by the Department in compiling and proposing a wide array of changes and improvements to the supports and services of the Medical Assistance program. We know first-hand that these services provide essential help to many of our most vulnerable citizens so that they can live meaningful and productive lives in their communities. And, while we support many of the proposals in the draft, we do have some serious concerns certain parts of the plan.

Community First Services and Supports (CFSS)

First, with respect to the proposals that will impact people with developmental disabilities, the proposal to reform Personal Care Assistance and CDCS to a new service, Community First Services and Supports (CFSS) is broad and will impact well over 20,000 people in Minnesota with disabilities. We applaud the effort to include persons who will no longer be eligible under the institutional level of care criteria.

While we are not a PCA provider, the proposal includes a plan to combine the current PCA program and the CDCS programs and to replace the FSE agencies under a new model called a Fiscal Management Entity (FME). I would be remiss not to disclose that Community Involvement Programs started as a Fiscal Intermediary - Employer of Record (FIER) and then transitioned to a Fiscal Support Entity (FSE). We currently support about 350 families and individuals as an FSE. We feel we have extensive experience and insight in working with the families and individuals who have participated in the CDCS program.

Included in the Reform 2020 proposal is the plan to take the current 15 FSE's and hundreds of PCA providers and to administer the program through as few as two to four Fiscal Management Entities. However we question such a need to reduce the number of FME providers. We believe by reducing the number of FME's to such a small number, access and choice for families and participants will be seriously restricted. The lack of competition would also force costs to rise in the long run. If the state plans to add over 20,000 individuals to the CFSS model, we believe the state and the people with disabilities and their families would be better served by having more FME's, not fewer.

Behavioral and Mental Health Services

There are a number of initiatives included in the draft of the Reform 2020 that propose to address the services to people who are challenged with a mental illness. With respect to the services that are proposed for persons with a serious mental illness, we have a number of comments.

Access to Medicaid funding for this population is critical in the long run for a sustainable, robust set of services to support people in the community. The recent proposal to change the Level of Care Criteria will force many people with a mental illness out of the current array of Medicaid and Home and Community-based Waiver options. We believe it is imperative that the Department continue to explore options under the 1915(i) that will allow these services to be developed for these individuals.

We also have not seen the most recent version of the MnCHOICES assessment tool. We understand that it is currently being “beta tested” for reliability and validity. We also understand from NAMI that while there have been some improvements when it comes to assessing people with a mental illness, but there is still work to be done to assure that the tool is adequate to determine the needs and services that a person with a mental illness may require. We would urge the Department to open up that development process so that the mental health community can give recommendations on how the tool could be improved and to avoid previous problems of persons with a mental illness being incorrectly screened and assessed.

Housing Stability Services Demonstration

We support your proposal with respect to the Housing Stability Services. Community Involvement Programs has been a leader in providing supportive housing to adults with a mental illness for almost 20 years and have participated in the Housing First and Ending Long-Term Homelessness efforts in Hennepin County. We have found that supportive housing is a cost effective approach to assure that persons with a mental illness can remain in the community and avoid costly hospital stays.

Again, we appreciate the opportunity to comment on some of the proposals that have been put forth by the Department. We know that the staff at DHS has put a tremendous amount of time and resources to put this proposal together. We hope you will consider our feedback based on our years of experience and insight in these areas.

Sincerely,

John T. Everett

Executive Director

Dooley, Lea M (DHS)

From: Cara Benson <carabenson@cfcaccra.org>
Sent: Monday, July 16, 2012 5:11 PM
To: *DHS_Reform2020Comments
Subject: Comments from

To Whom It May Concern:

I am glad to see Minnesota move toward a more consumer directed model of service. There have been many groups that have worked on this type of service for many years. After attending several sessions on the 2020 Reform, I am specifically commenting & asking questions on the CFSS services.

- 1) Please clarify/expand on the "Agency Option" under CFSS. Does it look like Agency With Choice-as it exists under CDCS now?
- 2) Define "Self-Directed." Currently some states mandate certain ways of self-directing, which may not be a good fit for all recipients.
- 3) Minnesota has a history with CDCS that affords recipients the choice of 15 different CDCS providers. It has been proposed the 2-4 agencies will provide the FME services. I urge the Department to consider more than 4. This will give recipients more options based on technology, customer service, and ability to respond to needs/questions. It will offer more consumer choice!!
- 4) Can the FME also provide the Case Management function?
- 5) How does Managed Care fit into CFSS? Will MC recipients that have PCA now stay with the MCO and have their services through the FME or Agency, as they choose?
- 6) If the recipient chooses the "Agency" route, will the Agency have their own Service Authorization to bill off of?
- 7) Will the FME have the authority to approve the plan (as opposed to the County approving the plan?) If the recipient choose the Agency route, does the Agency have the authority to approve the plan?
- 8) Are there services outside the FME that the recipient can purchase? If so, what might those be?
- 9) Can the recipient on CFSS choose to purchase "Waivered" services such as: In-Home Family Support, Respite, Personal Support? Can this be purchased from any agency currently providing that service?
- 10) It seems like CFSS effects PCA Traditional, PCA Choice, CDCS, and CSG in that these recipients would go to the FME, unless they choose the agency option. Please indicate if that is correct.

Thank you in advance for your attention to this response. I look forward to seeing how Reform 2020 is implemented in the next several months and years.

Cara Benson | Program Director |Voice: (952) 935-3515 | Fax: (952) 935-7112

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ACCRA HOME HEALTH, INC
CHOICES FOR CHILDREN, INC
ACCRA HOME CARE, INC

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Dooley, Lea M (DHS)

From: Shelly Elkington <shelly@avenuesforcare.net>
Sent: Monday, July 16, 2012 4:15 PM
To: *DHS_Reform2020Comments
Subject: Comments from
Attachments: QUESTIONS REGARDING 1115.docx

Attached is questions for public comment regarding the 115 proposal and it's impact on the PCA program.

Thank you for the opportunity to comment and I appreciate being heard.
Please do not hesitate to call with any questions, comments or concerns.

--

Shelly Elkington
Avenues for Care, Inc.
101 So. 1st St. Suite 200
Montevideo, MN 56265
320-269-2929
320-269-2278 fax

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QUESTIONS REGARDING 1115 AND THE IMPACT ON PCA AGENCIES:

What happens to recipients currently using PCA Choice and PCA Traditional as far as the transition? Will PCA agencies be informed of the letters being sent out. We are the point of contact for our clients; they will call here if given any information regarding the PCA program.

Who monitors “self-directed” program? Is there supervision still required? Who keeps the supervision documentation? Who is subject to audit for that documentation, the client? Who is responsible for fraud compliance and who pays back any dollars not spent in accordance with the program? We find that the more supervision, the less opportunity for fraud. Chippewa County has one client on CDCS now and neighboring county only has 5 recipients on CDCS. This is not a plan of choice for counties concerned with fraud.

Who does the assessment? PHN’s? Since more persons with significant medical issues are going to access the program, and will non medical personnel assess for medical needs?

“Annual review of the budget” is stated in the proposal. Is this is only oversight of dollars and services? What happens when recipients use all of their funds and are left vulnerable or without services for the remainder of the year? This is why flex use was put into place to protect recipients from this.

“Direct and manage”. Who determines if someone is capable of that? We will often get persons coming through as PCA Choice with are unfamiliar and unaware of those responsibilities, they often find that too daunting. This would be even more complex as far as management.

Since CDCS was already exempt from the relative rate cut, how does this work now when there will be a good percentage of relatives accessing money from this program? Won’t more recipients move to this program and place the same financial burden on it as the PCA program? Wouldn’t people who are attempting to commit fraud be eager to use this program as opposed to the current plan that has supervision and accountability?

What happens to PCA providers? Do PCA agencies become CFSS providers, and will there be plenty of time and information to go through that process? If they are eliminated, then who is the contact person for the assessor, and the recipient? Does eliminating most of the PCA agencies and having only a few handle all the PCA/CFSS simply create a very large profit for a few people? The potential for profit increases with volume of clients, this would put a large amount of money in some agencies, and can eliminate the choice for recipients who are happy with their agency and the attention they receive.

Page 38 of the proposal states: “The individual would have the option of handling administrative functions such as financial management of payroll taxes and insurance, or would have the option to choose to arrange for services”. How can that work if they choose to try it? This is a complex system at times, and can be cumbersome to manage. Again, where does DHS come to when fraud is committed and they want fund recoupment? What happens if a client with good intentions tries to do financial management and fails to pay payroll taxes and they are subject to fines and liens by the government for non payment of taxes? Do they get a tax ID number? If they choose a financial management entity,

who communicates with the client regarding timesheets, and payroll? Does this entity do case management as well? Who manages staffing issues, hiring process, required paperwork, insurance, background checks? Who has the liability for workers comp, bond, liability, and unemployment?

Will this cause a significant increase in workload to county case workers? Will they be doing “case management” and having to micro manage clients? That’s what PCA agencies do now. County case workers seem very short staffed and out of budget for what they currently have. What will the financial benefit be to the state in giving more dollars to counties for this? Currently case workers are given only minimum case management dollars on CDCS, families would have to “budget” for this and most do not.

What is the estimated number of recipients that could be affected by this and the number of PCA’s? What is the overall financial benefit (especially since there is no relative rate cut) given the rates, the potential for fraud, the supervision, increase admin staff to counties, reimbursement to financial support agency?

School social workers, school nurses and guidance counselors managing the cares of disabled children seems like more of a burden being put on already fiscally strapped schools. The proposal says this will require case management by these folks year round and they will coordinate all the community cares outside of the school. This is proposing that guidance counselors with no medical training are able to find resources in a community, determine the needs, and manage them? Isn’t that what a county case worker does? Are not they busy enough? Here, we have two school nurses for 4 schools, she does not spend the day in one building, she does not work the summer, and will the schools have to budget for this significant increase? How much financial responsibility would shift to the schools to do case management and oversee all the services?

Who manages the cares of clients with complex medical needs? This now requires RN supervision for good reason. These clients are medically very vulnerable and a trained person will know when to seek out additional resources.

Goals listed on page 37:

Maintain independence / Direct and manage own cares. The current PCA program currently allows for clients to remain at home much longer than they would without it. They are able to select their own PCA’s, work with the agency in training needs and care plan development. Our RN visits all recipients to assure that these recipients are not being taken advantage of and that the cares are being provided. The flexibility of the PCA program covers health needs, behavioral, and housekeeping. This is often a “one stop shop” for case workers whose clients need a variety of small services. This is a goal currently being met by the PCA program. Our recipients live very busy, complex lives when living with and managing the needs of a disabled person. Asking them to take on more responsibility and take away us as a direct resource will simply overwhelm many of them.

CFCO. Financially what is the savings to the state and is the purpose of revamping the entire program to access federal dollars? With the increase potential for fraud, are those costs being built into the costs?

Power point slide 11. If assessed by a PHN for services as they are currently, will all purchased services need to come from that one assessment? Currently, if they are assessed for 7 hours a day of PCA, they get 7 hours a day, but if they go on a waiver they are cut down to 2 or 3 so the case worker can fit in other services and supplies. Will this be the case now for everyone and if so, will recipients be informed of this beforehand?

I was unsure about the proposals reference to the diagnosis of Autism and being “medically necessary”. I’m questioning whether the intent is to not serve anyone diagnosed with Autism. ADA would need to know this as soon as possible so other programs could be put in place for this.

The disabled and elderly always seem to be the experiment group for new programs and it can often come at their expense. Those that are most impacted by this significant change are Minnesota’s most vulnerable citizens. Outstate Minnesota has limited resources, but this is one way we are keeping our citizens at home and out in the community by using the most cost efficient program that Minnesota offers. There has been a strong push by DHS to reduce fraud in the PCA program in the last couple of years, and it seems like the proposal does not address these on a significant level. I am urging decision makers to put much more thought into these proposed changes and address the concerns brought forward by agencies, case workers and school districts. A goal date of 2014 seems nearly impractical for revamping one of the largest programs used to keep the elderly and disabled independent and safe.

Shelly Elkington

Dooley, Lea M (DHS)

From: Bessler Daryl <dbessler@co.hubbard.mn.us>
Sent: Monday, July 16, 2012 2:36 PM
To: *DHS_Reform2020Comments
Subject: Comments from

Mr. Godfrey:

Thank you for the opportunity to provide input regarding the Reform 2020, Section 1115 Waiver Proposal. I want to compliment the Department for the substantial effort that you have put forth in creating this proposal. The proposal is extremely expansive/ambitious in nature, possibly too much so, but is clearly attempting to address some of the gaps of current waivers.

Your focus on right service at the right time is spot on. The portion dealing with ASD is also very needed and timely. The idea of integrating or collaborating around the health care and education needs of these children is encouraging. The medical and educational communities need to be plowing the same direction not against one another.

Your proposal in section 9.1 to assist those with complex needs but aren't at risk of institutionalization is totally on track. Sometimes providing a little help on the front end can avoid more expensive solutions longer term.

In general this is a very good proposal and I commend you for the work the Department has put forth. While it is a very comprehensive and thoughtful proposal I'm a bit concerned how the Federal government and even State government can continue to spend more dollars when the Federal government for all intent and purposes, is bankrupt.

Daryl Bessler, Director

Hubbard County Social Services
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To: Reform 2020, Pathways to Independence, Section 1115 waiver proposal committee

From: Minnesota State Council on Disability
Joan Willshire Executive Director

Date: June 21, 2012

Re: Comments on Reform 2020, Section 1115 waiver proposal

The Minnesota State Council on Disability (MSCOD) is a state agency statutorily mandated to advise the Governor, state legislature, state agencies and the public regarding disability issues. MSCOD would like to make comment on the Reform 2020, section 1115 waiver proposal.

We realize that sustainability of the Medicaid program has become a major concern and that this opportunity to make State level reforms creates an excellent window for promoting policies that encourage efficiency, effectiveness and inclusiveness. We support the guiding logic behind the waiver proposal that change is necessary and would like to emphasize on the following points.

In a major system overhaul such as this, it is not uncommon for the focus to shift from the intended recipients towards more systematic elements of policy creation/reform. We commend the committee's emphasis on individuals and their choices so far and urge that it continues to be a primary focus throughout this process. We know that this will be a challenge but it is what will make this whole reform a success for everyone.

We are very pleased with the changes in procedural support mechanisms and outcome expectations of the CFSS in comparison to that of the PCA. One of the complaints we hear in the disability community is the issue of PCA hours being reduced. The need for PCA hours will only increase as we all age. We applaud the CFSS's general flexibility and how it is tailored around individual choices/needs. Simplification of this system is long over due and is welcomed. Being able to employ and manage their own direct care is a huge step towards true independence. How this Implementation council works is vital and transparency will be needed for it to succeed. We want to again emphasize that through out this process to keep the person in mind at all times.

We are pleased that the reform policy emphasis on strengthening community support programs in the community. Establishing strong community support systems capable of accommodating the needs/preferences of individuals is a prerequisite to their transition from institutions into the community. We are glad to see that for those individuals that do not meet an institutional level of care will

be able to still access those services under another option. Seeking innovative approaches to service coordination with select school districts is a great way to try to do something's differently while working within a current system. Having a single coordinated plan that works across systems, across all disabilities, and to be able to live in the community of your choice, will contribute to better outcomes for the individual with a disability.

Over all we see a plan here that is introducing prevention, elimination of duplication of services, creativity in service development, focuses on employment as a part of ones life's goal, creating housing stabilization is a must, strengthening community supports, which will finally put the person with a disability in the driver seat again to be in control. People will need lots of education and training as this new system unveils.

MSCOD sees the biggest challenge for this waiver proposal will be the communication of the various sections of this waiver. MSCOD has always been a partner with the dept. Human Services and would like to offer to assist in the accessible communication of information regarding the waiver proposal and further developments to the public.

Thank you for the opportunity to pass on our thoughts regarding the Section 1115 waiver proposal. If you have any questions please feel free to contact us with any questions.

Joan Willshire

Dooley, Lea M (DHS)

From: Ratzmann, Eric <Ratzmann@mncounties.org>
Sent: Friday, July 13, 2012 1:44 PM
To: *DHS_Reform2020Comments
Subject: Comments from

To whom it may concern:

Attached are copies of comment from the Minnesota Association of County Social Services Administrators (MACSSA) on the Department of Human Services Reform 2020 proposal. The comment letter is submitted in both Microsoft Word and Adobe PDF. Additionally, the unformatted text of the comment letter has been copied below. Please let me know if the submission requirements have not been met.

July 12, 2012
David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

Re: Reform 2020 Public Comment

On behalf of the Minnesota Association of County Social Service Administrators (MACSSA), thank you for the opportunity to comment on the Reform 2020 Section 1115 Waiver Proposal. MACSSA is an organization representing the directors of Minnesota's County Social Service Agencies, which have significant responsibility for administering Medicaid based programs in the state of Minnesota.

MACSSA supports the proposal's stated goal "to provide individuals with the right services, in the right way and at the right time," and "[to] ensure the sustainability of the system through efficiencies achieved." MACSSA agrees that reforms are needed to build a more sustainable system and to simplify administration in order to better manage increasingly complex programs. In general, MACSSA supports the overall policy direction contained in this proposal.

MACSSA understands that at this stage of the proposal there are still many details to work out regarding implementation of the various initiatives and demonstrations. Given that there is still much detail to be developed, it is difficult to speculate with much accuracy what the specific impacts will be on counties and the constituents we serve. As such, MACSSA will respectfully request that the Department of Human Services engage counties extensively and proportionately to our level of responsibility as these initiatives are further developed. As the state's partners and the governmental entities with responsibility for administering many of these programs at the local level, counties have a valuable (and necessary) perspective to provide and interests that are unique from other affected parties.

While MACSSA supports the expansion of services to individuals that the proposal contemplates, we have questions regarding the ability of the state to maintain cost neutrality not just to the state budget but also within the overall *system*. MACSSA is concerned about the potential of increased operational costs for counties that may result from this waiver proposal; however, without a more detailed explanation of how the financing will work and what county roles are contemplated we are unable to fully analyze this issue at this time.

Moreover, MACSSA has questions regarding the role of counties in the various initiatives. For example, the new Community First Services and Supports program contemplates expanded utilization of self-directed care (which counties generally support) without addressing who is responsible for providing education and oversight to clients choosing that option. It is unclear whether this will be a designated role for counties and/or other entities. Without further detail on what county roles are contemplated in this proposal, we are unable to provide more specific comments.

Lastly, we would like to briefly address two specific initiatives contained in the proposal. First, MACSSA would like to thank the Department of Human Services for including housing-related support services. MACSSA agrees that stable housing is a key component to improving health outcomes and reducing health-related expenditures. Second, MACSSA is concerned that there is a proposal being considered to centralize reporting for vulnerable adult maltreatment that has not received county input. Changing the intake/screening process without considering the assessment/investigation function counties provide has the potential to tear apart the safety net for vulnerable adults. Counties will need more information regarding the goals and operational details of this proposal prior to being able to comment.

Thank you again for the opportunity to provide comments on the Reform 2020 Section 115 Waiver Proposal. Counties look forward to engaging with the Department of Human Services to assist in the further development of these reforms.

Sincerely,

John Dinsmore
MACSSA President

Eric Ratzmann
MACSSA Director

Eric M. Ratzmann
Director
MN Association of County Social Service Administrators
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St. Paul, MN 55103

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Dooley, Lea M (DHS)

From: Frost, Stephanie L <Stephanie.L.Frost@HealthPartners.Com>
Sent: Tuesday, July 17, 2012 4:43 PM
To: *DHS_Reform2020Comments
Cc: Clelland, Jennifer J; Devore, Julie; Lasker, Denise P; Sayre, Katie B; Zimmerman, Donna J; Sauer, Robert V
Subject: Reform 2020 Comment letter

Mr. Godfrey,

Both below, in this email, and attached are our overall comment letter and our more detailed comments as an appendix. Thank you for your consideration of our comments.

July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey:

HealthPartners appreciates the opportunity to review and respond to the *“Reform 2020 Pathways to Independence, Section 1115 Waiver Proposal”* draft document. HealthPartners is a longstanding partner with the Department of Human Services in improving the health of public programs enrollees across a range of different programs including Medical Assistance, Minnesota Care, Minnesota SeniorCare Plus and Minnesota Senior Health Options. We are a strong partner with the state both through competitive bidding in the seven county metropolitan area and on a bid basis in greater Minnesota. We are strongly committed patient health, committed to providing an exceptional experience in caring for those we serve, and focused on delivering top quality services with excellence and integrity. We currently serve over 82,700 state public programs enrollees with excellent quality results as demonstrated through our HEDIS scores year after year. We achieve this by being leaders in care innovation and integrated care delivery, by focusing on preventive care and through our interdisciplinary care teams. Our care delivery system was one of the early health care homes certified by the state. Our Triple Aim focus and the excellent results it achieves was just featured in a new Institutes for Healthcare Improvement’s book on care innovations: [Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs.](#)

The Triple Aim calls for accomplishment of three critical objectives at once:

- Improvement of the **health** of the population served;
- Improvement in the **experience** of each individual; and
- Improved **affordability** as measured by total cost of care.

We, therefore, appreciate the focus in the waiver proposal on providing the right care at the right time in the right place. We are committed to the Triple Aim in all we do – it is infused in every aspect of our organization.

The proposals in the waiver draft reach far and deep into a broad range of programs – some of which HealthPartners is currently a significant partner and stakeholder. As such, we believe that we are in a position to be a strong partner in the implementation of the waiver. With these points in mind, we provide the following comments on the Waiver proposal, with additional detailed points presented in the Appendix.

Overall, we support the theme of providing enhanced care coordination services to individuals that is found throughout these waiver proposals. As you are aware, HealthPartners is an experienced provider of care coordination services and has been a key partner with DHS for those services to state public programs enrollees. We also recommend that the

waiver request be clearer on the goals of the waivers – the full set of objectives and the timelines envisioned to achieve them. While the draft lays out the proposals, current situations and initiatives, the goals or objectives are not clearly articulated. Neither are the budgets for these proposals. We believe that it is critical that these important features be made explicitly clear in the waiver request. If we do not clearly understand the goals, timing and budget, it will be hard to measure whether the proposals, if implemented, have achieved them. We also suggest that it be made more clear which programs are impacted by which waiver proposals – fee for service, managed care or some other program. Finally, we urge the Department to focus strongly in each proposal on ensuring administrative simplification and streamlining rather than increasing complexity.

One key feature for which we are seeking a clearer understanding is how these proposals interact and intersect with the current PMAP+ Waiver. As a longstanding partner with DHS in serving public programs enrollees, we are seeking to understand **the role of health plans** in the various waiver proposals and how these proposals impact the current programs. There is little mention of managed care plans in the document and no mention of managed care plans' role in the waiver requests. This needs to be made clearer so that we can provide more informed input and suggestions.

Additionally, HealthPartners requests that we be “at the table” in discussions around reform transformation and payment reform as it is envisioned in Integrated Care System Partnerships. This concept occurs not only in the ACO/HCDs arena but also in the Duals discussion in section 2.3. As an Integrated Care Delivery organization, we have a unique perspective to bring to the discussions – be they around the implementation of Triple Aim or around effective design of Total Cost of Care arrangements or the development of quality measurement standards and methodologies for provider partnerships.

In Section 3 of the Waiver proposal – Accountable Care Demonstration, there are proposals for **expanding direct contracting** between the Department and integrated care provider organizations. We believe that it is premature to move quickly down this road when there are, as yet, no results from the HCDs or Hennepin Health experiences. In addition, we believe that maintaining successful operations of ACOs and other integrated care provider options hinges on an active partnership between providers and health plans. There is an important role for managed care organizations “at the table” in ACO discussions and planning.

In Section 4 (PCA) and Section 9 (HCBS), there is a focus on “reforms and improvements” and “redesign” but not a lot of clarity what this would look like. As we have learned over the years, it is particularly important that there be clear definition in both the services offered and those to whom they are offered. We strongly urge DHS to ensure **uniformity in program eligibility criteria** is designing these reforms. Additionally, we note that in both of these programs, DHS is suggesting a change to providing a lower level of service to individuals with lower needs. Has DHS seen evidence that that would be beneficial overall to health outcomes?

Section 5 envisions an expansion of **Consumer Directed Supports**. HealthPartners is strongly in favor of this proposal. We would be interested, within this initiative, to better understand what consumer protections would be put in place. We also emphasize the need to ensure quality and measurable outcomes. In addition, it is important that the program be designed to be flexible enough to allow those who would choose not to receive services in this way to be able to seek other care options.

In Section 9.1.2, there is a new proposal related to services for children with Autism Spectrum Disorder. We are committed to providing services to these children. In fact, two of our pediatricians participate actively on the state's Autism Task Force. We were supportive of the language that passed in the last legislative session requiring the Health Services Advisory Council to review available literature and make recommendations on services to be covered. The focus of this work, as well as all care provided under any of these proposals, should be on evidence-based care. As such, we are troubled that the draft proposal suggests that rather than use evidence or await the results of the HSAC and Task Force work, DHS may “initially propose” benefit and service utilization recommendations. In our experience, it is far harder to scale back a benefit already put into place than it is to proceed in a thoughtful and informed manner. We strongly urge the state not to be rushed by this waiver application to implement benefits without due consideration of the evidence base for benefits and services.

The descriptions of the ACO Title XIX Waiver requests (13.1.1) are straightforward, but we suggest that they need additional rationale to justify why the state would be moving away from such important consumer safeguards as

statewideness and freedom of choice or financial accountability standards as actuarial soundness. The state should make clear why these changes are needed and how inequities, lack of choice or financial risk will be managed to the benefit of Minnesotans.

We appreciate the opportunity to comment on this draft. We support the efforts to focus these proposals around the Triple Aim and to provide innovative approaches to those served by our state public programs. We look forward to the opportunity to remain engaged in discussion with DHS as this process moves forward. We want to be involved with these reforms and, given our integrated model, believe that we have much that we can bring to the discussion. Feel free to contact us with any questions or to include us in the development of any of these proposals.

Sincerely,
Stephanie Frost
Senior Policy Manager

Attachment

Reform 2020 Pathways to Independence, Section 1115 Waiver Proposal HealthPartners Detailed Comments

SECTION 2.0: Long Term Care Realignment

Concerns

- Much of the language references “pre-eligibles” for ECS. Since “pre-eligibles” are those that are not yet on Medicaid with a health plan, we are wondering what supports and services will be in place for those seniors that have 1-3 ADLs.

Questions

- Will the ECS (Essential Community Supports) be in place to support those MSHO/MSC+ seniors with less than 4 ADLs?

SECTION 4.0: PCA/CFSS

Comments

- CFSS appears to be an expansion of the MSHO model
 - Inclusion of waived services
 - Single care coordinator
 - Annual assessment
 - Criteria/eligibility for institutional vs. non-institutional
 - LTSS (similar to LTCC)
- Clinical care alignment – looking for more guidance
- Appreciate the “start fresh” approach and understand that strategically may position them for best results, but concerned that we may recreate the same situation as before, particularly if fiscal containment and fraud and abuse measures not built in
- The waiver significantly narrows some aspects of PCA and alternately broadens the benefit. It is our hope that there will be adequate transitional time built into this considerable change.
- We would like to see a phased approach – particularly if the entire population that could meet this criteria will need an assessment.

- We support the Services Coordination model demonstration for kids with CFSS.
- We support the narrowing of criteria for individuals to receive “traditional PCA” type services in that this allows for services to be provided to those with the highest needs.

Questions

- Will MSHO model retain its current structure?
- How will CFSS intersect with MSHO and EW?
- Where will the care coordinators for CFSS come from?
- Will the coordination be billable? If so, will a code be created/requested?
- Can family members be the coordinator?
- How will payers reimburse in cases where recipients elect to pay their own providers?

Concerns

- Lack of role for managed care – there is no mention of managed care in the waiver. It is unclear what aspects will be FFS initiatives/demos and which will affect those in managed care.
 - We would like to see language that captures the role of managed care
 - We would like to retain at least some flexibility to manage this benefit in way that makes sense for our organization and our members.
- Concerned there is no mention of measures that build in fraud and abuse monitoring/containment
- Concerned there is no mention of fiscal containment for payers (focus on flexibility for recipients)

SECTION 5.0: Expand Access to Transition Supports

Comments

- We would like to understand how the health plans will intersect with the “pre-eligibles”.

SECTION 6.0: Housing Stability Supports Demonstration

Comments

- HealthPartners agrees that there are significant challenges in finding stable housing for individuals in need
- We seek additional information about the funding streams for providing housing services for individuals that are being discharged from hospital settings

SECTION 7: Anoka Metro Regional Treatment Center

Comments

- In our experience, we have not seen impediments when individuals are discharged from Anoka Metro Regional Treatment Center to the community because of their IMD status
- Our experience is that there is continuity of care when individuals are discharged back to the community
- We seek clarification and additional information from DHS around the goals DHS hopes to achieve through these proposed changes

Questions

- We would like more information about the goals surrounding this Waiver initiative

SECTION 9.0: Current and Proposed Initiatives

9.1.2: 1915 (i) for Children with ASD Diagnosis

Comments

- HealthPartners supports evidence-based care and interventions
- We are very interested in the development of the time-limited service set and seek information about how this will be defined
- We seek additional information about and are very interested in the development of agreed upon standards, assessment tools, treatment plans and protocols for objectively measuring progress

Questions

- We understand that DHS may propose benefit and service utilization criteria prior to recommendations from the Minnesota Health Services Advisory Council. Will DHS seek stakeholder input during this process?

Concerns

- As noted in our attached letter, we are concerned that the draft proposal suggests that rather than use evidence or await the results of the HSAC and Task Force work, DHS may “initially propose” benefit and service utilization recommendations

9.1.4: Individuals with mental illness who are at risk for institutionalization without access to integrated community-based systems of care

Comments

- We support the move towards reducing the need to go to a higher level of care before services can be provided
- We also support providing community-based services to members

9.3 Redesign Home and Community Based Services

- We are hoping for a phased-in approach for MNChoices to allow providers the ability to obtain equipment and gain capability with the assessment process and the tool itself.

9.6: Intensive Residential Treatment Services

Comments

- We agree that addressing an individual’s medical needs while residing in an IRTS facility has challenges

- We support the Department in developing a proposal for improved integration of medical and behavioral health services for medically complex patients.

9.7: Children Under 21 in an “IMD” Facility

Comments

- We seek to understand as children under 21 in an IMD facility are eligible for Medicaid and can be seen on an out-patient basis now for any medical needs that may arise

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July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey:

SEIU Healthcare Minnesota appreciates this opportunity to provide comments on the State of Minnesota's Proposed Reform 2020 Section 1115 Demonstration Waiver. Our comments relate to the proposed Accountable Care Demonstration and the proposed Community First Services and Supports program.

SEIU Healthcare Minnesota is pleased to see the proposal for an Accountable Care Demonstration to build on Minnesota's strong track record in care integration, and we too support the stated goals of improving primary care and care coordination in a way that increases provider accountability for the quality and total cost of care.

SEIU Healthcare Minnesota strongly supports the overall vision for the Community First Services and Supports program—especially its focus on expanding self-direction, and the expansion of allowable services to include not only direct assistance but also skills acquisition and cuing, plus assistive technology, environmental modifications, and transition assistance. We also strongly support the state's intention to make these services and supports available to individuals who meet an institutional level of care as well as those who do not. We are pleased also that the proposal includes a commitment to provider training and qualifications (p. 33).

We support the plan's proposal to provide Financial Management Services to participants in the proposed CFSS program who choose to direct their own services and hire and manage their own caregivers, and the proposal to put these Financial Management Services out to bid through a competitive Request for Proposal process (p. 39). We would urge that in the selection process strong preference be given for Financial Management Entities that have a track record of providing similar services in the state of Minnesota.

Finally, we would urge that the Development and Implementation Council (p. 38) should in its recommendations to the legislature take into account not only the value of person-centered planning approaches but also the necessary relationship in self-direction between choice and risk—participants should, in exercising their full freedom of choice to direct their own services, be able to assume certain risks which they understand and choose to assume.

We appreciate the opportunity to provide these comments, and look forward to working with the Department as it continues to develop and implement this proposal.

Thank you for your consideration.

Sincerely,

Julie K. Schnell
President, SEIU Healthcare Minnesota

July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey,

I these are my personal comments to the Department of Human Services Reform 2020: Pathways to Independence proposal. I submit them on behalf of myself only as they have not been reviewed or approved by any organization with which I am affiliated.

I Applaud the Department of Human Services for the values of self direction, personal choice, individualized planning, and quality outcomes that have been driving the Medicaid Waiver process, and led to the development of the *Reform 2020* proposal. I agree with the stated *Reform 2020* goals of: better outcomes, the right service at the right time, and ensuring the sustainable future of long term services and supports. I am in agreement with comments previously submitted by the Minnesota Disability Law Center, Lutheran Social Services, and the Minnesota chapter of the National Alliance for the Mentally Ill (NAMIMinnesota).

In addition, I have the following comments and suggestions.

1. Title of Proposal.

I reiterate my concern regarding the inappropriateness of referring to "independence" as the goal of this proposal for Minnesotans with disabilities. No one is truly independent. We all depend upon others for our quality of life. The clothing we wear, the food we eat, the places we live, the roads we drive on in the cars we drive in all our the result of the efforts of many other persons upon which we rely, usually unconsciously, in our daily activities. To implicitly claim that persons with disabilities may obtain quote independence" which is unachievable by persons who are not disabled, is grossly unfair and misleading. Moreover, it furthers the radical individualism which permeates public and political discourse today. I urge the department to revise the title to read "Pathways to Interdependence."

2. DHS will have to grapple with the meaning of "community". Unfortunately, CMS That continues to seek public comment on this issue through its latest NPRM on 1915 (I). This is a critical issue for Olmstead compliance which requires that individuals with this abilities have access to the "most integrated setting" that is appropriate for them.

3. As currently written, the Reform 2020 proposal focuses upon system change rather than the benefits for individuals with disabilities and others covered by Medical Assistance. This focuses understandable But I Agree with L SS that effort should be made to focus upon what individual persons with disabilities have to gain (or lose) from the specific waivers and demonstrations outlined in the proposal. As I indicated during last Friday's group meeting with the Commissioner, each individual with a disability has unique abilities, functional limitations, and needs which they must address. Their individual realities should be the primary focus of any systems change proposal. The Development and Implementation Council is an excellent vehicle for DHS to be reminded of the barriers and problems faced by individuals with disabilities in their daily lives. DHS should establish similar councils comprised of a majority of the affected persons with disabilities for each of its programs and services. Individuals with disabilities who receive DHS or other state services are the real experts and stakeholders, not the advocacy groups, coalitions, and vendors who dominate existing stakeholder advisory groups.

In addition, any individual barrier raised by a consumer of DHS' services should be viewed by DHS as a systemic rather than an individual problem and action should be taken or planned to remove that barrier. As I mentioned last Friday, one of the members of the Olmstead Planning Committee who lives in rural Minnesota mentioned that she had difficulty receiving catheterization services. Apparently the Nurse Practices Act requires catheterization be done by an RN. However, the OPC member said that no RN would drive for one and a half hours to provide her with this 10 minute medical service. It is highly likely that there are more DHS consumers with this problem. DHS staff should fix or make plans to fix all the issues identified by DHS consumers because action at this apparently individual level, on a consistent basis, will result in systemic change as well as greatly improving the lives of Minnesotans with disabilities.

4. Comment 2. Of MDLC

I especially agree with MDLC that there are "serious concerns about the integration of long-term services and supports (LTSS) with health/medical care because of the likely emphasis on the medical model of service provision. ...we oppose control over all of one's LTSS services by a medical care provider without experience in housing, employment, transportation and social relationships in the community. Rather than assigning medical entities or health plans the authority and risk for every project, we recommend seeking proposals where the community support providers are in charge and can subcontract for medical services."

It seems to me that this is also a serious problem with managed care. Moreover, I am not comfortable with the degree of information available to DHS staff from managed care entities regarding both the scope of medical care actually being provided to managed care consumers as well as the degree to which such entities are sufficiently knowledgeable and desirous of approving long-term services and supports for their members with disabilities.

Olmstead liability may arise against Accountable Care Organizations and managed care entities who fail or refuse to provide needed community-based services and supports to their members with disabilities.

4. MDLC Comment 2.- **Demonstration to Reform Personal Care Assistance (PCA) Services, p. 25**

I strongly agree with MDLC's comments on these issues. I also agree with NAMI Minnesota's comments on the negative impact which will result for adults and children with mental illness if the more stringent Nursing Facilities Level of Care (NFLOC) is granted.

NAMI Minnesota continues to claim that MN Choices does not accurately assess the needs of Minnesotans with mental illness. MDLC agrees with NAMI Minnesota on this point. (See MDLC's comments regarding 9.3.2). On behalf of the OPC, I will be requesting a copy of all of the MN Choices questions for review in order to better understand NAMI Minnesota's concerns and objections. If the OPC agrees that MN Choices' questions are inadequate for the assessment of persons with mental illness, we will seek to have DHS make appropriate revisions. Frankly, I do not understand why this controversy continues without resolution. Olmstead liability may arise if DHS uses an assessment tool which discriminates on the basis of mental disability.

5. 4.23. Demonstration of Innovative Approaches to Service Coordination (children with CFSS), p. 41

I strongly agree with comments made by MDL see That and NAMI Minnesota. The last thing that school districts want is additional responsibility for students with disabilities particularly outside school hours.

6. 5.2. Demonstration to Expand Access to Transition Supports, Return to the Community, p. 44 and p. 127

NAMI Minnesota and MDLC both correctly point out that it is not appropriate to limit this programs to persons 65 or older. If it promotes community integration, it should be available to all Minnesotans with disabilities regardless of age.

7. **6.1. Demonstration to Empower and Encourage Independence through Employment Supports, p. 51**

NAMI Minnesota request DHS to use Individual Placement Supports (IPS) also known as evidence-based supported employment instead of the proposed approaches. I have no knowledge regarding IPS or evidence-based supported employment or its effectiveness. However, if NAMI Minnesota is correct about its effectiveness, DHS should adopt NAMI Minnesota's recommendation.

I also agree with MDLC's comments on this section, which also endorses the use of IPS.

8. I join the remainder of MDLC's and NAMI Minnesota's comments.

Respectfully submitted,

Christopher G. Bell

July 17, 2012

UCare Comments on DHS Draft *Reform 2020: Pathways to Independence - Section 1115 Waiver Proposal*

General Comments/Questions:

1. We would like more specificity as to how the proposals will impact managed care and managed care organizations. The draft waiver proposal seems to be written primarily with a Medicaid fee-for-service lens.
2. There is no financial information or budget projections provided as part of this proposal. Please provide information as to how many Medicaid beneficiaries will be impacted and what the costs may be to MCOs, county-based entities, and those establishing/implementing ACOs/ICSPs.

Technical Section 1115 Waiver Comments/Questions:

3. Does the Section 1115 waiver replace the existing PMAP+ waiver, or would these authorities run parallel to each other?
4. If the Section 1115 waiver does not replace the existing PMAP+ waiver, please provide a description of how the new Reform 2020 Sec. 1115 waiver proposal will impact the existing DHS PMAP+ waiver. Specifically, what changes, if any, will be made to the existing PMAP+ waiver if the Reform 2020 Section 1115 waiver is approved?
5. Does DHS authority to deliver services through health plans and county-based purchasing entities come from the existing PMAP+ waiver?
6. Is DHS seeking authority/arrangements with CMS that will limit or prohibit Minnesota from continuing to deliver Minnesota Medicaid services through managed care organizations (HMOs and/or county-based purchasers)?
7. To help stakeholders understand how the new Section 1115 waiver interacts with the existing PMAP+ waiver, please provide a summary comparison of the provisions/elements that are in each of these waivers and a statement about what each element achieves (actual or planned).
8. In general, UCare supports the streamlining of the various waiver pieces (CADI, EW, etc.), but without more detail and role clarity it is difficult to provide specific comments.

Section 2.2 – Long-Term Care Realignment Section 1115 Waiver

9. We are aware of the 2009 legislative changes and are concerned that these modifications to the Nursing Home Certifiable level of care criteria may negatively impact enrollees' eligibility for waivers. This may increase case management time and administrative costs.
10. The Support Alternative Care Program will present a challenge to determine eligibility for services. Will this be administered by a "local agency" such as a managed care organization? This may create more fragmentation over time.

Section 2.3 - Redesigning Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility. *Note: DHS identifies this as “pending with CMS,” and features are being discussed with health plans.*

11. At the bottom of page 18, we believe DHS means to refer to “Minnesota Senior Health Options” (MSHO), not “Minnesota *State* Health Options.”
12. UCare supports the leadership of the Department in moving to further integrate care for elderly dual eligibles.
13. Please clarify the statement that “DHS will continue to explore with CMS ways in which Medicaid and Medicare can be better integrated for people under age 65 with disabilities without pursuing a fully capitated model.”

Section 3 - Accountable Care Demonstration

14. Section 3.2.3, first paragraph: We believe DHS means to refer to “Minnesota Senior Health Options” (MSHO), not “Minnesota *State* Health Options.”

Section 3.2.3 says that “DHS will incorporate purchasing strategies... to stimulate new ‘integrated care system partnerships’ (ICSPs) between health plans and providers.” Specifically, ICSPs are referenced in conjunction with better serving dual eligibles. However, in Sections 3.3.1 and 3.3.2, no mention is made of partnerships with health plans for other forms of accountable care models. Does the Department contemplate a role for health plans only in the care delivery for dual eligibles, but not in other forms of accountable care models?

Failure to anticipate questions about how ACOs will work within the context of existing managed care programs may slow implementation of ACO initiatives. Please explain the Department’s vision for the role of managed care plans in a future of more direct contracting with ACOs. Because several health plan/provider relationships already exist and are operating effectively, we want to assure that the process allows for existing models to continue under this strategy.

15. Looking ahead to 2014 when the Minnesota Health Insurance Exchange is operational, it is important to note that many stakeholders have expressed an interest in ensuring that the same plans offering commercial products in the Exchange also offer a Medicaid product so that an enrollee does not experience a break in continuity of care or a break with a preferred provider if his/her eligibility for a commercial or Medicaid product changes. In the absence of any clear articulation in the waiver proposal of a role for health plans and ACOs, please reconcile the Department’s vision for a future of more direct contracting with providers with the fact that many new and renewing enrollees will be choosing a Medicaid plan through the Exchange.
16. If the ACOs and/or ICSPs are to be risk-bearing entities receiving public funding, will DHS require accountable care models to adhere to similar transparency requirements for financial reporting and independent auditing as is required for HMOs? If not, please explain why.

17. Regulation of the financial solvency of risk-bearing provider organizations in ACOs is important to ensure market stability. Bearing financial risk necessarily means that there is a possibility that a provider organization will face financial instability, or even fail -- thus the need for strong financial solvency regulations to ensure that the health care provider market remains stable and that patient care is not disrupted. Does DHS intend to regulate the financial solvency of providers in ACOs and/or ICSPs , and if so, how?
18. How do the July 10, 2012 CMS State Medicaid Director letters (SMD 12-001 and 12-002) regarding "integrated care models" impact this Section 1115 waiver? Will DHS need to amend its proposal due to the release of these two letters?

Quality

19. A number of quality and performance measures have been developed and are currently used to measure delivery of health care services to individuals enrolled in MCOs. Is DHS proposing developing new outcome measures to replace the measures currently in place? If so, to which products/delivery models (HCDS, Hennepin Health, PMAP/MnCare, SNBC, MSC+, MSHO) would the new measures be applied?

Benefits

20. For what benefits will HCDS demonstrations be at risk? Will all HCDS demonstrations have the same risk/gain sharing arrangements? Will the same range of service costs be included across all HCDS demonstration sites?
21. Are the costs of long term care services, including nursing facility and HCBS, included among the services for which HCDS sites will be at risk?
22. Is DHS planning on changing how dental services are provided to MHCP beneficiaries who currently receive dental services through MCOs? If so, how?
23. For dual eligibles, does DHS envision adding any new social and/or county services to the range of services for which managed care organizations (health plans and county-based purchasers) are currently responsible?

HCDS, ICSP

24. Does DHS plan on developing ACO arrangements beyond the nine HCDS sites with which DHS is currently working?
25. How many individuals does DHS anticipate serving through DHS direct contracts with HCDS?
26. If closed networks are implemented, what administrative processes will providers both within, and outside of, the ACO need to follow in order for members to access medically necessary services that are not available from providers within the closed network?
27. Under ICSPs, if closed networks are established, what entity will be responsible for handling appeals? DHS? The provider?

28. Will DHS publish HCDS contracts and payment rates on the DHS website, similar to how managed care contracts and payment rates are currently published?
29. Does DHS expect that over time, ICSP arrangements will become direct contracting/HCDS arrangements?
30. Does Section 3.2.2 correctly state that 10,000 individuals per month will participate in Hennepin Health? July 2012 Hennepin Health enrollment was 5,433 individuals.
31. ICSP arrangements or narrow/closed networks for dual eligibles seem to be at odds with CMS Medicare Advantage requirements for broad provider networks. Does this mean that MSHO will have to depart from the SNP/Medicare Advantage platform to fully implement ICSP?
32. Will ICSPs be allowed to partner with multiple health plans, or just a single health plan? UCare would support ICSPs having the option to contract with multiple health plans and allow for flexibility in the relationships as jointly developed.
33. Is it correct that the ICSP arrangements will only apply to dual eligibles enrolled in MSHO?

RFPs

34. Please confirm that DHS be issuing a RFI preceding the RFP as part of the process toward the creation of the ICSPs.
35. On page 25, first full paragraph, DHS mentions a RFP that will be released in early 2013. It also mentions, we think, that DHS will begin a stakeholder process prior to this 2013 RFP. Please confirm that we are reading this paragraph correctly. [Another way to read this paragraph would be that DHS is releasing two RFPs - one in the summer of 2012 and one in early 2013 – and we want to be sure that this is not what the Department is saying.]
36. However, if there will be two RFPs, please clarify which initiatives begin in what year, and for what activities. Will there be another HCDS RFP, or will be there an ICSP RFP? Will health plans be permitted to participate in the planning process? Are health plans considered providers in this context?)

Shared Savings with Medicare

37. On page 24, the bottom of the first paragraph, the draft proposal talks about sharing savings with Medicare for dual eligibles. Now that Minnesota's Financial Alignment Demonstration (FAD) will not go forward, is DHS still planning on developing a program under which shared savings from dual eligibles experience accrue to CMS?

Enrollment – ACOs

38. What changes in the current enrollment process does DHS envision related to the creation of ACOs? Please refer to Section 3.3.2.

39. Section 3.3.2 notes that: “Medicaid enrollees would directly enroll into these [integrated provider] organizations” Does DHS expect that health plans will continue to have a role in Medicaid managed care when HCDS is fully implemented, or is health plan involvement in Medicaid managed care expected to decline as HCDS capacity increases?

Data Reporting (top of page 25)

40. Regarding Section 3.3.2: What data reporting requirements does DHS see that will be needed by ACOs? What types of systems does DHS think will be needed to meet the ACO reporting requirements?

Section 4 - Demonstration to Reform Personal Assistance Services

41. Currently, PCA services are available as a State plan service (either through Medicaid managed care or fee-for-service) and, for those eligible, “extended” PCA services are also available through Section 1915(c) HCBS waivers such as TBI, CADI, CAC and EW. If PCA services are delivered as State plan services under the Section 1915(k)(institutional level of care) and 1915(i)(non-institutional level of care) authorities, will extended PCA services still also be covered under the existing Section 1915(c) HCBS waiver programs? Or will they only be covered as State plan services under the new model?

Or - will PCA services not be delivered via the Section 1915 waivers at all, and only via this proposed Section 1115 waiver? It is unclear, and we are hoping DHS will clarify under what authority PCA services will be part of Minnesota’s Medicaid package come 2014.

42. Under the proposed PCA redesign, does DHS anticipate the institutional level of care determination (under the Section 1915(k) authority) to be driven by the level of care criteria outlined on page 17 of the proposal (e.g., a high need for assistance in four or more ADLs; 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; or the person lives alone and risk factors are present)? Under the Sections 1915(i)/1915(k) model, what proportion/number of those currently receiving PCA services would no longer be eligible to receive PCA services either under the Section 1915(i) or the Section 1915(k) (or Section 1115) authority?
43. With the PCA redesign, does DHS still expect PCA services to be delivered via managed care organizations (health plans and county-based purchasers)?
44. Page 25, form of PCA services: What features of the current PCA delivery process does DHS consider most complex? What barriers, gaps and redundancies does DHS believe prevent people from accessing the service they need?
45. Page 26, second full paragraph: What groups/categories of individuals does DHS expect to receive the home care service coordination under the CFSS? Will it only be available to those receiving PCA services? Will it be available for both those enrolled in managed care and those who receive Medicaid services via fee-for-service?
46. Page 37: Fourth bullet is unclear – will members participating with a HCBS waiver be able to access CFSS or not?

47. Modification to the current PCA program is clearly needed; however, the proposed language doesn't seem more efficient. For example, members exercising the PCA Choice option often utilize the authorized hours of PCA services before the authorized time period has lapsed, resulting in the health plans needing to authorize additional hours beyond a member's assessed need. Going forward with the option described in the proposed Section 1115 waiver could logically require limits on members' flexing of the benefit and funding of the health plan for care coordination of service. Therefore, UCare suggests that the Department consider limits on use of the PCA Choice benefit.

Section 5 - Demonstration to Expand Access to Transition Supports

48. In general, UCare supports, as it means fewer people spending down to become eligible for Medicaid. However, because Section 5.3 seems intrusive and an unnecessary burden, and also has not been well received in the community, UCare does not support.

Section 6 - Empower and Encourage Housing, Work, Recovery and Independence

49. How will this section impact MCOs? We understand enrollment will be capped at 800 people at any given time.

50. Section 6.2.3, third bullet: Suggest that "and" be deleted and added right before the fourth bullet.

Section 7 - Anoka Metro Regional Treatment Center Demonstration

51. Would MCOs be responsible for paying for Medicaid services in IMDs?

Section 8 - Eligibility for Adults without Children

52. Section 8.1.1 (asset test of \$10,000 on adults without children): If Minnesota does not opt to expand Medical Assistance eligibility for adults without children with incomes 75% -133% FPL, as we understand it, there would be no need to seek a waiver of the asset test for these adults with incomes \leq 75% FPL. That is because (we believe) that the ACA Medicaid requirements otherwise effective 1/1/14 will not apply to states choosing not to expand Medicaid eligibility. Note: CMS may issue clarifications as a result of the June Supreme Court decision that impacts Medicaid eligibility.

If, on the other hand, Minnesota expands Medicaid eligibility, then this waiver to impose an asset test would be premature (for the MAGI groups) and would presumably violate the ACA's requirement of maintenance of effort in effect through CY '13. In addition, CMS may determine that as of 1/1/14 states that expand Medicaid eligibility cannot have Medicaid eligibility asset tests for the MAGI groups (i.e., the recently promulgated Medicaid eligibility rule applies to states that expand Medicaid eligibility pursuant to the ACA).

Lastly, UCare opposes an asset test for these adults, as the impact would be to create an additional barrier to some of those on the very low end of the scale – adults without children with incomes \leq 75% FPL.

53. Section 8.1.2: Pursuant to 2011 legislation, the Department seeks to re-establish a MinnesotaCare 180-day residency requirement for adults without children with income between 75-250% FPL. However, effective 7/1/12, approximately 4200 MinnesotaCare adults without children with

incomes between 200-275% FPL were terminated from MinnesotaCare and offered the opportunity to purchase health care via the Healthy Minnesota Contribution Program. Therefore, we believe the Department would want to revise this proposal and seek a residency waiver for adults without children with incomes between 75-200% FPL.

UCare has several comments:

a. We view the chances of CMS approving this waiver to be highly unlikely, regardless of state law mandating this waiver. In a June 2011 letter to the Department approving the PMAP+ waiver (but not the MinnesotaCare residency waiver), CMS was very clear that it would not approve the residency waiver, as it was contrary to federal law.

b. We oppose this residency requirement, as the impact would be to create an additional barrier to health care for some of our citizens.

Section 9 - Context of Reform: Current and Proposed Initiatives

54. Section 9.1.2: Based on the public concerns raised at the two June 2012 public hearings, we recommend that the Department clarify this proposed Section 1915(i) State plan benefit for children over age seven.

55. Section 9.1.2: Targeting the benefit to children under the age of seven aligns with the research on where intensive treatment models have the most benefit, so we support this definition. As we understand it, the intent on the school IEP driving services for older children is to reduce the number of different assessments currently required to access services. We believe this is a good idea.

56. The Section 9.1.2 language regarding adults is again attempting to move from fragmented funding streams and rules into a coordinated funding for that subset of the most impaired individuals who are in RTCs but who do not need that level of care. We believe this is a good idea.

57. Section 9.3.3: The first full paragraph, first sentence on page 91 uses “demonstrated” rather than “demonstration.” The last sentence in that paragraph seems to be missing the word “of”: “... and data entry lag time of county staff was reduced significantly.”

58. Section 9.3.9: UCare supports this section, which would reduce the substantial variability of vulnerable adult services across the state and potentially enhance effective response to the needs of vulnerable adults.

59. Section 9.4: It is unclear what DHS envisions regarding MCOs in this section. Health plans have extensive experience providing individual and group incentives for preventive care. Health plan representatives participate on the “We Can Prevent Diabetes MN” grant. MCOs welcome all opportunities to come to the table to work on preventive care initiatives.

60. Section 9.5.2 notes that “enrollees who seek care from a high value provider could have their copayments reduced or eliminated. Some people on Medical Assistance are exempt from copayments, so other incentives will have to be identified in order for them to take advantage of this initiative.” However, Section 9.5.3 states that “DHS will identify non-cost-sharing enrollee

incentives,” will seek CMS approval to implement those incentives, but will make no specific requests for federal waiver authority at this time.

As written, these sections are confusing. If some enrollees could have their copays reduced or eliminated – while others have differing copays - wouldn’t there need to be waivers in place? Yet DHS states that it will not be seeking waivers at this time.

Further, what “non-cost-sharing enrollee incentives” is DHS planning? Will the MCOs be involved in the “consultation with MDH”?

61. Section 9.6: We believe it is a good idea to integrate primary and behavioral treatment within this setting and to establish standards for what would be included.

Section 13- Waiver Authorities Requested

62. In Section 13.1.1, DHS is proposing a waiver of 42 CFR §438.6(c)(5)(iii) (actuarial soundness of payments under risk contracts), but there is no budget/financing information accompanying this proposed waiver, and it is not clear why this waiver is necessary.
63. Section 13.2.2: We think “demonstration populations” could be deleted in the first sentence, or perhaps it should be reworded as follows: “... following expenditures for demonstration populations not covered”
64. Section 13.3.1: Missing the list of Title XIX waivers sought.

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 17, 2012 4:35 PM
To: *DHS_Reform2020Comments
Cc: [REDACTED]
Subject: Comments on Changes for Autism Benefits

I was unable to come in person to your meetings. however, I would like to share my comments.

1) Please eliminate artificial age caps (both in early intervention and any medical therapy) - they are more detrimental to long term improvement and a persons ability to live more independently. The more improvement in functioning you can get before the children become adults, the less costly they will be in the long run.

I have a 15 year old son with very severe autism. He needs many services that are not accessible to him and were not accessible to him due to artificial "caps" in age.

For example - he has sensory issues to foods and requires feeding therapy to expand his repertoire of foods that he will eat. We have known this since age 8, yet at the time, providers would not take children over 6. At age 10, the providers changed their service limit to age 8. Now there are no age limits, but since puberty no providers have allowed them to complete therapy due to aggression, although we can show him how to work with him safely.

2) Do not limit access to services to the schools. They have no business getting in the medical decisions of families and physicians. Our son is in a Special and Unique school, which bills medicaid for the cost of a full time aide and "indirect" OT, "indirect" Speech, "indirect" PT, etc. I think it is horrible that they will not provide direct services and we are seeking services outside the school system. Your proposal would limit our sons ability to receive help permanently. The decisions to receive medical interventions should not be the schools to make - some have low quality tenured employees that do not keep up on the latest research and techniques. Medical interventions should be between the physicians and the patients. Also schools bill these services and parents never get to see what they are billing for, whether there children were actually at school on those days etc. The schools lack transparency in this process.

3) Include parents with children at a variety of functioning levels and ages in all future proposed changes to waivers.

Thank you for your time.

[REDACTED]

Dooley, Lea M (DHS)

From: courtney whitcraft <courtney.whitcraft@gmail.com>
Sent: Tuesday, July 17, 2012 4:27 PM
To: *DHS_Reform2020Comments
Subject: comments regarding Reform 2020: Autism

Hello!

I am Courtney Whitcraft, B.C.a.B.A (Board Certified assistant Behavior Analyst). I have primarily worked with children with Autism ages 1.5-11 years old since 2005. I have been working in the Behavior field since 1998, and achieved my B.C.a.B.A in 2006 (with adults and children with a variety of developmental and genetic disorders)

I encourage you all to consider giving those of us who have expertise in the behavioral field (with the B.C.B.A and B.C.a.B.A.) more responsibility. It's mutually beneficial! We bill at a lower rate (lower than psychologists) and we are specifically trained in all behavior applications, work hard to annually renew our certifications through work and Continuing Education units. Those who are B.C.B.A have to have a masters, those of us who are B.C.a.B.A take extra behavior classes. All of the training and classes allow for education, experience and expertise. Utilize us, please!! I want, need, and crave more responsibility. As I said, it's mutually beneficial, the state will spend less money if you give us more responsibility! It's more cost effective for the payer and benefits clients and providers because it opens up opportunities for us to provide a wider range of services.

Please think about utilizing us, the behaviorists. Through out all the research we do, we prove that using behavior analysts helps kids, teens, adults, everyone!

Thank you for your consideration!

Courtney Whitcraft, B.A., B.C.a.B.A
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July 16, 2012

The Corporation for Supportive Housing
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612-721-3700

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
Saint Paul, MN 55164

RE: Reform 2020 Draft Section 1115 Waiver Proposal

Dear Mr. Godfrey:

I write to you on behalf of the Corporation for Supportive Housing (CSH) with comments regarding the Reform 2020 Draft Section 1115 Waiver Proposal, posted on June 18, 2012. Chief among our concerns is the use of Medicaid for Housing Stability Services, as well as the Community First Services and Supports (CFSS).

CSH is a nonpartisan, nonprofit organization and Community Development Financial Institution (CDFI). We have been working in Minnesota for over 19 years, helping communities throughout the state change systems and leverage resources to create supportive housing. Supportive housing, as CSH defines it, is permanent housing with voluntary support services. This type of housing has been proven as an effective method of reducing Medicaid costs to states. Previous studies have shown an average savings of \$5,983 per person per year, of which \$3,270 of that is Medicaid savings alone, (Studies summarized in the attachment and available upon request.)

Comments and Recommendations on Demonstration to Reform Personal Assistance Services

Under section 4.2.2, the newly created 1915(i) would allow people with less than an institutional level of need access to Community First Services and Supports (CFSS). While this is an improvement from the currently existing Personal Community Assistance (PCA) services, the new regulation does not provide for all of the people in need of these services. The current requirement only accounts for individuals who need full time help with one or more Activity of Daily Living (ADL), which is only one way to determine if someone is medically in need of a PCA. The Housing Stability Services is planning to use a functional need analysis to determine if someone needs services, which has been a successful method of determining individuals who might some day end up in an institutionalized care. The individuals who would qualify under a

functional analysis, but may not qualify by using an ADL only criteria include those who are long term homeless with functional deficiencies that qualify them for the Housing Stability Services under section 6. This population has historically been underserved by Medicaid. An example of someone who does not have a defined ADL but does have a functional need is Maggie, a 55 year old woman who experienced 5 years of cycling from psychiatric inpatient care and homelessness for five years before being housed. After she was housed, she struggled to maintain her apartment due to mental illness. Maggie exhibited hoarding behaviors which led to lease violations as her unit was no longer compliant with the local fire code. Maggie was able to receive assistance; with the help of someone coming in to her apartment weekly and talking her through the process of getting rid of items she was able to retain her housing. Unless the CFSS eligibility standards are altered, individuals like Maggie would be ineligible to receive the services they need to stay in their housing and not be institutionalized. To ensure Maggie and others would be able to retain services, CSH strongly advocates extending the CFSS eligibility standards.

The Corporation for Supportive Housing recommends that eligibility for CFSS 1915(i) is broadened to include those who qualify for Housing Stability Services. Allowing most people who receive Housing Stability Services to receive CFSS benefits creates a more comprehensive package of services available to those most in need. If DHS is unwilling or unable to change the eligibility requirement under for CFFS 1915(i), then (DHS) should consider augmenting the services available under the Housing Stability Services to include a similar assistance package.

Comments and Recommendations on Empower and Encourage Housing, Work, Recovery and Independence

6.2 Housing Stability Services

CSH strongly supports including Housing Stability Services in the 2020 Medicaid Reform. Our organization has long known that securing and maintaining housing is crucial for treating our constituents' mental and physical health, and that housing reduces the costs associated with their health plans and health care providers.

CSH proposes adding language that makes clear to CMS that the intent of the Housing Stability Services is not to subsidize rents, but to provide the services needed for clients to find and maintain housing. Additionally, the waiver proposal can specifically state that housing will be available for individuals through state and federally funded housing programs, including GRH, Section 8, Housing Trust Fund, and the private market through earned income.

It is our recommendation that the provider qualifications for outreach workers be expanded. Many individuals who are most knowledgeable and best situated to create relationships with people experiencing homelessness are not academics, but instead are peer support specialists. Formalized training, while helpful, is not always reflective of one's ability to form relationships

with those experiencing homelessness. Instead, these relationships are often best fostered by people who have personal experience that allow them to form bonds based on mutual trust and respect. For that reason, the language should be changed to stress that qualified providers are those best at creating meaningful and lasting relationships such as Peer Support Specialists.

Another impediment to ensuring all those in need of services can receive them is the age requirement present in the waiver proposal. Currently, to be eligible, individuals must be at least 18 years old. This requirement should be removed. Recent studies, including the 2009 Wilder Homelessness Survey, have shown that the number of youth experiencing homelessness in Minnesota is rising, and among this number are many youth who have disabilities that allow them to qualify for Medicaid. This demographic must be served; early intervention will help to reduce chronic health problems from presenting, such as those we often see in the long term homeless. Further, those under the age of 18 can qualify to receive Medicaid on their own and meet the other requirements of a disability needed for Housing Stability Services. From that it follows that they should be eligible to receive these services, provided they meet the other requirements.

Providing benefits which lead to housing for those experiencing homelessness costs less than paying for Medicaid. For that reason, limiting the program to 5,000 individuals is unnecessary and should be removed. The waiver can be budget neutral without the cap, as housing has been proven in many states to be a cheaper alternative to providing benefits to those experiencing homelessness. Studies across the United States have regularly shown this to be true; therefore, more individuals can be served by Housing Stability Services while maintaining fiscal neutrality by lowering Medicaid costs significantly.

It is CSH's position that Housing Stability Services would better assist those in need by enhancing the current service package through adding the CFSS services. These services would help individuals maintain their housing once they have been housed. Many people who have not been housed for long periods of time have a difficult adjustment period once they get their own housing. They need assistance in learning tasks needed to preserve their housing status, including cleaning, managing bills, relationship with neighbors, and making and keeping medical appointments. Adding these services would ensure that those who are housed remain so, and the full economic impact of housing on our Medicaid system is realized.

When the Housing Stability Services billing rate is being determined, CSH recommends a baseline of no lower than \$500.00 per individual served. The current rate for Group Residential Housing (GRH) is \$459.85 per client per month, which allows for a 15-1 ratio of client to case manager caseload. Hennepin County has put a 15 client cap on their Housing First GRH programs because they have determined this to be the highest number of clients a case manager can effectively serve. This caseload is manageable with the high level of need the average client presents. If the billing rate were to be smaller than our recommendation, the ratio

of clients to providers would increase; the level of service would decrease, as would the rate of housing stability.

6.3 Project for Assistance in Transition from Homelessness and Critical Time Intervention Pilot

CSH believes that the use of Critical Time Intervention (CTI) is an effective way to transition individuals receiving services from a high level of service to a lower level. The PATH program can benefit greatly from using CTI to effectively increase the number of people they serve by transferring more clients off their caseloads.

The first-come, first-serve policy the PATH CTI pilot recommends will result in a lack of services for the most vulnerable clients. PATH's goal is serve homeless individuals with mental illnesses; historically those people experiencing homelessness with the highest level of mental health need do not request services due to their mental illness.

CTI is only as effective as the community supports that exist for PATH providers. Currently housing and case management supports can be limited for PATH providers. For CTI to be effective there must be services for PATH clients in place before the demo is implemented. A good fit would be the CFSS services proposed to support once a client is in housing.

Thank you for the providing CSH with the opportunity to comment on these proposals. We look forward to working with the State of Minnesota as the final waiver is created. If you have any follow up questions you can contact me at 612-721-3700. Ext. 108.

Sincerely,

George Stone
CSH Minnesota Director

Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560
651 662-8000
800 382-2000



July 17, 2012
David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey:

Blue Cross and Blue Shield of Minnesota appreciates the opportunity to provide comments on the draft document, *Reform 2020: Pathways to Independence Section 1115 Waiver Proposal*, which was released to the public on June 18, 2012, by the Minnesota Department of Human Services (DHS).

Blue Cross is the largest not-for-profit health plan in Minnesota, covering 2.3 million members. Blue Plus, a licensed health maintenance organization, has participated in Minnesota Health Care Programs (MHCP) since 1993. Blue Plus currently has more than 134,000 members in the Prepaid Medical Assistance Program (PMAP), MinnesotaCare and Minnesota Senior Health Options (MSHO) and is the largest health plan serving MHCP members in greater Minnesota.

Minnesota introduced managed care for MHCP over two decades ago because the fee-for-service program left too many enrollees without access to consistent, high-quality medical care. Blue Plus and other managed care organizations made their extensive provider networks available to MHCP members, managed financial risk for the state, and offered a wide variety of care management and other services. Over the years, we have also worked with the state to develop and implement innovative programs such as MSHO and participated in stakeholder workgroups for initiatives such as development of the assessment tool known as MnCHOICES. These collaborative efforts have contributed to Minnesota's leadership in access and quality for Medicaid enrollees who participate in managed care. To cite just one example, a recent DHS study found that individuals enrolled in MHCP managed care plans were more likely than fee-for-service enrollees to receive a wide range of preventive services. According to the report, "FFS rates are well below rates that are achieved in the managed care delivery system".¹

¹ Robert J. Lloyd, *2010 MHCP FFS and Managed Care Performance Measurement Comparison*, Minnesota Department of Human Services Performance Measurement and Quality Improvement Division (December 2011)

In light of our 20-year history of participation in MHCP, Blue Cross notes with concern that the draft waiver proposal rarely mentions managed care. The document makes an effort to link together the programs and services that will be launched or extended through *Reform 2020*, but it does not describe the context in which these reforms will operate. Because more than 600,000 Minnesotans are enrolled in MHCP managed care plans, this context is necessary not only to help reviewers understand the framework of MHCP – but also to clarify which changes will apply to managed care, fee-for-service or both.

The draft waiver proposal includes a major section on the expansion of the Health Care Delivery System (HCDS) into an Accountable Care Demonstration that encompasses total and partial cost of care arrangements. Minnesota health plans are national leaders in partnering with providers to create innovative payment models, such as Blue Cross' nationally recognized aligned incentive contracts. We believe that successful operation of accountable care models hinges on an active partnership between providers and Minnesota's health plans. Additionally, these efforts should incorporate two important principles that are not clearly reflected in the current draft proposal. The first is simplicity. It is essential to ensure that new models of care delivery and payment result in easier and more affordable access – rather than additional complexity, administrative costs, and discontinuity of care as people move among programs (and between MCHP and exchange coverage after 2014). The second principle is a level playing field. To the extent HCDS/accountable care arrangements take on responsibilities often fulfilled by managed care organizations, they must be held accountable for meeting solvency, coverage and other requirements that apply to MCOs. It is not clear whether the five waivers requested for the Accountable Care Demonstration – especially the two waivers of managed care regulations - would contribute to similar treatment of accountable care organizations and managed care organizations.

The *Reform 2020* proposal also includes important changes that, in some cases, will provide MHCP members with greater flexibility of services and providers. To ensure quality, budget neutrality and enrollee satisfaction, it is important that all parties – MHCP members, providers, health plans and DHS – have a shared understanding of program parameters. The importance of such clarity increases as the program becomes more flexible, and the draft proposal would benefit from revisions to clarify who is and is not eligible for which services. The sections about personal care and transitional services, in particular, currently leave the reader with questions about the services available to people who do or do not meet level of care requirements.

Thank you for the opportunity to provide these comments on the draft waiver proposal. Blue Cross also participated in developing the letter submitted by the Minnesota Council of Health Plans, and we endorse the comments presented in that letter.

Sincerely,

A handwritten signature in black ink that reads "Scott A. Keefer". The signature is written in a cursive style with a long horizontal line extending to the right.

Scott A. Keefer
Vice President
Policy and Legislative Affairs



2446 University Ave. W.
Suite 110
St. Paul, MN 55114-1740
phone 952-920-0855
fax 952-920-1480

July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 644998
St. Paul, MN 55164

Dear Mr. Godfrey:

We are responding to the requests for comments on the **Reform 2020: Pathways to Independence, Section 1115 Waiver Proposal**. Thank you for this opportunity to provide feedback on this important proposal.

For many years, members of The Arc Greater Twin Cities and other members of the disability community have urged the department to transform our service delivery system into a more self-directed and responsive model. We believe that this proposal takes significant steps toward reaching these goals.

There will be challenges in the years ahead in the implementation of these waivers to ensure that these goals remain and do not get lost. We commend the department for embarking upon this path and stand ready to provide as much assistance as we can to fully realize these goals. We urge you to encourage the involvement of individuals and families on the implementation council.

We want to express our full support for the comments that have been submitted by the *Minnesota Disability Law Center* and *The Arc of Minnesota*. There has been a coordinated effort by the *Minnesota Consortium for Citizens with Disabilities (MN CCD)* to present this information to the entire disability community and to gather input.

1.2.2 Demonstration to Reform Personal Assistance Services

We fully support the proposal to adopt the Community First Services and Supports (CFSS) as a Minnesota version of the Community First Choice Option that will expand Personal Care Assistance Services (PCA) and expand self-directed options as previously authorized in the 1915(K) option. However, the redesign of the current PCA services must minimize service interruption to current users.

The definition of dependency should be changed to include persons who need **prompting and cuing** to accomplish ADLs and health-related tasks.

1.2.3 Demonstration of Innovative Approaches to Service Coordination (Children with CFSS).

There has been a goal of better integrating school and home and community-based services for children. However, we are in agreement that the proposal to promote coordination with school services for children who have two or more complex health-related needs, receive mental health services, or exhibit physical aggression will not work well in school districts because of the lack of experience and knowledge base of school staff in serving the individual needs of children outside of the school setting. This was tried in the past with the IIP process; that system did not work to support students and families.

1.2.5. Demonstration to Empower and Encourage Independence through Employment Supports

We support increased efforts around employment for persons with disabilities. Individuals with disabilities are significantly over-represented among citizens who experience long-term poverty. Without an increase in competitive employment, individuals with disabilities will continue to have limited access to the opportunities, choices and quality of life available to other citizens. We ask that the reform emphasize competitive employment as a desired outcome.

1.2.6. Housing Stability Services Demonstration

We support the proposal to expand housing options for persons with disabilities. Housing services are one of the most critical services for assuring that vulnerable individuals retain the supports necessary to remain in the community. We have worked with the Housing Access Services Program (HASP) and know that providing a full range of supports that begins with lifelong planning is beneficial to the individual and is also cost-effective.

9.12 Services for Children with Autism

As part of the Reform 2020 Medical Assistance (MA), DHS has proposed providing treatments and services to children with autism under a coordinated "Autism Benefit Set." DHS's written proposal purports to provide more streamlined services to children aged 0 through 7, while requiring children over age 7 to receive services through the public school system. This is a reduction of service.

The Arc Greater Twin Cities is very concerned about the lack of detail in the proposal and any age limit on services. Services should be based on need. The plans outlined lack emphasis on service quality and provider standards. It is extremely important that all children who have autism receive MA coverage for medically necessary care. Families of children with autism need affordable access to a range of options for treatments, services and supports.

Thank you for the opportunity to comment. We believe your efforts to welcome and incorporate stakeholder involvement in these reform initiatives will continue to be critical for creating effective and safe services. We look forward to opportunities for continued input through the Implementation Council and other stakeholder work groups and meetings.

Respectfully,



Debbi Harris
Board Chair



Gene Martinez
Senior Public Policy Advocate

Dooley, Lea M (DHS)

From: Weeks, Stacie <sweeks@mnlisap.org>
Sent: Tuesday, July 17, 2012 4:13 PM
To: *DHS_Reform2020Comments
Cc: Godfrey, David W (DHS)
Subject: UPDATE to Legal Aid Comments to Reform 2020 Waiver

Importance: High

Hi,

My sincere apologies! There was a mistake in our first submission of comments to the Reform 2020. Please replace that submission with this submission of comments (See below, and attached for the word version.) Again my apologies for any administrative burdens this may cause. Please don't hesitate to call if you have any questions. If you need a signed version, please let me know.

Thank you!

Stacie

Stacie L. Weeks, JD, MPH
Staff Attorney, Legal Services Advocacy Project
651.842.6903 (Office); 612.354.6889 (Cell)

July 17, 2012

VIA EMAIL

David Godfrey, Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164-64998

Re: Comments on Reform 2020: Pathways to Independence, Section 1115 Waiver Proposal

Dear Mr. Godfrey:

The Legal Services Advocacy Project (LSAP) appreciates the opportunity to submit comments on Minnesota's Reform 2020 Section 1115 Waiver Proposal. LSAP is a statewide division of Mid-Minnesota Legal Assistance, which advocates on behalf of all low-income individuals and families in Minnesota.

COMMENTS

I. Section 3: Accountable Care Demonstration

LSAP strongly urges the Department to establish robust consumer protections and accountability measures for the accountable-care demonstration. This includes, but is not limited to, creating requirements for direct notification to patients of their assignment to an ACO, their rights regarding that assignment, any limitations on access to providers and how they can overcome these limitations, and easy and accessible appeal processes to redress future issues or complaints. LSAP also recommends that the Department create guidelines and evaluation procedures to

ensure the dissemination of information and delivery of care is conducted in a culturally and linguistically appropriate way.

LSAP has concerns regarding the Department's request to waive patients' freedom of choice of provider. Waiving such choices has the potential to result in an adverse impact on access to and continuity of care. This is especially true for underserved or more remote areas of the state, where there are typically a limited number of providers and venues for accessing care.

For this reason, LSAP respectfully requests that the Department build in further consumer protections that specifically look at access issues. This includes, but is not limited to, regular data collection and tracking of health care access, adequate safety-net programs and provider networks, mechanisms to ensure continuity of care, and an easy and accessible appeals process to obtain care outside the accountable-care program to ensure that the patient's health outcome remains paramount to any short-term savings.

II. Section 8: Eligibility for Adults without Children

a. Asset test for adults without children in Medical Assistance.

LSAP strongly opposes the waiver request to impose an asset test of \$10,000 on adults without children who are enrolled in Medical Assistance. Asset-test policies discourage individuals from building the savings and assets they need to become self-sufficient and financially stable. Asset tests also add an unnecessary administrative burden and cost to the system, which conflicts with the state's current efforts to improve public-program efficiency.

Moreover, the federal Affordable Care Act (ACA) explicitly prohibits states from using asset tests for determining eligibility in the Medicaid Expansion program (adults without children) and applies this prohibition in 2014 to most Medicaid eligibility categories. Therefore, like adults without children, parents will no longer have an asset test—unless they are elderly, medically needy individuals, eligible because of other aid or assistance, or individuals who are eligible for Medicare cost sharing.

LSAP believes that, if the state is to achieve the stated goal of equity in eligibility rules for Medicaid enrollees, Minnesota should be moving away from asset tests, altogether, in accordance with the ACA, instead of reinstating such tests for adults without children.

b. 180-day residency requirement for adults without children in MinnesotaCare.

LSAP strongly opposes the reinstatement of the 180-day durational residency requirement for adults without children in MinnesotaCare. LSAP believes reinstating such a requirement would be not only bad policy, but also unconstitutional under the Fourteenth Amendment of the U.S. Constitution.

In *Saenz v. Roe*, 526 U.S. 489 (1999), the U.S. Supreme Court ruled that states were not free to condition the receipt of financial assistance through the imposition of residency tests that limited benefits for newly arrived residents, based on need. The Court concluded that such provisions violate the third component of the constitutionally protected right to travel by imposing a discriminatory classification on travelers who have elected to become permanent residents of the state in which they are being denied benefits. At this time, LSAP is unaware of any U.S. Supreme Court decisions that have modified or overturned the *Saenz* decision.

c. Fiscal Analysis for Reform 2020 Section 1115 Waiver

LSAP appreciates the information as provided in this proposal. However, it is difficult to make a full assessment of this waiver without fully understanding its overall fiscal impact. Therefore, LSAP respectfully requests a fiscal analysis of Reform 2020 Section 1115 Waiver. For this reason, LSAP respectfully reserves the right to amend its comments to the waiver once this aspect is provided and reviewed.

CONCLUSION

LSAP appreciates the opportunity to provide comments on the Reform 2020 Section 1115 Waiver Proposal. We also appreciate the Department's efforts to provide public forums for discussion and review of the information in this proposal and look forward to future discussions.

Respectfully submitted,

Stacie L. Weeks, JD, MPH
Staff Attorney



July 17, 2012

Mr. David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey,

On behalf of nearly 700,000 members in Minnesota, AARP appreciates the opportunity to submit the following comments in response to the Minnesota Department of Human Service's (DHS) Reform 2020: Pathways to Independence, Section 1115 Waiver, hereinafter referred to as the "Pathway waiver." We will also provide comments on reform proposals under 1915i, 1915k and other state initiatives.

AARP applauds the Department for taking on such a huge undertaking, and recognizes the enormous challenges our state faces both in terms of an aging population, as well as the budget pressures of how we will pay for this care.

As a result, AARP is supportive of the Department's efforts to reform the system to be more person-centered in order to achieve better outcomes and efficiencies, improve health, and reduce reliance on institutional care with the goal of creating a system that can most effectively meet the need of an aging population.

We remain concerned, however, that the Medical Assistance (MA) State plan and Essential Community Supports may not be adequate to meet the needs of those terminated from eligibility for the Elderly Waiver because they no longer meet the Nursing Facility Level of Care (NF LOC) as is recommended in the Long Term Care Realignment 1115 Waiver -- submitted previously to the Centers for Medicare & Medicaid Services (CMS).

Thus, we urge the Department to continue exploring ways to mitigate the potential harm to these seniors by exploring how the application of the 1915i state option might be broadened beyond just the recommendations set forth in the Pathway Waiver to address the loss of coverage. As the Department acknowledges, the 1915i state plan option permits states to target populations with specific services packages but it also allows the state to require eligibility criteria that are more stringent for institutional services than the criteria for community services.

On the following pages, are additional comments as they relate to the Pathway Waiver, including the development of new delivery reform models through Accountable Care Organizations (ACOs), Personal Care Assistance (PCA) Services Reform, and the Expansion of Transition Services, along with several other initiatives.

Accountable Care Demonstration – The Need for More Detail on Consumer Protections

AARP supports the development of new care models through Accountable Care Organizations (ACOs) to address barriers and fragmentation of care delivery, and to better align the financial incentives to provide and improve the quality of care. However, AARP believes delivery reform will not succeed without beneficiary acceptance of new care models and active patient engagement in their care. We believe beneficiaries need clear and consistent information before they decide to receive care from a clinician or institution participating in an ACO.

Thus, we urge the Department to provide more specificity around the development of consumer protections in these models and to provide more detail around the risk-sharing mechanisms. In particular we would like to see more detail around the following consumer protections:

- Development of an Independent Complaint and Appeals process for consumers to file complaints or grievances.
- Adequacy of Provider Networks—including geographic proximity of providers.
- Transparency of risk/gain sharing arrangements and mechanisms that avoid either windfall profits or devastating losses.
- Enrollment and Opt-Out Provisions for consumers who choose not to enroll in the ACO.

Demonstration to Reform Personal Care Assistance (PCA) Services

AARP supports efforts to reform PCA Services to enable Minnesota to provide person-centered, consumer-controlled, home- and community-based attendant care services through the application of the 1915k and 1915i state plan options. AARP has a long history of working to ensure people age with choice, independence, and dignity. Community First Services and Supports (CFSS) – which will replace our current PCA benefit under the state plan – can take us a long way toward achieving a person-centered, cost-effective, long-term care system in Minnesota. In addition, it will provide a six percentage point increase in federal matching assistance payment (FMAP). Below are our specific comments related to the new CFSS demonstration:

1. **Use of 1915i in the State Plan Option for individuals who do not meet an institutional level of care** - We are pleased that the Department intends to use the 1915i option which allows our state to provide PCA services to individuals who do not meet an institutional level of care, but choose the PCA self-directed option. Also, we appreciate that the Department will apply the special income eligibility rules used for home and community based waivers to a portion of the population that would receive CFSS, but we would encourage the Department to extend this to all individuals in the demonstration, including those who do not meet the institutional level of care. We believe the special income rules will ensure that all individuals have adequately resources to pay for all of their household expenses in order to live independently in the community.

As we stated in our opening paragraph, we continue to urge the Department to consider using the 1915i application for seniors who no longer meet the NOLC under the 1115 Long Term Care Waiver. We suggest this because we believe the new ECS program will not be as adequate to meet the needs of many seniors who are currently on the Elderly Waiver program. Additionally, we believe it is consistent with the Department's desire to streamline and simplify the complexities around the myriad of home and community based waiver programs.

2. **Addition of Care Coordination and other services with PCA Services** - AARP supports the provisions in the CFSS option to expand services provided under the PCA self-direction option to include home care targeted case management and service coordination, along with other services such as assistive technology, environmental modifications, skill acquisition and assistance with activities of daily living which includes household chores, shopping and other tasks to maintain independence in the community. However, we believe that PCA services must be restored for those individuals needing prompting and cuing as a dependency. This includes individuals with cognitive limitations, mental illnesses or brain injuries. Finally, we are hopeful that the addition of home care targeted case management for those who choose self-direction may help to address Minnesota's low ranking in home care quality indicators scores.
3. **Criteria for PCA Services which do not align with the Level of Care Criteria** - Under current rules PCA services require meeting criteria that is stricter than the proposed Nursing facility Level of Care. We do not believe that it is consistent for someone to be eligible for an institutional level of care and not be eligible for PCA services. PCA services are actually broader, and therefore anyone who meets institutional level of care should also meet the criteria for PCA services.

Demonstration to Expand Access to Transition Services

AARP strongly supports the proposal to expand access to transition services, including the addition of the long term care consultations and to receive federal matching dollars for these services. With the population rapidly aging in our state, it will be important to offer long term care planning earlier and more often. At AARP, we hear from consumers who tell us that making decisions about long term care planning can be very confusing and that more often than not, families wait to make decisions until a crisis occurs. Thus, there is a real need for more unbiased information for consumers on long-term care planning, along with critical information on financial options.

Long-term care consultation helps consumers understand the costs and choices in available to them, whether that be in a nursing facility, housing with services or at home, where most people prefer to be. In addition, this is projected to save the state millions of dollars, as consumers are expected to stay in their homes longer rather than spend down their assets sooner when they move into more expensive Assisted Living.

Additional Proposals:

Use of 1915i state option for those People with Complex Needs - AARP supports expanding the 1915i state option for those with complex needs, including adults with co-occurring developmental or cognitive impairments and serious mental health conditions.

Lifting the Cap on Medically Complex Seniors who are Vent Dependent - AARP is supportive of this provision which allows individuals who are assessed at this level of need to continue to receive Elderly Waiver Services in their own home or in a housing with services setting, rather than living in an institution to receive this kind of needed care.

Mr. David Godfrey
July 17, 2012
Page Four

MA Eligibility for Adults without Children - We oppose the waiver request to make eligibility more restrictive for Medical Assistance and MinnesotaCare by imposing a residency requirement of 180 days and establishing an asset test of \$10,000 for adults without children who have incomes under 75% of the Federal Poverty Level. We believe this will force more people onto the rolls of the uninsured, and thus cost the state more.

Strategies for Integration of Long-Term Services and Supports with Other Initiatives, Health Home Demonstration - We are very supportive of the many proposals to integrate long term services and supports into the state certified health homes; the development of the Alzheimer's Health Care Home Demonstration to implement an integrated primary health and community service model for patients with Alzheimer's disease; and the health home demonstration to integrate behavioral and physical health care for people with mental illness.

In conclusion, AARP believes that the Pathway Waiver -- along with many of the other proposals being undertaken by the Department -- are generally consistent with AARP's goal of ensuring that people have the quality services and supports they need to stay in their homes and communities, instead of more costly institutionalized care. Nevertheless, we remain concerned about the adverse impact the 1115 long term care waiver may have on some seniors who may lose coverage under the EW program and thus would encourage the Department to look at the 1915i state plan option for this population similarly to what the Department is doing with other populations in the Pathway Waiver.

Again, thank you for the opportunity to comment. If you have further questions or need additional information, please do not hesitate to contact me or Mary Jo George, AARP Associate State Director for Advocacy at mjgeorge@aarp.org or at 651-271-6586.

Sincerely,

Michele H. Kimball
Director

Dooley, Lea M (DHS)

From: Burandt, Barbara J <Barbara.Burandt@allina.com>
Sent: Tuesday, July 17, 2012 4:05 PM
To: *DHS_Reform2020Comments
Subject: Comments from MNHPC

Palliative Care Services

The Minnesota Network of Hospice and Palliative Care (MNHCP) is an organization whose mission is to promote quality of life in our communities. Our goal is to increase understanding and access to the following vital components of healthcare: advance care planning, palliative care, and hospice services.

MNHCP proposes palliative care services be included as an essential benefit in the Minnesota Health Care Reform 2020. These services are provided to adults, children, and the families of those experiencing a serious and/or life-limiting condition.

Palliative care services offer:

- relief from pain and other uncomfortable symptoms;
- assistance with difficult medical decision making throughout the continuum of care;
- coordination of care services and assistance in navigating the health care system;
- guidance in the development of a plan for quality living based on needs, concerns and goals of care;
- emotional, psychosocial, and spiritual support to patients and their families.

Palliative care, available from birth to adulthood, has the goal of improving the quality of a seriously ill person's life and providing community-based support to patients and families from the time of diagnosis. This differs from hospice care, which focuses on relieving symptoms and supporting patients with a life expectancy of months, not years.

Palliative care, when included in a benefit package, will support robust primary care, facilitate care coordination to reduce fragmentation in the health care delivery system, improve quality of life, and lower the cost of non-beneficial care.

For these reasons, MNHCP strongly believes palliative care services are an example of high quality, cost-effective care and must be included in the Minnesota Health Care Reform 2020.

Links:

<https://www.revisor.mn.gov/statutes/?id=256B.021>.
<http://www.icsi.org/search.aspx?searchFor=palliative+care>.
<http://www.stratishealth.org/expertise/longterm/palliative.html>

Barbara Burandt PHN
MNHPC Chair
Public Policy Committee
Barbara.burandt@allina.com



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Southern Prairie Health Purchasing Alliance

Alliance member counties: Chippewa, Cottonwood, Jackson, Kandiyohi, Lincoln, Lyon, Murray, Nobles, Redwood, Rock, Swift and Yellow Medicine

July 17, 2012

Delivered via email to: Reform2020Comments@state.mn.us

David Godfrey

Medicaid Director

Minnesota Department of Human Services

P.O. Box 64998

St. Paul, Minnesota 55163

Re: SPHPA Comments to Waiver Proposal Draft

Dear Mr. Godfrey;

Southern Prairie Health Purchasing Alliance (SPHPA) is pleased to submit comments to the draft *Reform 2020* Section 1115 Medicaid Waiver Request that was released for public review on June 18, 2012.

SPHPA is a developing collaboration in the 12 counties in rural southwestern Minnesota that are named above. The Counties have been working together for more than five years to develop a new approach to care delivery for the population that lives and works within our borders. Our developing model features a partnership between the Counties, tribal services, local providers and community services, and is focused on assuring improved care coordination, improved health outcomes and cost savings. The model we envision is much like what has been described on page 21 of the Waiver Request draft regarding Hennepin Health.

We are pleased to read that the State supports the need to better coordinate and integrate these services in order to best support our residents who are enrolled in public programs. While we are ready to respond to the next round of RFPs for Health Care Delivery System Demonstrations, we would encourage the State to consider the following:

- Implementing the proposed Integrated Care Partnerships (ICSPs) for the dually eligible population as an intermediate step toward full risk or partial risk sharing with provider systems, may not be necessary. The continued involvement of health plans may delay achieving the goals outlined in the Waiver Request draft – holding providers accountable for care and outcomes.
- Initiating an additional round of stakeholder input into the major design elements and policy decisions, before releasing the next version of a proposed model and RFP, will likely delay the process for those provider groups who are ready and eager to move forward. While we

appreciate the importance of open dialogue, we would welcome the opportunity to begin a demonstration of our model in 2013. We are willing to be a 'blended' demonstration for the State by providing the integration of county health and social services with medical care (as is being tested by Hennepin Health), along with moving forward with a robust reward-sharing Health Care Delivery System demonstration, while also providing many of the health plan 'back office' functions (such as claims payment, enrollment, etc.). We are not a health plan, so taking insurance risk for those participating in our program is not an option at this point. We are more than willing to eliminate the duplicative functions that now occur at the health plan level and provide them at the delivery networks level.

- The Waiver Request draft indicates that counties, tribes, and other community organizations 'can and will be encouraged' to participate in integrated care provider organizations. We suggest that counties must take on leadership roles in developing these organizations in rural areas. Counties are the safety-net for residents who fall through the cracks of the current 'medical' system and for those whose behavioral and mental health issues prevent them from accessing support.
- Data collection and sharing across the team of service providers is critical to the success of these projects. There is a need for both an immediate exchange of key indicators for service delivery purposes and a need for complete data on all services received for population health management and financial accounting. We applaud the State's vision to include in the Waiver Request authority to share data between the state, providers, health care and welfare systems. However, the challenge from our perspective is how to fund the cost of developing data warehousing structures and analytic capabilities. We would encourage the State to think creatively about how it can facilitate financial support for these activities and prevent each accountable network from having to 'recreate the wheel' in this regard.

We appreciate the opportunity to provide our thoughts on the Waiver Request draft and to provide you with a brief description of our vision for the future of health care delivery in rural Minnesota. Please contact me directly, at 507.215-2280 or email jmfischer@starnet.com if you have any questions.

Sincerely,

Mary Fischer
Executive Director

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 17, 2012 3:42 PM
To: *DHS_Reform2020Comments
Subject: [REDACTED]

My nephew [REDACTED] has autism. He is unable speak but communicates his needs non-verbally. He attends the [REDACTED] and it has changed his life. He reads, follows directions and is much calmer since he has been at the [REDACTED]. [REDACTED] will not outgrown autism. The need for him to attend the [REDACTED] is crucial to his family and to [REDACTED] development.

Kids don't grow out of autism by age 7 so why should the state end the funding? These kids deserve every opportunity to get help and I want my tax dollars to help these kids. I am doing this for [REDACTED] -Age 8. He is a non-verbal kid with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

My name is:

[REDACTED]

[REDACTED]

Sincerely,

[REDACTED]
Aunt to the amazing [REDACTED]

Dooley, Lea M (DHS)

From: Heather Kilgore <Heather.Kilgore@PACER.org>
Sent: Tuesday, July 17, 2012 3:02 PM
To: *DHS_Reform2020Comments
Subject: PACER Center Comments on Reform 2020: Pathways to Independence proposal

David Godfrey, Medicaid Director
Minnesota Department of Human Services

Dear Mr. Godfrey,

Thank you for the opportunity to comment on the draft Section 1115 Waiver Proposal "Reform 2020: Pathways to Independence." As a nonprofit parent center, PACER has worked to ensure inclusion of children and youth with disabilities in their educational, recreational, and other community settings to the greatest extent possible. Minnesota has been a national leader in the quality of service and commitment to supporting individuals with disabilities in achieving their fullest potential in the community. PACER commends the efforts and commitment of the MN Department of Human Services (DHS) and others in seeking to continue this history while reforming services and supports for individuals with disabilities. PACER's comments focus on three proposed demonstration projects: Section 4 - Demonstration to Reform Personal Assistance Services and Demonstration of Innovative Approaches to Service Coordination (Children with CFSS), and Section 9.1.2 – 1915(i) for Children with ASD Diagnosis.

Section 4: Demonstration to Reform Personal Assistance Services

PACER supports the intent to focus the reform of personal care assistance services on consumer direction. Improving personal care assistance services will allow more individuals to live independently, and will have a long term positive effect on individuals with disabilities and their families and communities. The newly renamed program, Community First Services and Supports (CFSS) includes expanded eligibility and increased minimum levels of service. PACER supports these two improvements, and many of the families we serve, who have children and youth with disabilities and/or special health care needs would benefit from these reforms. PACER also supports the efforts to streamline and simplify the access and planning for CFSS. A particularly important reform is the added flexibility of the CFSS program to include skills acquisition and assistive technology. The addition of service coordination for those individuals not already receiving case management will be a critical improvement.

These reforms will require frequent and clear communication with individuals and families, and PACER encourages DHS to include community-based disability organizations as partners in communicating these changes. Through training and individual assistance, PACER assists many families to navigate the current PCA system, and would welcome the opportunity to provide additional services for families. PACER also urges additional efforts at recruitment and retention of qualified staff (including relatives) to provide CFSS because the supply of appropriate, reliable, and skilled PCAs has never fully met the need across the state. Finally, PACER encourages that the training provided to existing and new case managers and those providing the expanded service coordination under the new CFSS program include information on the unique needs of children and youth with disabilities and special health care needs and their families.

PACER has significant concerns with the Demonstration of Innovative Approaches to Service Coordination (Children with CFSS) proposed project. The description of this demonstration raises many questions for PACER as a parent advocacy organization. Though school districts would be chosen based on their willingness to participate, would families have the same ability to opt out? It is critical that families are able to choose whether or not to have school-based service coordination, and still retain access to home care service coordination. Because PACER's primary advocacy services are related to schools and students in special education, we urge close collaboration with school staff and the Minnesota

Department of Education in designing this demonstration. The full support of the school will be critical, particularly for the level of training that a school-based staff member would need to fully coordinate CFSS services for a family.

Section 9.1.2 – 1915(i) for Children with Autism Spectrum Disorder (ASD) Diagnosis

PACER supports the stated intent to deliver coordinated early intervention services for children ages 0-7 with a diagnosis of ASD, including “service coordination, evidence-based behavioral interventions, family psychoeducation, psychological counseling, state plan medical services, and respite.” The need to provide children with ASD and their families with comprehensive services and supports is long overdue. PACER has major concerns with ending this comprehensive approach at age 7 and with the reliance on the Individualized Education Program (IEP) for special education under the Individuals with Disabilities Education Act (IDEA) for services for students with ASD over age 7. The idea of increased integration of Medicaid entitlement programs with the Free Appropriate Public Education (FAPE) mandate under IDEA has complex ramifications for schools and families. PACER has an issue with the lack of detail included in this proposal, as this section raises many questions and offers few answers. PACER urges close collaboration with the Minnesota Department of Education, as well as with parent advocacy organizations specializing in special education if this effort is to move forward.

PACER commends DHS staff for their efforts at reforming Minnesota’s Medicaid programs to better support individuals with disabilities and their families in their communities. Many of the reforms outlined in the Section 1115 Waiver Proposal “Reform 2020: Pathways to Independence” will improve the lives and expand the opportunities for Minnesotans with disabilities. PACER has concerns about the coordination of these reforms with special education under IDEA, the impact on services for children and youth, and with the availability and training of staff and home care service coordinators under the proposed CFSS program. We look forward to participating in further discussions as the process moves forward.

On behalf of PACER Center, thank you for your consideration. We may offer further comments as the process unfolds.

Sincerely,

Paula F. Goldberg, Executive Director
PACER Center
Wendy Ringer, Director
PACER’s Health Information and Advocacy Center

July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey,

Lutheran Social Service of Minnesota (LSS) applauds the Department of Human Services for the values of self-direction, personal choice, individualized planning, and quality outcomes that have been driving the Medicaid Waiver process, and led to the development of the *Reform 2020* proposal. I agree with the stated *Reform 2020* goals of better outcomes, the right service at the right time, and ensuring the sustainable future of long term services and supports.

The comments to follow suggest areas where *Reform 2020* can be enhanced to communicate the depth of commitment found in Minnesota to assuring that each individual with a disability is seen as a unique individual, and is understood first for their abilities to design their own life and not have anyone else design it for them. Minnesota will have achieved true reform when each person with a disability is able to achieve optimal quality outcomes and community integration because using the tools afforded by Medicaid supports, they are living their choices and thereby pursuing their life's dreams.

The identifying characteristics that are fundamental to this vision include:

- The system of supports first sees each individual from a standpoint of ability, and asks how supports can be designed to maximize their design for full life in community.
- Service options are easily accessible; the system is navigable so individuals with disabilities and their trusted partners have the tools and information needed to implement their life plans.
- Quality outcomes are set by the individuals and relate intimately to achieving their personal life goals.
- Choice and achievement of personal goals are the driving forces for evaluating plans, and are values that drive licensing functions to focus on personal outcomes and quality of life.
- Individuals with disabilities are knowledgeable of all financial resources available to them and where they have flexibility in spending resources to meet their needs.
- Annual budgets for people with disabilities include accrued savings.
- Minnesotans expect to see and benefit from the full inclusion of their neighbors with disabilities as they creatively engage in all facets of public and private life.
- Full implementation of the Americans with Disabilities Act – with special attention to the standards developed to empower personal choice.
- Simplification of case management that allows for a single case manager, chosen by the individual, who can support full implementation of the individual's life plan. The case

manager should be any person or provider selected by the individual with a disability, and can be hired and fired at will by the individual.

Specific recommendations and edits, numbered one through five below, for *Reform 2020*:

1. System reform can shift the discussion away from the individuals the reforms seek to support. Though there is collective interest in assuring all people with disabilities in Minnesota benefit from *Reform 2020*, the framework of the proposal does not explicitly focus attention on how the proposed benefits will impact individuals. Attached is an edited version of the *Reform 2020* Executive Summary, pages 10-12, changed in tone to reflect the focus on individuals with disabilities in Minnesota.
2. Personal choice as a guiding goal and principle for *Reform 2020* must be accompanied by a robust budgeting tool that affords each individual with a disability the opportunity to fully understand resources they are eligible to utilize. With this full knowledge, people with disabilities and their trusted partners will have true self-direction.

Suggested edit, page 37, add in the first section:

- Build off of the MnCHOICES assessment a complete budget that presents to each person their global individual budget with explanation of how each funding stream applies to them and how it may be utilized to support their life plan (eg. use of funds for Housing, Employment, SNAP and other supports that relate to each person's eligibility). Achievement of this goal would be that the person would be able to decide how to flexibly utilize resources allocated to them in any way they chose (eg. saving on housing and spending more on employment).
3. The Partners Panel has advised throughout the waiver design process that a thoughtful discussion of personal choice and associated risk must be a priority for public deliberation. Achievement of the goals of the proposal require that the understanding of choice and risk and associated system behaviors be updated to reflect the goal of full self-direction and optimal self-determination. There appears to be significant tension between standards aimed at protecting “vulnerable adults” from making choices which may cause them harm and potential tort liability for a provider organization and the ADA which prohibits consideration of risk to self when a person with a disability is otherwise eligible to participate in a program or activity. These issues must be part of the continued stakeholder work, held within the Development and Implementation Council.

Suggested edit, page 38 paragraph three, beginning line three: We will expand participation in the next phase of development and form a separate Development and Implementation Council during the summer of 2012 that will assist the Department in the more detailed planning and protocols, including incorporating the value of person-centered approaches and genuine self-direction with choice and risk into operational structures, that will be necessary when preparing legislation for action by the 2013 Minnesota Legislature, and implementation plans to terminate the PCA program, and establish the Community First Service and Support in its place.

4. Minnesota was early to create opportunity for self-direction and thus has a long track record of effective Fiscal Support Entity (FSE) engagement. New Fiscal Management Entity (FME) contracts established to support exponential growth in self-direction should build off of the proven track record of current FSEs to assure that the quality of service, local knowledge and principled leadership found in the FSE system continues.

Suggested edit, page 39 paragraph three, beginning line three: Candidates will be evaluated based on proven track record of self-directed service within Minnesota, holding appropriate current state credentials, and demonstrating quality of service. FMEs will sustain and enhance current FSE best practice including streamlining services by charging FMEs to complete plan approval and authorize services, and maintaining the high quality, high touch customer service provided to Minnesota today.

5. Demonstrating success must include metrics that reflect the quality of self-direction obtained through implementation of the waiver proposal. Evaluation metrics should include outcomes that speak to quality and rigorous assessment of whether true self-direction has been achieved

Suggested edit, page 108, add to Major Outcomes:

Survey data of CTSS participants to measure personal response on questions of achievement of true self-direction, personal choice, individualized planning, and community integration.

Quality Council cumulative report on Value Of Individual Choices and Experiences (VOICE) reviews conducted with individuals using CTSS. Reportable measures will speak to the VOICE areas of basic assistance, special assistance, relationships, choice, inclusion, economic support, safety and dignity, and coordination.

Lutheran Social Service of Minnesota remains committed to people with disabilities in Minnesota living a “My Life, My Choices” life as soon as possible. I am grateful for the opportunities we have had to contribute to the development of *Reform 2020*. LSS is ready to assist the Department in advocating for the quickest possible turnaround of the proposal at CMS.

Thank you for your commitment to people with disabilities in Minnesota living fully human lives of their own design.

Sincerely,

Jodi Harpstead
CEO

Attachment:
Reform 2020_1 Section One_Executive Summary



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with Disabilities
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To: David Godfrey, MN State Medicaid Director

From: The MN Consortium for Citizens with Disabilities

Re: Public Comments on the Reform 2020 Section 1115 Waiver Proposal

Date: July 17th, 2012

On behalf of the Minnesota Consortium for Citizens with Disabilities (MN-CCD), a state-wide, cross disability public policy coalition, we thank you for the opportunity to submit public comments on the Reform 2020 Section 1115 Waiver Proposal. We agree with the proposal's identified goals of achieving better health outcomes, simplifying programmatic administration and access, ensuring the long term sustainability of the Medicaid program, increasing the flexibility and responsiveness of the LTSS system, and supporting Minnesotans to have a meaningful life at all stages according to their own desires. These proposal goals align well with the three founding principles that guide MN-CCD in our disability policy advocacy work: access to needed services, empowerment and choice, and quality of care.

However, despite the strong alignment between the high level proposal details and MN-CCD's guiding principles, we are all aware of the critical and significant implementation and operational decisions that have yet to be made and that will greatly determine the impact of this proposal on the lives of Minnesotans with disabilities. To that end, below we have outlined specific opportunities that we see for further developing the proposal in such a way that it positively impacts Minnesota's disability community. We have structured our comments around some of the specific initiatives included in the proposal that we feel will most significantly impact Minnesota's disability community. Many of our member organizations (disability advocacy and provider organizations across the state of Minnesota) will also be submitting public comments that will touch on the specific initiatives below as well as other proposal components of interest to the disability community. We are happy to discuss further any of the points below. Again, thank you for the opportunity to provide comments on the proposal.

Section 3: Accountable Care Demonstration

MN-CCD agrees with the overall vision of this section of restructuring provider incentives such that providers are discouraged from providing care in ways that shift costs to other parts of the service system. For Minnesotans with disabilities, a population that can have complex health and long term service needs, this step towards more fully integrating various care needs is positive.

In the "next steps" section of the Accountable Care Demonstration section, an upcoming (Spring 2013) RFP process is described that will allow direct provider contracting with integrated care provider organizations. The proposal describes a stakeholder process that will take place prior to the release of the RFP, and we at MN-CCD encourage the administration to ensure that attention to consumer choice is a formal and explicit agenda item for this stakeholder process. As this proposal describes, Minnesota is currently moving forward with a great number of positive initiatives focused on the provision of



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healthcare for the disability community. We as a state must make sure that each of these initiatives supports choice for the consumer in how, where and when they access their healthcare and other care needs.

In addition, we continue to have serious concerns about the integration of long-term services and supports (LTSS) with health/medical care because of the likely emphasis on the medical model of service provision. While we certainly support effective coordination of health care and LTSS, we oppose control over all of one's LTSS services by a medical care provider without experience in housing, employment, transportation and social relationships in the community. Rather than assigning medical entities or health plans the authority and risk for every project, we recommend seeking proposals where the community support providers are in charge and can subcontract for medical services. This would be of particular value for persons with high LTSS costs and average to low medical costs or those whose costs are quite stable year to year. We think it is essential to assure that persons who need long-term support services to remain as independent as possible in their communities are able to direct their own services based upon a person-centered plan rather than directed by a medical clinic or hospital. We urge that this proposal include clear safeguards, data reporting, appeal rights and disability-relevant outcome requirements for the provider.

Section 4: Demonstration to Reform Personal Assistance Services

MN-CCD agrees with the overall vision of this section of transforming the current PCA program into a new CFSS program with increased flexibility and overall programmatic simplicity. As has been identified and articulated in multiple studies and reports, the PCA program is a critical service for thousands of Minnesotans with disabilities, so this transition to a new program will be significant. We look forward to working with the administration on the development of the details of this transition, as there is not a great deal of detail in the proposal given how significant this change will be (perhaps understandably as this allows for increased stakeholder input as to the operational details).

We strongly support the proposal to use both the 1915k option and 1915i option in order to continue serving people who do not meet Minnesota's institutional level of care criteria. This is especially important given Minnesota's pending request to make the nursing facility institutional level of care (NFLOC) criteria more stringent, thus eliminating eligibility for important Home and Community-Based Services Waiver programs (EW, CADI, BI) for many people who need assistance to remain in the community. Additionally, we urge inclusion of institutions for mental disease (IMD) as an institution for the level of care requirement in CFSS, as allowed under federal law. We also support the increase in the minimum amount of time for persons who have one dependency in an activity of daily living (ADL) or Level 1 behavior to at least 90 minutes per day.

We urge that the Department of Human Services (DHS) retain the PCA Choice Option by offering three models for CFSS: a fully agency directed support service; an agency service which maintains the beneficial aspects of the PCA Choice Option, such as choosing your staff, training and scheduling; and the new self-directed option with an individual budget. We believe that many people currently using the PCA Choice Option will be reluctant to choose the totally self-directed option, at least initially. These



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individuals will be hurt by losing the self-directed authority they now have and by a reduction in their PCA staff wages. Clearly the pay for PCAs can be higher in the PCA Choice Option because nurse supervision and other administrative costs are lower for the agency. An abrupt decrease in the hourly wage of many PCAs will threaten the well-being of all current PCA Choice recipients.

We are in strong support of the self-directed option under CFSS with an individualized budget. We urge that the budget administrative cost be carefully determined with input of stakeholders so as to provide the maximum amount to the eligible individual for services.

The 1915k State Plan Amendment Option offers other beneficial aspects, such as skill acquisition, assistance with health tasks and an updated description of instrumental activities of daily living, which includes traveling and participating in the community, as well as communicating by phone or other media, shopping, essential household chores, managing finances, meal planning and other tasks related to maintaining independence in the community.

In addition, the 1915k option requires that assistance and supports be provided in the most integrated settings without regard to the type of disability, age or type of assistance needed to live an independent life. We strongly support these important requirements and believe that a reformed PCA program can offer more flexibility and assistance in tasks needed for persons with disabilities to remain as independent as possible in their communities.

On page 38 of the Reform 2020 proposal, a “Development and Implementation Council” is referenced. It appears that this development and implementation council will be responsible for providing recommendations to the administration on a number of critical issues associated with the transition from PCA to CFSS. We strongly encourage the administration to ensure representation of service recipients (this is already identified as a requirement in proposal) as well as service providers who have expertise in providing PCA services on this implementation council. Specific critical decisions will likely be made by this implementation council, including what will be considered allowable and unallowable expenditures from an individual’s CFSS budget, as well as how the identified service needs will be met through the CFSS program. These types of decisions will greatly impact how this program does or doesn’t work for those who access it, so we strongly urge the administration to seek out the expertise of those who have been accessing and providing PCA services for a number of years here in Minnesota. We, as MN-CCD, would be happy to help connect service recipients and providers with the administration to this end.

Additionally, on page 39 of the proposal, language describes the planned change that will take place in transitioning from Fiscal Support Entities to Fiscal Management Entities. The language indicates that “the final number of entities will be limited, although adequate in number to allow individuals a choice between at least two entities, regardless of where they live in the state.” Given the dramatic reduction this will be from the current number of FSEs here in MN, in moving forward with this specific component of Reform 2020 we would encourage the administration to ensure that individuals will indeed have meaningful choice between at least two high quality providers.



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Section 4.23: Demonstration of Innovative Approaches to Service Coordination for children with CFSS

We urge that DHS find another way to assure coordination with school services for children who have two or more complex health-related needs, receive mental health services or exhibit physical aggression to oneself or others or engage in property destruction requiring the immediate intervention of another person. We do not believe funneling intensive service coordination through school districts is a sound idea for a number of reasons. Schools do not now provide services 24 hours a day, 7 days a week. While districts could contract with agencies to do so, this is simply not part of the experience or institutional practice of school districts, and we believe will be inordinately difficult and lead to many gaps and problems for high-need children. Because schools do not provide services all day, 7 days a week, year round, staff are often unaware of the many needs a child has within the community and within their families. Again, it may be possible for a school district to contract with an agency with this expertise, but we do not understand why such a major shift in responsibility would result in positive outcomes for high-need students in a short time frame. Many families do not want all of their medical information to be shared with schools and teachers. It is important to remember that most students have different teachers and support staff every year. In addition, many high-need students have more than one teacher or other staff person during a school year. The spreading of one's private medical information across the school district is simply not warranted or desired by most families.

Additionally, relying on school resources, such as school psychologists, is mentioned as a reason to use the school as a basis for innovative service coordination yet Minnesota ranks low among states in the number of school psychologists across the districts. School psychologists do not have the training required for this level of treatment and service coordination. Our schools are simply not staffed with the professional resources to contribute to this effort. There is some concern that implementation of service coordination would result in cost shifting from special education services to Medicaid. We are concerned because schools have very strong incentives not to identify a student's needs. With authority over Medicaid, we believe the opportunity for cost shifting is increased. We do not think shifting authority to school districts is a sound method to assure children get both the educational and the health care services they need.

Instead, we suggest a demonstration to provide innovative approaches to service coordination for the children described based in our current human services system and relying upon a range of experienced providers to work closely with school districts to assure common approaches to the complex needs of these children in school, within their families and in their communities.

Section 5.2: Demonstration to Expand Access to Transition Supports, Return to the Community

We urge that the "Return to the Community" transition supports for people in nursing homes be clearly described as a service available to persons in nursing homes of any age. The emphasis in the description is on seniors but many persons under 65 could benefit from this effort.

Section 6: Empower and Encourage Housing, Work, Recovery and Independence

Access to housing and employment is a critical issue for Minnesotans with disabilities, and we at MN-CCD support efforts such as this to begin to address this issue. On Page 54 of this proposal, the specific



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services that a navigator under this demonstration project will provide are described. It is noted in this description that navigators will have access to DB101 in their work to support individuals in this demonstration. We would encourage the administration to include more explicitly in the list of navigator provided services: “information about employment impacts on housing benefits”. We at MN-CCD have found that one barrier to employment for individuals with disabilities has been unclear information on the impact of employment on housing benefits, particularly when the individual benefits from one of a long list of local and project-specific housing subsidies.

On page 54 of the proposal there is language around the provider qualifications that will have to be met for an organization to be considered as a potential navigation site, and we strongly encourage the administration to maintain those provider standard requirements, particularly the requirement of a demonstrated history of providing employment assistance services to workers with physical or mental health issues. Additionally, the overview of the evaluation and data collection processes that will be used with this particular demonstration project that is described beginning on page 55 is a positive step towards true measurement of this demonstration’s success, and we encourage the administration to seriously consider the findings of the evaluation and use this information to inform programmatic changes.

Additionally, while we support a statewide demonstration program focusing on five target groups of young adults, we are concerned that the requirements to be employed or to have been employed within the year or to have experienced an employment shift within the past year is too onerous for some of the target groups listed. In particular, targeting 18-year-olds and imposing these employment requirements simply misses the mark. We certainly agree that 18-year-olds in the circumstances described in the five groups could well benefit from navigation assistance, but we are concerned these individuals will not be included because they do not have employment experience. We think it is especially important to target young people graduating from high school for employment supports. The longer a person is both out of school and not working the more likely the person will be to seek the total and permanent disability status of Social Security. We urge that the employment eligibility requirements be expanded to include young persons in their first year after high school graduation in the categories listed, regardless of employment experience.

Section 8: Adults without Children Eligibility

We oppose the requested waivers to make eligibility for MinnesotaCare adults without children more restrictive by imposing a durational residency requirement of 180 days and establishing an asset limit of \$10,000 for Medicaid eligibility for adults without children who have incomes under 75% of the Federal Poverty Level.

Section 9.1.4: 1915i To Support Individuals with Mental Illness who are at Risk for Institutionalization without access to Integrated Community-Based Systems of Care

We strongly support the development of a 1915i state plan option to provide services which are flexible in terms of type, such as in-home services, employment supports or other therapeutic services and flexible in terms of intensity. The criteria for qualifying for the proposed services, however, are very restrictive. We



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support broadening a 1915i state plan proposal in order to provide services to persons before they end up in psychiatric hospitals, prisons, jails or nursing facilities.

Section 9.2.1: 1915(i) for Children with Autism Spectrum Disorder Diagnosis

The need to develop unique services for Minnesotans with ASD is something that advocates, providers and the state have all agreed upon, and we are glad to see attention to this issue in the Reform 2020 proposal. On page 80 of the proposal, language describes the vision for Minnesota to develop a 1915 (i) service to deliver early intervention services to support Medicaid eligible children age 0-7 who have a diagnosis of ASD. While there is much language in the proposal about the services that will be offered to this 0-7 age group, there is far less language around services that would be available to individuals with ASD who are over 7 years of age. We would encourage the administration to reconsider this decision given how many individuals with autism are not diagnosed until after age 7, as well as the significant service needs of those with ASD over age 7.

Additionally, we also support the proposal to ask CMS for technical assistance to assure that children from families with income over 150% FPL qualify for Medicaid under TEFRA or HCBS waivers because they meet those criteria for MA eligibility for children with disabilities in families above the required MA poverty levels. However, we urge that this issue be carefully reviewed with stakeholders given the pending changes to the nursing facility level of care (NF-LOC).

Additionally, on page 81 of the proposal it is noted that due to legislation passed during the 2012 legislative session requiring the MN Health Services Advisory Council (HSAC) to review treatments for ASD, it will be these HSAC recommendations, along with stakeholder input, that will guide the program policy on type, frequency, and duration of services to be covered by the 1915 (i). However it is also noted in the proposal that due to timelines, the department may initially propose benefit and service utilization criteria for this service in advance of recommendations by the HSAC, and will then consider amending the submission to CMS if changes are deemed necessary when HSAC completes its work. We would encourage the administration to be more explicit about this potential amendment process, perhaps by including timelines and explicit action steps that will be taken, to ensure that any potential service set implications of HSAC's findings are taken seriously.

Thank you again for the opportunity to comment.

Dooley, Lea M (DHS)

From: Mary Powell <mapowell5@comcast.net>
Sent: Tuesday, July 17, 2012 2:20 PM
To: *DHS_Reform2020Comments
Subject: Reform 2020 comment
Attachments: reform 2020 Autism.docx

Please accept this public comment. Thank you.
Mary Powell, President, Board of Directors
Center for Engaging Autism

The Center for Engaging Autism, an organization dedicated to promoting the successful participation of children with autism spectrum disorders and their families in their home, school, or community, is pleased to support the proposed initiative of the Department of Human Services to develop a 1915 (i) waiver to deliver early intervention services to children ages 0 – 7. We share the concern that many young children with ASD have been unable to access appropriate intensive services. Since 1994 research in ASD has provided evidence that young children with ASD show gains in communication, socialization, behavior control, and cognition through intensive intervention by trained therapists. (JADD, 1995) Quality therapeutic services are critical for the development of children with ASD.

The Center for Engaging Autism supports the development of a program of high quality services. These services should be individualized, based on a sound understanding of research in autism spectrum disorders. They should be evidence-based, including the research in the comprehensive behavioral intervention conducted by Sally Rogers (AAP in 2009). We strongly support the intention to coordinate program services with medical and educational services. However, CEA feels that the proposed autism waiver should also include a family centered approach that considers the value of family empowerment to the development of children with ASD.

The Center for Engaging Autism supports of this initiative and offers its participation in the planning and implementation of the proposed waiver. Please contact us at WWW.CEA4autism.org or 612-735-4332.

Center for Engaging Autism Board of Directors

Mary Bergaas

Lesley Heil

Susan Nyvold

Margie Paller

Mary Powell

Tammy Pulver

Joan Shoepke

Beth Synder

Kathy Teegarden

Anne Harrington, Executive Director

Dooley, Lea M (DHS)

From: Troy Fry <frybcba@embarqmail.com>
Sent: Tuesday, July 17, 2012 2:17 PM
To: *DHS_Reform2020Comments
Subject: Reform Feedback

July 17, 2012

*David Godfrey, Medicaid Director,
Medicaid Director Minnesota Department of Human Services P.O. Box 64998
St. Paul, Minnesota 55164*

To Whom It May Concern,

Topics Included (1) Recognition of Behavior Analysis, (2) Quality assurance for Behavior Analysis, (3) Adoption of a standard of assessments, (4) age and service consideration, (5) school readiness and willingness to collaborate, and (6) focusing on those individual that represent the greatest cost.

I wanted to take provide some feedback on the reform proposal. As a practicing Board Certified Behavior Analyst for the past 25 years in a variety states, I hope the following recommendations will provide some additional insight into future proposals or modifications. First, I would recommend looking to states (Florida, California, Tennessee, etc.) for guidance on the practice of Behavior Analysis. Second, consider looking into the standards and guidelines outlines for practicing Behavior Analyst outlined on the Board Certification site (bacb.com). Despite providing coverage for behavioral services, there is little in the way of adopted standards, program requirements, ongoing program review, etc., which quite concerning as a professional and as a tax payer. The field of Behavior Analysis prides itself in objectivity, transparency, and accountability which I see as asset to both consumers and the state. Perhaps adopting a Behavior Analysis coordinator to oversee the practice, collaborate with relevant agencies and interest groups would provide for effective leadership and ensure quality and effective/efficient practice is occurring across the service delivery spectrum. Bringing together professionals in the field as policy is being forged is critical. Behavior Analysis offers everything the state is seeking...the ability to provide effective and efficient services to all individuals with developmental disabilities with years of evidence-based proof. Behavior Analysis is not a one size fits all, rather treatment is highly specialized to the individual.

I am also concerned about any age caps and assumptions about school readiness. I believe that it is my job to prepare individuals and families for school, which requires different repertoires for different learners, but often there is still a need for schools to modify their systems/supports to ensure the individuals continue to learn and effectively participate in the setting. Unfortunately, even when there is interest on the teacher level to modify and or collaborate, the system often puts up road blocks or simply refuses to team for reasons other than what is best for the child and family. Providers must be accountable to be teaching the right skills, at the right time, in the right way. Assuming a individual will go from intensive 1:1 programming to school without difficulty is not fair by the learner or the school. We need to make sure we are getting kids in groups early, fading structure, fading staff, fading reinforcement, eliminating barriers to learning or using skills, etc. Funding needs to allow for fading within centers by having a billing code for less intensive ratio's making the cost of providing effective treatment significant less. As a Director of a clinic, and someone who wants to be accountable to kids families and funding sources, it was right by the individual and right by the funding source to fade out staffing supports as quickly as possible (i.e., the individual would continue to acquire "targeted" skills). The idea of 1:1 then to school is not likely a successful model for most learners and providers should be encouraged to reinforced for fading supports in more systematic and effective manner. All individuals regardless of age can benefit from Behavior Analysis, the issue is ensuring the right skills are being taught (first things first) in the right way at the right time in the right setting. Clearly, the trajectory is different (age, degree of disability, etc.) but the ability to improve quality of life for individual, family, and systems as well as decrease long-term cost is the same.

I also think that the State would benefit from adopting specific assessments that guide and measure progress for all levels of learners; those following a more typical developmental sequence and those who require a more functional curriculum. Most learners

can achieve "best outcome" if and I think it should be defined as being able to effectively participate in your community without the need for extra supports. Further, I think additional measures are important when determining "outcomes" such as parenting stress, community access, overall individual and family safety, etc. If an individual can become an effective speaker (make his/her wants and needs known, an effective listener (honor the requests of others/community), and limit the number of barriers to accessing the community (family, school, etc.) they and their family can achieve a high quality of life without the need for additional or lifelong "extra" or "significant" supports. Further, the family can stay together as there is less stress, as individual is now able to effectively participate and survive in the "community". If programs and funding only follows those learners who have the best chance to being typical learners, we will have failed greatly as those learners do not represent the "extremely costly" population if effective services are not provided.

Behavior analysis has a lot to offer individuals and the State. With effective implementation we will not only improve the quality of life of individuals with developmental disabilities and their families but will do so in a way that will result in cost savings to the State allowing for a sustainable system.

Thank you for your continued commitment to individuals with developmental disabilities and their families. Your task is massive, but know there are folks like myself who can and will assist if afforded the opportunity.

Regards,

Troy A. Fry, MS BCBA

Dooley, Lea M (DHS)

From: Krista Bean <KBean@stdavidscenter.org>
Sent: Tuesday, July 17, 2012 2:08 PM
To: *DHS_Reform2020Comments
Subject: Accommodation request

July 16, 2012

Dear DHS Reform 2020 representatives,

First, I would like to take the opportunity to commend DHS for a creating and releasing a redesign for the PCA program that really shows how innovative and thoughtful we are as a state. The new umbrella of services under Community First Choice Option (CFSS) broadens the scope and menu of services that recipients can use. At times throughout the service it has felt like are trying to put a square through a round hole. The program has morphed into something more than it was originally intended for and is definitely in need of a makeover. Amidst the challenges within the program there are pieces of the structure that are successful and I believe should remain intact.

In the redesign of the program I think it is incredibly important to offer an option similar to the PCA choice option. This service allows for families to have independence in directing the service without having to take on all the administrative duties of self direction. St. David's has a strong traditional program which could be an option for families who are not comfortable self direction, but it would create larger limitations for the recipient to self direct care. The model of the choice program is very unique and does provide a nice support option for families.

Over the past two years the state has put great emphasis on supervision and quality care within the program. This model would allow for more flexibility in the use of the service, which if used appropriately will be very valuable. However, as a state how will we mitigate our risk for fraud/waste/abuse in a larger consumer directed program? Currently, there are supervision requirements in place to assist in monitoring the usage of service, what will this look like under the new program? As an agency we strive to educate our families and operate under a program that protects the integrity of the service. The incorporation of this within the new design of CFSS will be critical for us to evaluate for our organization, as we attempt to calculate our risk.

Again, thank you for your thoughtfulness in the design of this program, the investment that was put into this reform is very apparent.

Sincerely,

Krista Bean

Krista Bean
PCA Program Director, LSW
St. David's Center for Child & Family Development

Building Relationships that nurture the development of every child and family

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From: Deborah Saxhaug <dsaxhaug@macmh.org>
Sent: Monday, July 16, 2012 1:53 PM
To: *DHS_Reform2020Comments
Subject: Accommodation request

4.2.3: Demonstration of Innovative Approaches to Service Coordination (Children with CFSS)
Providing service coordination through a limited number of school districts.

The Minnesota Association for Children's Mental Health does not support schools being the lead agency for this service coordination initiative. We request that the department revise this proposal with direct input of the current school-linked mental health providers and children's mental health advocates.

Among our concerns is the shortage of nurses, counselors and psychologists in many of Minnesota schools. In addition, in most of the schools these individuals are not licensed or qualified mental health professionals. Schools are also most often in session 9 months of the year leaving a potential 3 month gap in services. There are currently two other initiatives in schools that should be at the table in discussing this service coordination model - School Linked Mental Health Grants (DHS) and PBIS (MDE). The existing school based service structure mentioned as a method or vehicle to deliver services does not exist in most schools unless it is related to the School Linked Mental Health Grants.

We would be willing to be part of a conversation that would look at alternatives to having a school function as the lead agency.

Deborah Saxhaug
Executive Director

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July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

Hand-delivered to DHS

Dear Mr. Godfrey:

We are submitting these comments to the State's Medicaid Section 1115 Waiver Proposal – Reform 2020: Pathways to Independence on behalf of the Employment First Coalition.

The Minnesota Employment First Coalition is a grassroots movement of employment champions from a broad range of disability advocacy organizations, federal, state and local government agencies and educational institutions. Since 2007, the Coalition has hosted employment summits, published summary reports and championed initiatives to support changes in employment policy and practice for Minnesotans with disabilities.

Employment First is the vision of making integrated competitive employment (with or without supports) the first priority and preferred outcome of Minnesotans with disabilities. It is critical to raise expectations about employment through policy and practice, focusing on regular employment with the same wages, standards, responsibilities, expectations and opportunities available to any working-age adult.

Employment is the path out of poverty and into the mainstream of American life. The employment rate of Americans with disabilities is less than one-third that of other citizens, and 65% of individuals trapped in poverty long-term are individuals with disabilities.

Employment of Minnesotans with disabilities is a win-win for all Minnesotans.

- It improves the mental health, physical health, social connections, economic stability and self-sufficiency, and personal growth of Minnesotans with disabilities. It is fundamental to an individual's quality of life and earning the means to exercise freedom and choice as a citizen.
- It increases state revenues and decreases expenditures for public benefit programs, benefiting all Minnesotans with a healthier economy.

Even Minnesotans with significant disabilities can successfully join the workforce providing businesses with valued employees using a strengths-based approach to identify marketable strengths and assets and developing customized job supports to gain and retain employment.

Earlier this year, the Employment First Coalition worked toward including language in the DHS Policy Bill to ensure that certified assessors inform waiver recipients about the benefits of competitive employment, with or without supports. That language included a definition of "competitive employment" used by Vocational Rehabilitation Services, to better align the two departments in their efforts to improve employment outcomes. Throughout the rest of this document we will be using that

definition when using the term “competitive employment” which includes integration in the regular workforce and can be with or without ongoing employment supports.

We believe the Reform 2020 proposal falls short in emphasizing competitive employment for Minnesotans with disabilities as a means to achieve the department’s stated goals to:

- Achieve better health outcomes
- Increase enrollee independence
- Increase community integration
- Reduce reliance on institutional level of care
- Simplify administration and access to program
- Create a program that is more financially sustainable

Integrated competitive employment, with or without supports, has been proven to have a positive impact on better health outcomes improving both mental and physical health. It increases independence and, by definition, community integration. It reduces reliance on paid caregivers by building the capacity of businesses to support Minnesotans with disabilities at the workplace.

Individuals living in poverty have less choice in controlling the circumstances of their lives. Reliance on public benefits significantly limits many fundamental choices including where and with whom to live. Competitive employment increases choices with respect to a wide array of personal, occupational, and economic goals available to any citizen. It opens up the different types of work to be considered. It also provides higher earnings than center-based or group community-based employment. Economic power expands opportunities not otherwise available to many individuals with disabilities and those opportunities are directly related to measures increasing quality of life. Through increasing expectations and opportunities with respect to work, Minnesota can multiply the number and diversity of choices available to its citizens with disabilities by expanding participation in both the labor force and community.

The Minnesota Work Incentives Connection has calculated some of the financial impact when Minnesotans with disabilities work. Specifically, the Connection found statistically significant decreases in the following government benefit amounts received at 12-month follow up, as compared to intake:

- | | |
|--|--------|
| • Supplemental Security Income (SSI) | -13.0% |
| • MN Supplemental Aid (MSA): | -14.7% |
| • Food Support: | -31.9% |
| • MN Family Investment Program (MFIP): | -30.9% |
| • Housing Subsidy: | -10.8% |

As people with disabilities increase their level of employment, government benefits are reduced. Collectively, benefits received by the 1,559 individuals studied were \$83,131 per month lower at

12-month follow up than at intake. Potential savings in government benefits equal \$1 million for each year these participants remain employed, or almost \$10 million over 10 years.

The group studied by the Connection represents a fraction of Minnesotans with disabilities, and thus only a fraction of benefits program savings that could be realized if more people with disabilities were working. Those who work also pay federal, state and local taxes, and contribute through FICA taxes to the Medicare and Social Security retirement systems, increasing revenues at all levels. They are also better able to support their families and contribute to their communities.

During 2009 and 2010, over 200 individuals participated in listening sessions facilitated by the Minnesota Employment Policy Initiative (MEPI) focused on the question, “What will it take to double employment of Minnesotans with disabilities by 2015?” Groups identified that employment improves the following factors, many of which are consistent with the goals of the Department in their proposal:

- Self-esteem and self-worth
- Identity
- Sense of purpose
- Structure and routine
- Economic stability
- Opportunities to use talents
- Contributions to society
- Physical health
- Mental health & recovery
- Social network
- Impacts society’s view about the abilities of individuals with disabilities

Competitive employment is an expectation of citizens without disabilities, but that expectation is absent or “conditional” among many individuals with disabilities, families, educators, the medical community, employment and disability professionals, and employers. The expectation of competitive employment is also not reflected in many public policies.

About 30% of adults without disabilities do not participate in the workforce, and not all citizens with disabilities will work either. If competitive employment is an expected outcome of Minnesotans with disabilities, individuals (and their families where appropriate) could still choose to “opt out” of competitive or other employment, but the expectation of employment would shift the dynamic embedded in the current system which requires individuals and families to “opt into” competitive employment in the face of significant pressure to choose a system of segregated, low paying employment or not to work at all.

Like many states, Minnesota has many individuals with disabilities in segregated, facility-based employment. Recent federal actions through the Department of Justice have challenged the limited access individuals with disabilities have to integrated employment in other states. Minnesota is vulnerable to those types of actions without policies and regulations that are aligned to enhance competitive employment as the preferred outcome for the populations affected by the Department’s proposal. To achieve better competitive employment outcomes, the Department, in partnership with

other state agencies and community organizations, will need to build the infrastructure through training and technical assistance to support competitive employment in local communities throughout the state. The report card of DTH services should include data on competitive employment outcomes, comparable to the data collected by other state agencies, to monitor progress toward this important goal.

The Department's proposal includes individuals with mental health disabilities as its primary focus in the area of employment in 6.1: Demonstration to Empower and Encourage Independence through Employment Supports. The Employment First Coalition supports the importance of better employment outcomes for this group. However, the Coalition does not fully understand why employment recommendations as proposed in **Reform 2020** do not aggressively advance a well-researched, evidence-based practice in the use of Individual Placement and Supports (IPS). The adoption of IPS policies and methods has been documented to significantly increase job placement and competitive employment outcomes of job seekers with serious mental illnesses (SMI) by a factor of three. In recent years, Minnesota launched its own IPS initiative and already has several highly successful state-funded IPS project demonstrations in operation. The Coalition believes the state agency collaboration established by DHS and DEED provides an excellent framework to expand IPS opportunities throughout Minnesota with the right policy directives and fiscal incentives.

The IPS Supported employment strategy is an evidence-based practice documented by national research studies to increase the job placement and employment success rates of youth and adults living with SMI. A number of studies have shown employment to be a critical ingredient to individual treatment and recovery from SMI because a competitive job helps to shape a life's purpose, daily structures and routines, and increases earned or discretionary income. Competitive employment also promotes higher levels of social interaction with peers in the workforce and community, opportunities to use education and training, increasing contribution of skills and talents to the economy, and increasing self-dependence and self-esteem. One researcher has even identified satisfying competitive employment as important to recovery as the use of medication in managing personal mental illness symptoms.

While the Coalition understands Minnesota's core principle for cost neutrality in implementing the Medicaid reforms, supported employment is also known to be less expensive than other forms of mental illness treatment. In fact, many research studies document a significant reduction in mental illness symptoms, overall cost-savings in healthcare, and less reliance on more expensive forms of medical and mental health treatment for those individuals who choose and engage in competitive work. For these reasons, the omission of IPS within the 1915i provision of the reforms seems to be an opportunity lost and we respectfully suggest you reconsider its inclusion in the 1915i waiver reforms so all Minnesotans with SMI can choose work as a component of their treatment.

The Minnesota Employment First Coalition endorses and supports the State's reform efforts to:

- Deliver technical and navigational support to employed Minnesotans with SMI in the workforce who require assistance to access the services, resources, and expertise they need to stay well and stay working. With this said, however, the engagement of these employment supports and convergence with other mainstream models of employment assistance such as IPS is not well presented. For example, the recommendations do not identify how these services will be integrated within primary healthcare, mental health, and core workforce systems to insure an organized system of care and access to services. Although the Coalition fully supports the idea of keeping employed people working in the labor force, we wonder why the critical needs of "unemployed" Minnesotans with SMI are not included in Phase One of the proposed reforms.

- Engage disability benefits and healthcare planning assistance so job seekers with SMI gain a better understanding of Social Security work incentives and are encouraged to work as appropriate. This reform is absolutely critical to the engagement of effective employment services and obtaining successful employment outcomes. Although Disability Benefits Planning 101 (DB 101) is a highly useful software tool, a majority of people will still need assistance in fully grasping its implications and taking the next steps to go to work. This means there is a significant need to offer technical training in the use and application of the tool throughout Minnesota. Also, it is imperative to engage some individuals with Certified Work Incentive Coordinators (CWICs) to provide a more detailed, clear understanding of how working impacts benefits, healthcare, and other basic living needs. This is an essential hurdle to encouraging more people to work and beginning a cultural shift in the mindset that youth and adults with SMI can work in the right job with the right supports.
- Provide policy support to Minnesota's Medical Assistance for Employed Persons with Disabilities (MA-EPD) to address the healthcare needs and cost barriers of job seekers with high medical expenses. This is also an essential ingredient to competitive employment formula. Access to assistance with healthcare expenses remains a significant and driving factor in the decision of Minnesotans with disabilities to go to work. MA-EPD remains a powerful incentive to work and increases both confidence and encouragement so more people will choose work if MA-EPD is sustained and better communicated to prospective job seekers.
- The proposed demonstration to support the job placement and employment success of youth, ages 18-26, with serious mental illnesses is a very wise addition to the reforms. The Coalition has been working actively with student self-advocates, educators, and families to solicit suggestions on ways to improve policies and practices to remove known barriers to successful transition from school-to-careers. In order to effect sweeping systemic change, it is important to invest in new ideas to support the job placement and competitive employment of youth and young adults. The systems capacities to support the transition of youth into competitive employment with and without support (supported employment) will go a long way in reducing reliance on other forms of mental health treatment and public assistance programs.

The Minnesota Employment First Coalition also believes Minnesota would greatly benefit by the establishment of a cross-functional taskforce or work group specifically organized to study interagency policies, practices, and potential financial models to increase access to IPS and other services leading to competitive employment. SMI is a pervasive illness that impacts thousands of Minnesotans including working-age youth in transition, adults supported by assertive case management teams, adults served in day treatment programs, individual and group therapies, and other community mental health services, adults supported by state-operated services, refugees served by Minnesota Family Investment Programs, disabled veterans returning from foreign wars, and offenders supported by the State and county correctional systems. The complexities of addressing recovery, independence, and sustained productivity in the workforce requires a shared vision and mutually agreed goals by multiple state agencies (MDE, DHS, DEED, MDH, DOC), consumer advocacy organizations, job training and workforce development agencies, and privately and publically-run businesses. The focus of this work group would be to establish a statewide, uniform definition of competitive employment, standardize procedures for

state agency data collection and measuring progress, refresh state agency policies to encourage an employment first vision, and promote the use of evidence-based and emerging practices to increase the employability of Minnesotans with mental health disabilities. The work group would measure its success by measurable changes in the competitive employment participation rates of Minnesotans with SMI.

Finally, the co-morbidity and mortality rate for individuals living with SMI is well-documented. Adults with SMI will die 25 years younger than their adult peers. The State of Minnesota's 10 X 10 Wellness Initiative Campaign is designed to address opportunities for public education and promoting holistic healthcare and wellness. Of course, this means better integrating primary healthcare with mental health treatment and engaging community-based services in ways to support the goals of recovery, self-dependency, and enhancing quality of life indices.

The Coalition believes a lifetime of poverty, dependency, and inactivity exacerbates the symptoms of serious mental illness. And frankly, meaningful recovery from mental illnesses is improbable without significant changes in the employment participation and career development rates of Minnesotans with SMI. According to the Substance Abuse and Mental Health Administration (SAMSHA), active participation in satisfying employment is among the "eight dimensions of wellness" in recovery from SMI. Until competitive employment is viewed, accepted, and incorporated as a core, integral component of mental health treatment in Minnesota, the goal of wellness and recovery will continue to be marginalized and beyond the reach of many. The unacceptably low employment participation rates experienced by Minnesotans living with SMI is a testament to the failure of our workforce and mental health systems to engage and move people forward with confidence and success.

Thank you for the opportunity to provide feedback on the proposed Medicaid reforms. The Coalition is available to answer any questions and clarify our comments made in this document. We appreciate the opportunity to comment on such a significant proposal and look forward to working with the Department toward a better employment and economic future for Minnesotans with disabilities.

Sincerely,

Don Lavin
Vice President
Rise, Incorporated
8406 Sunset Road NE
Spring Lake Park, Minnesota 55432
Phone: 763-783-2815

Carol Rydell
Kaposia, inc.
380 E. Lafayette Freeway South
St. Paul, Minnesota 55107
Phone: 651-789-2815

On behalf of the Employment First Coalition

July 16, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey,

The Mental Health Association of Minnesota (MHAM) is Minnesota's first mental health advocacy and education organization. Lay and professional leaders concerned about the horrible conditions in custodial settings founded MHAM in May 1939. For over 70 years, MHAM has worked toward improved lives for people with mental illnesses. Our mission is to enhance mental health, promote individual empowerment, and increase access to treatment and services for persons with mental illnesses.

Mental health treatment is not currently mandated for self-insured plans. Few plans cover the mental health model benefit set that is included under MA and MinnesotaCare. For someone who needs a significant service set because of mental illness, state/federal programs may be their only option. Despite this, these plans have historically not been designed for them, an issue that persists in this outline.

Eligibility for the PCA program was changed to be more restrictive so that many people with a mental illness were no longer eligible or had their hours reduced drastically to roughly half-hour a day. Medicaid Reform must address the loss of eligibility for services. When isolation is a significant barrier to recovery in this population, we need to be very concerned about decreasing access in the name of increasing quality.

The MNChoices program does not adequately assess the needs of children and adults with mental illnesses. This will result in them not being eligible for programs and not having their needs addressed.

The components of the Reform 2020 proposal are, therefore, extremely important since children and adults with mental illnesses are being pushed out of current home and community-based MA programs. We are afraid that Reform 2020 will not create the programs needed to support those who will no longer be eligible for the CADI and PCA programs.

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Community First Services and Supports (CFSS)

The MNChoices assessment tool, and eligibility will be based on the new NFLOC. This will result in many people with mental illnesses not being eligible for services under CFSS. When the changes were made to the PCA program by the legislature many of those who no longer qualified for the program or who lost all but 30 minutes of day of service had a mental illness.

We do not think that one ADL or IADL fit the needs of people with mental illnesses well. However the increase to 90 minutes of service a day will help. Our final stance on this facet of the reform will largely depend on the final form the assessment takes. Previous drafts and finalized assessments have historically greatly underweighted the concerns and realities of adults with mental illnesses.

Demonstration to Empower and Encourage Independence through Employment Supports

It is unclear what the future of IPS is in the document. IPS helps people in community mental health service systems to become a part of the competitive labor market. IPS is more effective than other vocational approaches in helping people with mental illnesses to work competitively. IPS is cost-effective when the costs of mental health treatment is considered. MHAM supports continuing IPS as an Evidence Based Practice.

We are not certain that using the Disability Linkage Line is an effective way to engage people with mental illnesses and would recommend some other method be used.

Anoka Metro Regional Treatment Center Demonstration

MHAM supports DHS seeking to waive the IMD exclusion for the Anoka Metro Regional Treatment Center (AMRTC). AMRTC is more like a short-term intensive hospital program in the community than it is an institution. We support being able to receive MA funds for the care and treatment provided.

We understand that a work group will be putting meat on the bone of this proposal, but Community Behavioral Health Hospitals (CBHHs) and their inability to be at capacity needs to be part of the discussion. Without the inclusion of the CBHHs, we are not certain success can be realized.

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1915(i) to support individuals with mental illness who are at risk for institutionalization without access to integrated community-based systems of care.

MHAM supports the development of a 1915i with the input of the work group that was discussed. We especially feel that being able to put ARMHS services under 1915i would benefit a great many people and keep the program viable.

The increasing focus on networks, capitated payments, and managed care needs to be balanced with equal attention to the access issues created by this system. Already, SNBC plans have used restricted formularies and limited pharmacy networks to deny access to medication supports needed by people with mental illnesses. Recent developments in anti-psychotic medications mean that many lack generic options or are omitted from formulary coverage due to higher costs. Traditional coverage restrictions, e.g. the requirement that a person try a less expensive option first, do not make sense for these medications. If a person is successfully in recovery with a next-generation medication, the risk to their health presented by a medication change to test a lower cost option may be significant.

Thank you for the opportunity to comment on the Reform 2020 proposal. We wish you all the best in your negotiations with CMS.

Sincerely,

Edward T. Eide
Executive Director

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of Minnesota **mham**

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Dooley, Lea M (DHS)

From: Paul Omodt <pomodt@voamn.org>
Sent: Tuesday, July 17, 2012 1:43 PM
To: *DHS_Reform2020Comments
Subject: Comments from Volunteers of America -- Minnesota

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164
July 17, 2012

RE: Reform 2020 Medicaid Waiver Reform Proposal

Thank you for the opportunity to comment on the proposed Section 1115 Waiver Proposal, Reform 2020: Pathways to Independence. Volunteers of America – Minnesota’s mission is to help people gain self-reliance, dignity and hope, and we believe the trend we see from DHS moves in closer alignment to our stated mission. We welcome DHS’s efforts to promote greater independence and self-direction for some of Minnesota’s most vulnerable individuals. We know that these proposed changes will have a positive impact on persons with disabilities, older adults, caregivers and our communities.

Our primary comments are in three general categories: the availability of mental health services, modification of PCA program, and the availability of affordable housing for changing programmatic models. We believe these three general areas are vital to the eventual success measures we collectively seek.

- **Mental health services are crucial.**

We want to affirm the proposed integration of primary care and mental health services. Since one in five older persons suffers from a diagnosable psychiatric condition, mental health services should not be viewed as an auxiliary to primary care. The number of people age 65 and older with a psychiatric disorder is expected to double over the coming decades according to NAMI. At VOA-MN, we have seen first hand how mental health conditions can negatively affect a person’s ability to function on a daily basis. These negative effects can result in unnecessary hospitalizations, poorer health outcomes and increased mortality rates. For example, recent research has shown that older person who suffer from depression have worse outcomes after medical events such as hip fractures, heart attacks or cancer treatment.

We believe mental health parity is crucial and we need to continually guard against those with mental illness getting lost in the ‘shuffle’. We need to be mindful of these considerations as we move forward.

- **Modification of the PCA program can be beneficial.**

We have two primary points: We believe in working to unhook the PCA access from the waivers, and we believe working to promote quality assurance is essential. Going beyond generalizations and measuring real-life experiences will be key to informing how the PCA program can be best designed.

- **Lack of availability of affordable housing could capsize the plan.**

We need to be fully conscious of the need to have the affordable housing options available for this model; without adequate housing opportunities, the model will fail for a lack of 'where' to provide the services. We need to be innovative and look at how this plays out in communities all across the state. VOA – MN provides services in both the metro and in greater Minnesota and know that finding affordable housing in which to provide these services is essential to a more community based care model.

VOA-MN looks forward to working with DHS to successfully implement these initiatives. We want to contribute to a state where older adults and persons with disabilities have the best information, access and resources to help support their choices. Thank you for the opportunity to participate in this process.

Sincerely,

Volunteers of America – Minnesota

/s/

Paul G. Omodt

Vice President of External Relations

Paul G. Omodt, ABC, APR, MBC

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July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

Dear Mr. Godfrey,

On behalf of Hennepin Health, Hennepin County's integrated healthcare initiative designed to serve the unique needs of a challenging segment of the county's safety net population, we appreciate the opportunity to comment on the Department of Human Services (DHS) **Reform 2020: Pathways to Independence** federal waiver proposal.

We support the DHS proposals to develop innovative and effective Medicaid payment and delivery models and firmly believe by integrating medical, behavioral health, public health human services, and health plans in a patient-centered model of care, the Hennepin Health program can improve health outcomes and lower the total cost of care for our target population (adults without children on Medical Assistance with income at or below 75 percent of the federal poverty level).

To date, a key barrier to communication and streamlined service delivery is the inability to share data among the network participants. We have seen efforts across the nation which may serve as models for us to improve this in Minnesota. The criticality of providers working together across systems for the benefit of those we serve is crucial to gain efficiencies and reduce redundancies. We want to work with DHS to achieve the improved care and cost savings that will result if we can find ways to both facilitate the coordination of care and protect patient/client privacy.

We have given input and support to the response from the Minnesota Association of County Social Service Administrators (MACSSA) and that of Metropolitan Health Plan (MHP). Hennepin Health looks forward to working with DHS on the continued development and implementation of DHS' vision as outlined in the Reform 2020 proposal.

Sincerely,

Jennifer DeCubellis, LPC
Hennepin Health
www.hennepin.us/healthcare

Dooley, Lea M (DHS)

From: Diane Cross <dianec@fraser.org>
Sent: Tuesday, July 17, 2012 12:48 PM
To: *DHS_Reform2020Comments
Subject: Fraser comments on Reform 2020 proposal

June 17, 2012

Mr. David Godfrey
Medicaid Director
Minnesota Department of Human Services
Post Office Box 64998
Saint Paul, Minnesota 55164

Dear Mr. Godfrey:

Thank you for the opportunity to submit these comments in response to the section 1115 Medicaid waiver proposal titled Reform 2020.

Fraser provides healthcare, education, and housing services to thousands of children, adults, and families with special needs. One area that we are noted for is being the oldest, largest, and most comprehensive autism program in Minnesota.

My comments are focused on the "Alternative to the Personal Care Assistance (PCA) program" described in section 4.2 of the proposal, also referred to as Community First Services and Supports (CFSS).

Fraser supports efforts to make the PCA service more flexible and responsive to consumer needs. In particular, we applaud the proposal to raise the minimum service plan in CFSS to at least an average of 90 minutes per day.

As the department considers how to replace PCA with CFSS, please keep in mind that the current PCA service is not financially sustainable for community providers. In addition to low reimbursement rates, the service currently is overburdened with too many regulations and paperwork. Additional financial investment and streamlined regulations will be needed in order to support new client offerings, such as skill acquisition.

On a related note, creating areas of specialty within CFSS will be important to best serving individuals with complex needs. However, achieving this goal will be unlikely without providing a rate differential to support the additional training and oversight needed.

Finally, one suggestion is to integrate the new CFSS provider registry into the existing MNhelp.info platform that already is planned to be rolled into the upcoming MnCHOICES tool.

Again, thank you for considering these comments.

Sincerely,

Diane S. Cross, president and chief executive director
(612) 798-8317
Diane@Fraser.org

Fraser
2400 West 64th Street

Minneapolis, Minnesota 55423

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 17, 2012 12:19 PM
To: *DHS_Reform2020Comments
Subject: Comments re proposed changes to MA for people with autism

Importance: High

I am the parent of a 12 year old son with autism. I am writing regarding the proposed changes to the autism benefit set, particularly, that of limiting therapies (outside of public school) to ages 7 and under. We did not even apply for MA benefits for our son, [REDACTED] until he was almost 9, as asking for public assistance was not in our nature. It was only after much urging from our county social worker that we realized the benefits that our son would obtain from receiving MA and being on a waiver. The assistance has proved invaluable to his development, as well as to our ability to properly care for him in our home. He has received therapies which have vastly improved his communication and social skills, and we, his parents, have received occasional respite and the will to continue moving forward, being buoyed by his progress.

While public schools may provide some therapies, they do not have the funding, staffing, tools, time, expertise or diversity needed to serve the vast majority of children with autism. Every child requires a unique set of aides depending on the severity of their autism and exact nature. There is a significant difference between Asperger's and autism, as well as differences within these diagnoses (that's why they refer to it as "autism spectrum disorder.") Many public schools are barely able to provide educational services to mainstream children, much less the highly individualized therapies needed by children with autism. The current proposal would put a much heavier burden on our already-struggling public school system, and would leave the needs of the children with autism unaddressed.

I can't even imagine what our situation would be now if our son, [REDACTED], did not have access to the MA benefits. I know of several other families that have delayed applying for benefits for their children for similar reasons, as well as several who did not even receive a proper diagnosis of autism until after their child was older. The proposal would effectively eliminate many children from receiving any benefits for these reasons.

The proposal to limit benefits to age 7 may seem like it would save money in the short term, but it leaves a huge gap in the child's most formative years, which would mean the difference between them attaining independence and productivity as an adult, and being institutionalized. In the long run, the cost will be much greater than what the short-term savings may appear to be, and not only in financial terms. The cost of a human life – not just a "human life" but the lives of our sons, daughters, siblings, and other loved ones – is what is at stake, and cannot be measured in dollars and cents. There is a saying about being "penny wise and pound foolish." It may be a cliché, but I believe the DHS and State of Minnesota would be well-served to heed that adage. Thank you for your consideration.

[REDACTED]

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 17, 2012 12:09 PM
To: *DHS_Reform2020Comments
Subject: Funding

Hello!

Kids don't grow out of autism by age 7 so why should the state end the funding? These kids deserve every opportunity to get help and I want my tax dollars to help these kids. I am doing this for [REDACTED]-Age 8. He is a non-verbal kid with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

[REDACTED] is doing the best he can but he needs our continued help, for the rest of his life. He didn't ask to be autistic, it was he was dealt in life. Please help his parents do the best they can for him!

If you had to walk in his parents shoes for just a week and help [REDACTED] thru life you wouldn't have a doubt in your mind what he needs to get thru every day.

Please help him and others like him. He is the sweetest little boy and deserves all the help in life he can get.

Thank you,

[REDACTED]



COURT INTERNATIONAL BUILDING
2550 UNIVERSITY AVENUE WEST
SUITE 255 SOUTH
ST. PAUL, MINNESOTA 55114
651-645-0099 FAX 651-645-0098

July 17, 2012

Mr. David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey:

Thank you for the opportunity to review and provide comments on the *Reform 2020 Pathways to Independence, Section 1115 Waiver Proposal* draft document.

The following comments are submitted on behalf of the Minnesota Council of Health Plans (Council). The Council's membership is comprised of Minnesota's seven licensed nonprofit health plans: Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan and UCare.

The Council's mission is aligned with the State's: To strengthen Minnesota's position as the nation's healthiest state by leading or supporting efforts with community partners that increase the value of health care services. Specifically, the Council believes in high standards of quality care, broad access to health care coverage and services, affordable health care and a climate that facilitates improvement in quality, access, and affordability.

For over two decades, managed care has been the foundation of Minnesota's Medicaid Program. This model, which is recognized across the country for its excellence and innovation, receives high rankings for quality, access, and enrollee satisfaction. The availability of managed care plan resources – such as broad provider networks, care coordination/case management, and preventive and wellness services – has significantly improved health care access and the quality of care for Medicaid enrollees.

The Role of Medicaid Managed Care Plans in New Accountable Care Models

Discussion of the role of Medicaid managed care plans is virtually absent from the draft proposal. This makes it difficult to understand how managed care fits into the proposal's various components. Council members are especially concerned by the aggressive expansion of direct contracting with provider organizations that is described in Section 3 (Accountable Care Demonstrations).

For example, Section 3.2.3 states that DHS will incorporate purchasing strategies... to stimulate new "integrated care system partnerships (ICSPs) between *health plans and providers*." Specifically, ICSPs are referenced in conjunction with better serving dually eligible people. However, in Sections 3.3.1 and 3.3.2, no mention is made of partnerships with health plans for other forms of accountable care models. Does the Department contemplate a role for health plans only in the care delivery for dual eligibles, but not in other accountable care models?

In fact, Council members maintain that successful operation of ACOs and other models hinges on an active partnership between providers and Minnesota's health plans. The Council's members are committed to working with providers and the State to ensure that individuals receive the care they need, when they need it. Failure to anticipate questions about how ACOs will work within the context of existing managed care programs may slow implementation of ACO initiatives. A sampling of some of the resources and expertise health plans can bring to payment and delivery system transformation include, but are not limited to, the following:

- Facilitating population health management and health risk identification/reduction.
- Providing advanced IT infrastructure for efficiently performing clinical, operational, and administrative functions and performing complex data management and health care analytics.
- Managing networks to ensure individuals can choose among providers that meet high standards. This function includes the performance of credentialing activities, and activities designed to recognize outstanding provider performance.
- Assuming and managing risk to ensure financial stability.

Managed Care Plans and ACOs in the Health Insurance Exchange

As Minnesota moves toward implementation of the insurance exchanges and other provisions of the Affordable Care Act (ACA), it becomes increasingly important to ensure that state reform initiatives are designed in a manner that complements the post-2014 health care environment. This is particularly important in the case of Medicaid. For example, the ACA requires states to develop procedures to apply, renew, and enroll in Medicaid coverage through an internet website, which in turn will allow individuals to obtain information about coverage under Medicaid and Children's Health Insurance Program (CHIP) and compare such coverage to that available through the Exchange.

Program changes that increase the complexity in the health care system, not only in terms of services offered but how an individual accesses the system, will increase problems associated with churning and disruption of care. The following questions pertain to the relationship of ACOs and Medicaid managed care plans in the Health Insurance Exchange environment:

- Does DHS intend to include ACOs as an option from which individuals may choose to enroll in Medicaid through the Exchange?
- If so, will DHS include information on Medicaid ACOs in the required training for navigators and brokers?
- If a county or a non-profit organization provides services under contract with an ACO, is that a conflict of interest that would prohibit that same entity from serving as a navigator?
- Many stakeholders have expressed an interest in ensuring that the same plans that offer commercial products in the Exchange also offer a Medicaid product so that an individual does not experience a break in continuity of care or a break with a preferred provider if his/her eligibility for a commercial or Medicaid product changes. In the absence of any clear articulation of a role for health plans and ACOs, please reconcile the Department's vision for a future of more direct contracting with providers with the fact that many new and renewing individuals will be choosing a Medicaid plan through the Exchange.

Regulation, Reporting, and Financial Transparency of New Accountable Care Models

Council members also recommend that as the State pursues a direct contracting relationship with a provider, it is imperative that a level playing field is established across contracts. Specifically, we believe that provider groups should be required to provide the full range of program benefits and services as currently provided by health plans, meet established financial solvency requirements, and manage risk. The State has a stated value that an individual covered by Medicaid should have access to all needed services through his/her health plan, yet many HCDS entities are not able to provide some of those services (e.g., dental care).

The following questions elaborate on the regulatory requirements for ACOs:

- If the ACOs and/or Integrated Care Provider Organizations are risk-bearing entities receiving public funding, will DHS require accountable care models to meet similar transparency requirements for financial reporting and independent auditing as is now required for managed care organizations? If not, please explain the reason. Minnesota has set high standards for public disclosure and transparency for public programs. We believe that these standards should be maintained regardless of how the state contracts for these services.
- Regulation of the financial solvency of risk-bearing provider organizations in ACOs is important to ensure market stability. Bearing financial risk necessarily means that there is a possibility that a provider organization will face financial instability, or even fail; thus, there is a need for strong financial solvency regulations to ensure that the health care provider market remains stable, and that enrollee care is not disrupted. Does DHS intend to regulate the financial solvency of providers in ACOs and/or Integrated Care Provider Organizations, and if so, how?

In addition to these larger policy concerns, the Council has identified a number of areas in which the proposal needs further clarity. Attached is an addendum that lists specific questions and issues related to various sections of the waiver.

Finally, if the waiver proposal is approved, there will be significant operational issues that will need to be resolved. We are willing to provide any assistance and expertise that the State requests.

Again, Council members thank you for this opportunity to provide comments to this important proposal.

Sincerely



Julie Brunner
Executive Director
Minnesota Council of Health Plans

Attachment

Addendum for Reform 2020 Pathways to Independence, Section 1115 Waiver Proposal
MN Council of Health Plans Comments

- *MCOs' roles and how MCOs fit into this Sec. 1115 waiver is not clear.*
 - What impact will the waiver have on MCOs (vs. FFS)?
 - How will the proposed Sec. 1115 waiver intersect with the current PMAP+ Sec. 1115 waiver? With state law (current or to be proposed)?
 - What changes, if any, would be made to the PMAP+ Sec. 1115 waiver if this proposed waiver is approved?
- *Concerns with Sec. 3 (ACOs)*
 - Is DHS seeking authority/arrangements (ICSPs, for example) with CMS that will prohibit the state from continuing to deliver Medicaid (includes MinnesotaCare) through managed care (includes county-based entities)? If no, how might direct contracting impact MCOs (and FFS)?
 - In Sec. 13.1.1, DHS is proposing a waiver of 42 CFR §438.6(c)(5)(iii) (actuarial soundness of payments under risk contracts), but there is no budget/financing information accompanying this proposed waiver, and it is not clear why DHS is pursuing this. Actuarial soundness requirements are necessary to protect states and the entity they contract with for risk contracts. We would not support this type of waiver for managed care organizations or anyone else.
- *MCOs have a long history of collaborating with the State and community partners on prevention and quality initiatives. MCOs desire to continue to participate in initiatives focused on improving health outcomes.*
 - As one example, Sec. 9.4 (promote personal responsibility): *We Can prevent Diabetes grant* aims to reward health outcomes. Health plans have extensive experience providing individual and group incentives for preventive care. Health plan representatives participate on this grant. MCOs welcome all opportunities to come to the table to work on preventive care initiatives.
- *Intersections with other requirements or groups needs more definition:*
 - The Sec. 1115 waiver will require legislation. How might that impact various components?
 - The Minnesota Healthy Contribution program isn't mentioned in Sec. 8.1.2, but should be (i.e., the cap for MinnesotaCare is now at 200% FPL).
 - Eligibility requirements under the Affordable Care Act will have an impact.
 - In Sec. 8.1.1, (asset test of \$10,000 on adults without children): If Minnesota does not opt to expand Medical Assistance eligibility for adults without children with incomes 75% -133% FPL, as we understand it, there would be no need to seek a waiver of the asset test for these adults with incomes ≤ 75% FPL. That is because (we believe) that the ACA Medicaid requirements otherwise effective 1/1/14 will not apply to states choosing not to expand Medicaid eligibility. *Note: CMS may issue clarifications as a result of the June Supreme Court decision that impacts Medicaid eligibility.* If, on the other hand, Minnesota expands Medicaid eligibility, then this waiver to impose an asset test would be premature and would presumably violate the ACA's requirement of maintenance of effort in effect through CY '13. In addition, CMS may determine that as of 1/1/14 states that expand Medicaid eligibility cannot have Medicaid eligibility asset tests (i.e., the recently promulgated Medicaid eligibility rule applies to states that expand Medicaid eligibility pursuant to the ACA).

**Addendum for Reform 2020 Pathways to Independence, Section 1115 Waiver Proposal
MN Council of Health Plans Comments (continued)**

- *It's often not clear which components are integral to the Sec. 1115 waiver.*
 - Which components of the proposed waiver does the State already have the authority to do?
 - Exactly which activities would require federal waiver approval?

- *More clarity is needed for specific programs as well as for goals and expected outcomes for programs.*
 - It often seems (but is not clear) that DHS' goal is to expand the service but reduce eligibility for that service. See, for example, Sec. 4 (Community First Services and Supports).
 - It appears that DHS is creating a new State plan service for children with autism up to age 7. After age 7, will those services be funded by the school system? If so, what responsibilities will the MCOs have? The current DHS contract states that "Medically Necessary Medical Assistance services that would otherwise be covered by this Contract that are provided by school districts or their contractors and are either: (1) identified in an Enrollee's Individual Education Plan (IEP), or (2) Individual Family Service Plan (IFSP), are not covered."
 - CFSS eligibility criteria are not clear.

- *Timelines should be clarified for each Section and subsections within.*
 - In addition, while it is clear that PCA changes are scheduled for 2014, issues related to workers' training, financial statements etc. have a 17 month development period.



July 17, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
Saint Paul, MN 55164

Re: Comments on Proposed Reform 2020 Medicaid Waiver Request

ARRM is an association of 150 providers of long-term care services supporting thousands of people with disabilities through the DD, Brain Injury, CADI, CAC and Elderly waivers, and ICFs/DD and SILS. ARRM is committed to assuring that Minnesota has a viable private provider sector to promote consumer choice, adequate funding, and appropriate regulation. On behalf of our members and the individuals we serve, ARRM is submitting the following comments on the proposed changes in the Reform 2020 Waiver Request.

ARRM strongly supports the goals of the Reform 2020 Proposal for the individuals we serve: improving outcomes for individuals based on their specific needs, providing the right service at the right time, and increasing the efficiency of resources to maintain the long-term care system's sustainability. After reviewing the waiver application, we believe the initiatives included can accomplish those goals. In order to be successful, ARRM believes stakeholder involvement in their development and implementation will be crucial. We look forward to participating.

Now, here are some specific comments on portions of the waiver application:

1. Development of the Community First Services and Supports (CFSS) Option

ARRM believes the current personal care service (PCA) benefit lacks the flexibility in services and payment options to provide the most-effective services for individuals. Replacing the current PCA benefit with a more adaptable set of services will enhance service quality, and allow more individuals to live more independently. Including options like prompting and coaching, not current allowed under the PCA program, will allow providers to meet the needs of more people. However, enhanced flexibility and infrastructure changes in the services delivery system requires a well-trained, highly-skilled, and adequately-compensated workforce to meet demographic challenges, promote stability, and ensure quality. With additional flexibility provided by the federal government under the new 1915 series of waiver options, providing these services also makes sense from a fiscal standpoint. We strongly agree with this proposal.

2. Individualized Budgeting for Services

The movement toward providing individualized service budgets for new and existing long-term care services is also an aspect ARRM supports. In the Reform 2020 Proposal, the department is proposing individuals' budgets for the CFSS and other disability waived services. We agree that system changes promoting greater individual control in choosing and directing is essential to achieving a greater degree of independence. For this to be most effective, consumers need access to sound and valid information to make informed choices in achieving person-centered outcomes. The types of information and methods of distribution will be important, and should be developed with significant stakeholder input. Finally, the methodology for determining individual budgets needs to be highly transparent and based on a reliable and valid assessment tool.

Also, there needs to be oversight to ensure the proper use of taxpayer resources. The Reform 2020 Proposal references a new financial management structure for self-directed options. We understand the importance of reducing administrative complexity; however, the rationale for replacing the current fiscal support entity (FSE) system is not well-defined. The application specifies fiscal management entities will be chosen by the state (with input from stakeholders) via an RFP process, and limited to allow individuals a choice between at least two entities. It is unclear what advantage is gained by limiting the number of entities, or how one might be chosen over another. In this area as well, ARRM believes stakeholder involvement and transparency will produce the best outcome for the individuals directing their own services.

3. Enhancements for Current Waivered Services

The Reform 2020 Proposal includes new and enhanced services for the existing waivers. We strongly support creating system changes that support people in having meaningful lives at all stages of life; with a primary goal of a simpler system to enhance service access and efficiency. These include more flexible options reimbursing for longer periods. ARRM strongly supports this idea. In the 2012 legislative session, we proposed legislation as part of our *Blueprint for Reform* to create a daily rate for independent living services (ILS). We believe a daily rate for ILS is very similar to this, and will allow more individuals to be moved out of adult foster care so those facilities can serve individuals requiring that level of care.

4. Increasing Access to Housing and Employment

Supporting individuals in community is an important factor to keep them in that setting. However, housing is a huge barrier and requires creative solutions and continued collaboration with all stakeholders and housing partners. In the Reform 2020 Proposal, the demonstration projects to provide new services to maintain housing and employment will advance efforts to maximize community integration. ARRM proposed several initiatives our *Blueprint for Reform* to help individuals secure and maintain their own housing. The additional supports in the waiver application will build on our efforts and we support them. However, more resources and attention must be addressing the housing needs of individuals with complex physical disabilities and health needs is required.

5. Trends in Provider Reimbursement

The new accountable care models have real promise to create a more sustainable and integrated service delivery system. In the Reform 2020 Proposal, these changes only affect traditional health care services. ARRM believes this model will eventually be applied to the services we provide. Our members' knowledge of and experience in managing care delivery will be crucial to developing strategies to reduce costs for long term care services. Consulting providers and soliciting their input in the creation of any new models of payment or service delivery will achieve the best outcomes.

ARRM appreciates the opportunity to provide comments on the Reform 2020 Waiver Proposal. While we support the goals and direction of the reform efforts, stakeholder engagement and involvement developing the details and implementation of the separate initiatives is needed to ensure success and avoid unintended consequences. We look forward to further participation with the department and other stakeholders to preserve and protect Minnesota's most vulnerable residents.

Sincerely,

Darlene Scott
President

Bruce Nelson
Chief Executive Officer

Dooley, Lea M (DHS)

From: Carol Sime <carol.j.sime@gmail.com>
Sent: Tuesday, July 17, 2012 10:46 AM
To: *DHS_Reform2020Comments
Subject: Disability programs

I haven't had a chance to thoroughly study or discuss the plan, but I can tell you that a lot of people would like assurances that their loved one will not be worse off as a result of these changes. What happens with the money following the people if the money gets cut? What if someone is perfectly happy with their living situation and would be adversely affected by not living with their good friends any longer?

Dooley, Lea M (DHS)

From: Laura Kadwell <laura.kadwell@headinghomeminnesota.org>
Sent: Tuesday, July 17, 2012 9:51 AM
To: *DHS_Reform2020Comments
Cc: Carleen K. Rhodes; Laura Kadwell
Subject: Comments from Heading Home Minnesota
Attachments: Laura Kadwell.vcf

To Whom it May Concern:

The Heading Home Minnesota Community Leaders Council (“the Council”) is a public-private partnership of community leaders supporting the work to end homelessness in Minnesota. The Council appreciates the opportunity to comment on Reform 2020: Minnesota’s Section 1115 Waiver Proposal to the Centers for Medicare and Medicaid Services.

Background.

The Council, which includes leaders from the philanthropic, business, faith and government sectors, began its work in 2006 with a focus on leveraging resources in support of the State’s Business Plan to End Long-Term Homelessness. The Business Plan, which began implementation in 2004, has been successful in creating over 3,500 supportive housing opportunities for individuals, youth and families with children with long histories of homelessness. The Plan has also leveraged significant community resources that are ending homelessness for thousands of Minnesotans.

The primary strategy of the Plan is to create permanent supportive housing – housing with the services needed for people to obtain and maintain housing and to improve their lives. Significantly, these services, so important to improving the lives of Minnesotans, also have potential to reduce public costs – money now being spent for emergency and inpatient hospital care, jail, prison, shelter and detox services. (See Waiver Proposal, p. 65 for supporting research.)

For the past few years, the supportive housing community, including Heading Home Minnesota, has been exploring the nexus between Medicaid and services needed in supportive housing. Housing is the foundation for successful health care. The studies mentioned in the Waiver Proposal, and specifically a study completed by Hearth Connection, Minnesota’s Supportive Housing and Managed Care Project, show improvement in well-being of people who are housed, along with a reduction in the use of expensive emergency and hospital-based interventions. The question then has been to define services that could be offered in supportive housing and funded with Medicaid. Supportive housing providers have been meeting regularly with DHS staff (Medicaid, Mental Health, Community Living Supports) to define these services.

Comments

The Heading Home Minnesota Community Leaders Council appreciates the significant steps DHS is taking in the Reform 2020 Waiver Proposal to bring necessary services to some of our most vulnerable Minnesotans – those who are or are at risk of homelessness.

Our comments are directed to Section 6.2: the Housing Stability Services Demonstration. We believe this demo is absolutely headed in the right direction – recognizing the importance of housing in reaching and maintaining successful health outcomes. We appreciate the connections DHS has made with the supportive housing community to define this proposal and expect to continue working with DHS as the Waiver is refined, adopted and implemented.

The Council believes that, in general, the definition of Target Population (p. 61 ff.) is appropriate and believes the inclusion of people now in supportive housing is especially important (these are folks who would be homeless without services currently provided). The Council further applauds the benefits included: outreach/in-reach, tenancy supports, and service coordination. In a perfect world, the service package would be more comprehensive but this is a good starting place.

The Council was concerned when we learned that DHS, in order to maintain cost neutrality, intended to implement Reform 2020 only with households now receiving GRH Rate 2. While a significant subset of the overall homeless population, this group is, nevertheless, a subset. The Proposal as originally drafted did not address the needs of the broader population.

Since the Waiver Proposal has been out for comment, however, we understand that DHS has considered significant modification to this section. We support these modifications now under consideration:

- Expanding the Target Population to include folks who are homeless, receiving General Assistance and are frequent users of high-cost medical services. This modification puts the Waiver Proposal directly in sync with the purposes of supportive housing.
- Including “Community Living Assistance” in the set of services. These services 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. We understand this set of services is available to other populations at DHS and believe consistency of services across populations is an important goal, where possible.

The Council understands the importance of maintaining cost neutrality in the overall Reform 2020 proposal. And we understand it is necessary to balance the rate structure with the number of households to be served in order to maintain cost neutrality. We strongly favor maintaining a rate structure that will allow providers to deliver necessary services, even if it means reducing the number of Minnesotans who can be served under the Waiver. If rates decline to a point where providers cannot provide adequate services, people will not be able to maintain housing and the Waiver will be pointless. Conversely, if the State can demonstrate the success of the 1115 proposal with this population, there will be opportunities in future to expand the reach of the Waiver.

Once again, the Council appreciates the extent to which DHS has reached out to the housing community in drafting the current proposal and the progress represented here in serving folks who are homeless or at risk of homelessness. We look forward to continuing to work with the Department on this and other proposals to address the well-being of the most vulnerable Minnesotans.

Sincerely,

Laura Kadwell
HHM Community Leaders Council
Statewide Director

On behalf of
Carleen Rhodes, President and CEO
Minnesota Philanthropy Partners
HHM CLC Co-Chair



Dooley, Lea M (DHS)

From: MADSA <info@madsa.org>
Sent: Tuesday, July 17, 2012 8:45 AM
To: *DHS_Reform2020Comments
Subject: Reform 2020: Pathways to Independence

July 17, 2012

David Godfrey

Medicaid Director

Minnesota Department of Human Services

P.O. Box 64998

St. Paul, Minnesota 55164

Dear Mr. Godfrey,

MADSA appreciates the opportunity to comment on the Department of Human Services' Federal Section 1115 Waiver Proposal, entitled "Reform 2020: Pathways to Independence."

Sec 2.2 Long-term Care Realignment- MADSA continues to support modifying the nursing facility level of care standards, but we advocate that the state find a way to decouple that standard from the community supports level of care. We note that in **Sec 9.3 Redesign Home and Community-Based Care**, the Department proposes "person-centered choices" with "efforts to reach people earlier to prevent or delay use of public programs and more costly services." Contemporary research indicates that the keys to preventing decline are (1) begin adult day services early enough in the course of an individual's chronic disability and (2) provide continuity and frequency that meet the individual's needs.

We further support the facets of Sec. 2.2 that seek federal matching funds for the Alternative Care and Essential Community Supports Programs. Currently, Adult Day Services clients can make use of the Alternative Care funds. That option has not been extended to those who receive Essential Community Supports. The waiver proposal states that ...in the event that Minnesota is successful in obtaining federal matching funds for the AC and ECS programs, DHS will use at least a portion of the state savings that result to expand the benefits available under the ECS program. MADSA takes the position that consumers should be able to choose whether to spend this benefit on adult day services, even if the total dollars impose natural limits on the extent of services.

We urge the Department of Human Services to continue work to improve the availability and quality of consumer information services, particularly for people faced with what can be sudden changes in their needs and urgent transitions in their care. We note that for individuals who will Return to the Community from nursing facilities and for those who will rely on the Money Follows the Person Program, services available in adult day centers are far more than activities and socialization. Adult day centers can be the place where baths are given, blood pressure checked, and physical therapy provided. This approach saves time, transportation arrangements, and ultimately money. Finally, in the spirit of making complicated systems more consumer-friendly, we are in favor of giving the Maltreatment of Vulnerable Adults Reporting network one centralized

call-in number. This not only makes reporting more direct for the general public, it will make our trained staff's reports more efficient and effective because there will no longer be questions about which county to call when the vulnerable adult lives in one county and the center is in another.

If you have any questions or would like additional information, please feel free to contact me at 763.464.2698 or info@madsa.org.

Sincerely,

Lynn Buckley
MADSA President

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Monday, July 16, 2012 10:47 PM
To: *DHS_Reform2020Comments
Subject: comments about DHS proposal on Autism Benefit set

Dear Sir/Madam,

I am writing this email to express my concerns regarding to the DHS proposal on the Autism service. As a mother of a boy with Autism, who has fighting the battle to help my son to reach his highest potential for 4 years, I am deeply worried about the new proposal's age cap. We all know that each child with Autism is different and unique. Some kids might be able to mainstream into the public school education by age 7 after years' early intensive intervention with no or little support. While the other groups of kids, though cognitive normal, still need tons of support in the area of social interaction and communication even at the age 7. Being enrolled my son in the public school's special education program for 1.5 years, I can tell you that the public school cannot take this challenge. Due to the complexity of the Autism, you truly need the experts in the behavior management, social interaction and play, speech and occupational therapy to help this unique and challenging group. Those professionals have years of training specialized for working with these children. You can hardly find such qualification among teachers in the public school systems. Letting the school take over at age 7 regardless if the child is ready will fail those kids and also frustrate the teachers. Teachers are only experts in education. Treating Autism needs more than the educational approach. My own experience of trusting the public school help my Autistic son is a big mistake. That is the period my son made little progress. Because of the detour, my son starts the intensive in-home behavior therapy at 5 y old. So far, we just have a year of therapy. He has already made huge progress in lots of areas in terms of language, self-control, behavior. He just recently starts making progress in social interactions. I expect him continue growing and learning the new social skills. By providing all the medical necessary treatment for him, including speech, ABA, occupational therapy, social skills training, I have no doubt that he will eventually be independent and become a contributor to our community.

Perhaps one day he will work with me: his mother in the field of improving cancer treatment like he always wants now.

So please let all kids with Autism access to the medical necessary treatment regardless their age. The new findings in the neuroscience show the brain plasticity even in the adulthood. Having the age limit of 7 for the autism treatment is not scientific valid anymore. Why not keeping to treat them as long as they make measurable progress.

Thank you so much for your time and kind consideration!

A concerned mom

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Monday, July 16, 2012 9:18 PM
To: *DHS_Reform2020Comments

To who it may concern,

Please do not stop helping my grandson, he is and nonverbal , what will his parents do. No child with autism is cured at any certain age , what are you thinking ? You support people with drug and alcoholism problems and yet children with a lifetime and have hope you want to stop it . As a long time taxpayer and grandmother, please think of my grandson and all the other children and families struggling everyday to help their child!!!

Thank you,

[REDACTED]

David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

July 16, 2012

Subject: Reform 2020 Section 1115 Waiver proposal

Dear Mr. Godfrey,

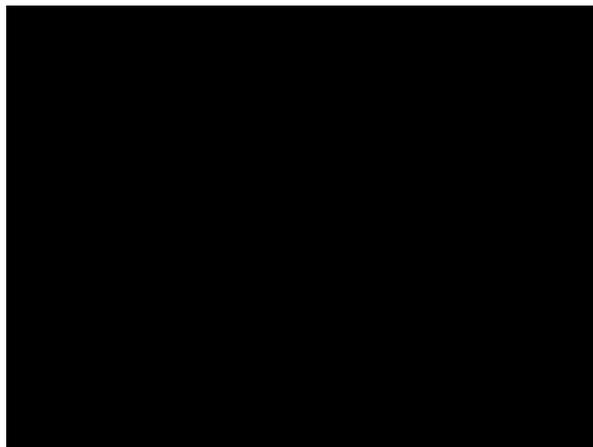
I'm writing this letter to inform you that I am a Minnesota resident and I firmly believe children of all ages should have access to medically necessary autism intervention treatments. I have a son (redacted 6 years old) who has a medical diagnosis of autism. (redacted) was diagnosed at the very young age of 16 months old. (redacted) has received numerous treatments during our autism journey, and by far the most effective has been in-home ABA provided by the (redacted)

(redacted) is continuing to learn new skills, and I know as a parent who lives and breathes autism 24 hours a day that he will continue to learn and grow beyond the age of seven. Please do not cap medically necessary treatments at the age of seven.

I can also tell you that every child with autism is very unique. There is no perfect treatment that covers all kids. It's exactly why they call it a spectrum disorder. I also urge you to please continue to allow individually tailored medically necessary treatments.

I want (redacted) to have a chance at the highest level of independence he can achieve. I know this will also help him live a happy life. Please do not make decisions today that will prevent children of all ages reaching their potential. Reducing treatments today will actually cost the state of Minnesota more money in the long run.

I'd like to quickly try to tell a personal long story short. (redacted) and was diagnosed with CLL (chronic lymphocytic leukemia) a few years ago. The disease is starting to have a large impact on my (redacted) including fatigue. Travel to Minnesota for visits is becoming increasingly difficult for (redacted), and I never thought we'd be able to control (redacted) behaviors for a trip to (redacted). Due to all the recent success of (redacted) ABA therapies, we decided we would try a trip. (redacted) did very well on the trip, and (redacted) was absolutely pleased to have his grand-children visit him for the first time in (redacted). Attached below is a picture of (redacted) (red shirt) and his younger brother (redacted) on a (redacted). This will be a treasured moment forever for our family that would have never been possible without (redacted) ABA treatments.



In conclusion, I urge you:

- Please do not create an age cap for treatment and services.
- Please do not take away individually tailored medically necessary treatments
- Please do not make short-term decisions that will ultimately create a larger burden for Minnesotans in the future

Kind Regards,

A black rectangular redaction box covering the signature area.



July 15, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey:

Thank you for this opportunity to provide public comment on "Reform 2020: Pathways to Independence, Section 1115 Waiver Proposal." On behalf of the Autism Society of Minnesota, whose mission is to enhance the lives of individuals with autism spectrum disorders through support, collaboration, and advocacy, we would like to provide specific feedback on section 9.1.2 – 9.1.3, 1915 (i) for Children with ASD.

According to the Center on Disease Control National Center on Birth Defects and Developmental Disabilities, the average age of an autism spectrum disorder (ASD) diagnosis is now 4 years of age. Children of color oftentimes are diagnosed later with some research showing that black children receiving Medicaid were diagnosed nearly 2 years later than white children. Given this data, children are already being diagnosed much later in the Birth-7 year age timeframe in your proposal. We are unclear, given the statement in your proposal as to providing an "intervention service set that tapers off as progress is made, or that children age out of as they transition to school" and how that relates to the 0-7 age range you are proposing. The Autism Society of Minnesota remains concerned about the lack of clarity in this proposal and recommends that DHS provide interventions that would taper off as the child progresses or extend to at least the age of 21.

As DHS moves toward more clarity in this proposal, we would also like to provide the following recommendations:

- The largest investments we make in children with ASD are healthcare and education. These investments need to be coordinated and collaborative to maximize the return on our investments and to ensure the best possible outcomes for students. Consequently, all agencies that provide services need to be working together along with parents and other advocacy organizations. For example, DHS should work with the Minnesota Department of Education to improve interagency service coordination, especially for children 3 years and older.
- We need to develop an integrated service delivery system between the healthcare and education systems. Currently, both systems continue to operate as separate entities, oftentimes to the detriment of children with ASD and their families.
- A broad range of "high quality, medically necessary, evidence-based therapeutic, neurodevelopmental and behavior intervention treatments (in and outside of school) should be covered because every child is different and responds positively to different treatment options. It is unclear if this proposal would cover such interventions as RDI and Floor time, which have

also been successful for children with ASD.

- Quality standards and performance measurements for Minnesota Department of Education and DHS service providers need to be in place to ensure high quality therapies and treatments. These standards and performance measurements should be transparent and shared in a format that is as “parent friendly” as possible.

We applaud DHS for considering the establishment of a learning collaborative to improve quality of care in community settings for individuals with ASD. We would like to make the following recommendations to be included as they relate to quality of care:

1. Promotion of Medical Screenings for ASD by 18 months of age. This recommendation is consistent with the American Academy of Pediatrics recommendation that screening be done as early as 18 and 24 months of age for ASD. This will help us identify children with ASD earlier and get them intervention sooner, which will in turn improve outcomes. In order to capture more children with ASD, DHS should partner with the Minnesota Department of Health and physicians to determine strategies to reach parents that may not otherwise utilize regular health checkups for their child.
2. Support for Expansion of Medical Homes for children with ASD. This should include ensuring that providers are rewarded for quality care and outcomes as well as reimbursed at a competitive rate for their services.
3. Promote cultural competency training for professionals serving children with ASD so diverse populations will be diagnosed earlier.
4. Promote ASD certification of case managers so they can better serve the needs of this population across the spectrum.

We also support the two year plan to enhance the integration of Medicaid within the school system. As part of that integration, DHS should work with the Minnesota Department of Education to continue to streamline the billing process through the Medicaid 3rd Party Billing requirement to ensure that schools can do this effectively and efficiently, while providing transparency to parents about services billed back for their child.

Lastly, we would like to thank DHS for bringing this proposal forward. The conceptual framework in the proposal has many key recommendations that will move Minnesota forward in serving children with ASD. Please consider us a partner in this effort and don't hesitate to call upon us for additional information if needed.

Sincerely,

Kim Kang
President

Sherrie Kenny
Executive Director



July 14, 2012

Mr. David Godfrey, Medicaid Director
Minnesota Department of Human Services
P.O. Box 644998
St. Paul, MN 55164

Mr. Godfrey,

Thank you and the Department of Human Service staff for your work to transform the delivery of services to children and adults in Minnesota through the Reform 2020 Proposal.

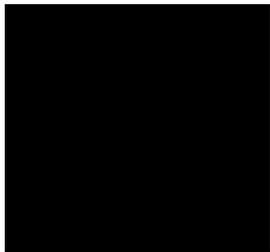
As a professional serving citizens impacted by developmental disabilities, I welcome the exploration of new models for service coordination and delivery that are “functionally driven according to person-centered plans.” This not only provides access to the lowest cost, highest quality outcomes for people — it is also how the community wants to be served. I applaud your plans for both community and provider input throughout the implementation of these ideas.

As a parent of a 4 year old with Autism, I have particular interest in 1915(i) for Children with Autism Spectrum Disorders (ASD). I appreciate the Department’s effort to create clear access to effective early intervention services. This is a critical need. There are 3 areas about which I’ll specifically comment: the importance of service quality, strategies for transitioning children to school, and a few thoughts about the importance of accessing emerging treatments.

Quality of Service: it’s critical to ensure that services in Minnesota deliver on the promise of Early Intensive Behavioral Intervention (EIBI). Behavior Analysis is a specialized practice, and treating children and adults with Autism is a specialty inside that practice. I urge DHS to bring effective consultants to the table and acknowledge the unique skills required to deliver effective, positive behavioral supports.

While the reform document speaks to developing standards of assessment and treatment as well as measurement, I urge DHS to go further. The practice of Behavior Analysis must go beyond a developmental sequence grid to have a real impact on the lives of children with Autism. A learning cooperative is an important element, and we must require credentialed professionals.

Accessing the therapeutic services recommended by our son’s physicians was complex, but unfortunately our early experiences in that service system have been heartbreaking, both through the school system (ECSE staff discouraged assessing my son for Autism) and in our first private therapy experience (where undisclosed, unnecessary aversive and deprivation procedures were implemented). While our son gained some skills in this ABA program, we saw minimal functional improvement and eventually regression before allegations of abuse surfaced.



The methods that developed without skilled Behavior Analysts on staff in this center should be of great concern to DHS. Supervision of services was provided by a contracted psychologist, who does not list early intervention as a competency with his licensing board. At other times supervision was provided by a Marital and Family Therapist.

Current professional standards have little relationship to the competencies really needed for effective services. An expectation that “Applied Behavioral Analysis” would be *applied* by a *Behavior Analyst* is reasonable.

The design of our Early Intensive Behavioral Intervention (EIBI) programs in Minnesota must match evidence-based practices. Quality services, quality outcomes. Structures and service allocations (e.g. hours/week) should be based on need; how service allocations will be made is unclear at this time, which is also of concern.

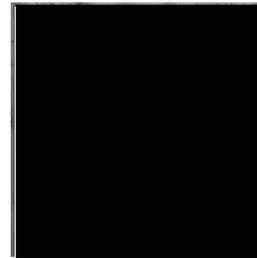
In addition to collaborating with the Minnesota Northland Association of Behavior Analysts (MNABA) to make appropriate determinations in this and other areas, I hope that DHS is utilizing the work already completed by the Behavior Analyst Certification Board and other State Associations for Behavioral Analysis

- Behavior Analyst Certification Board - www.bcba.com (conduct guidelines)
- California Association for Behavior Analysis - www.calaba.org (including a task force report on ABA Service Guidelines from 2011: www.calaba.org/sstf/guidelines-abatx.shtm)

Today our son now receives ABA services in a program staffed with skilled professionals: Board Certified Behavioral Analysts, Occupational and Speech therapists, and trained staff. In less than 6 months he has made remarkable progress, far beyond what was accomplished in more than a year in the prior setting.

Progress may seem hard to measure -- but it is obvious. Our son is physically stronger, better coordinated, able to follow direction and is more engaged with others. He is dressing himself (with structural and verbal cues), playing more appropriately (we finally have toys all over the house!) and progressing in his learning (e.g. matching items, making choices).

Most importantly, while he has no verbal language, we are quickly establishing an effective method of communication. The world is opening up for him. We can't help but wonder how far he might have progressed already if our current team had been with us from the start. Every child deserves quality intervention.



School Age Transition: I understand that DHS has clarified an intention to transition to the school system at age 7, not to reduce services. This leaves some open items of concern:

- While the legislature has requested recommendations by age, all other areas of this initiative focus on “people not programs.” A benefit set for Autism should follow suit.
 - There must be enough flexibility to meet individual needs. Some children will not have exhausted the opportunity of intensive interventions by age 7, especially those who were diagnosed or began treatment late. Some children may need extended service.
 - Behavior therapy can also be important for gaining and maintaining independence across the lifespan; it is “the right service, at the right time” for many young people and adults with a variety of disabilities, at a variety of ages.
- When we move children from 1:1 therapeutic interventions to traditional, IEP-guided classroom settings, we put at risk the very benefits of early intervention.
 - New models for early intervention must match funding allocations to the professional tiers of service required for effective results (credentials, supervision, parent training).
 - Funding streams should remove barriers to appropriately fading services and staff ratios as children progress. Such a system must be based on need, not age.
- Plans to provide service coordination within the school system also raises concerns. Given the gaps that currently exist in the schools, it's concerning to think that a resource outside of the school system would no longer be available to families. The details of this plan through CFSS services should be outlined for public comment (who, when, where, etc).

We all want our children in regular schools too—but a system that funnels kids into traditional, segregated special education programs won't work—our kids deserve to be tapped, not trapped.

- It seems wise to provide pathways for existing, high quality providers to partner with the schools, rather than limit CTSS services to schools after age 7. We need to discover how to leverage the expertise of the therapeutic community to support both transitions to school and the ongoing success of kids at school and at home.
- As many parents who testified indicated, school districts often refuse behavior-based strategies. Many schools are unprepared to welcome learners on the spectrum. Without a substantial change, the culture of interventions in many schools is unlikely to support kids with ASD to maintain skills, much less continue to build them.

Our story with the schools ended shortly after we received an Autism Diagnosis. Our team recommended we not “waste our time and money” on the assessment. We fortunately knew to act anyway; there was no question my son was regressing.

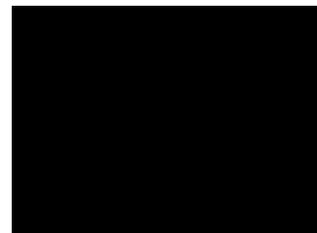
After his diagnosis, they offered a few mornings of service a week (pending several appointments for an educational diagnosis; one diagnosis is a direction I celebrate). The school system was not then and is not currently structured to offer the evidence-based methods my son needs.

Emerging Treatments: I was hopeful to hear that this benefit set may provide access to a wider variety of treatments, including emerging treatments. Increased access to interventions will improve outcomes, reduce long term service costs and support families for whom many interventions are out of reach. There are many promising medical treatments, including many outside of traditional pharmaceuticals. I urge DHS to consider inclusion of less-traditional biomedical interventions under areas of “coverage with evidence development.”

Our son has many allergies, reactive-airway/asthma and significant communication barriers. Exposure to an allergen can lead to extended disruptions in sleep as well as skin and/or digestive health, which become barriers to learning.

We encourage DHS to consider nutritional and biomedical interventions; such careful interventions have made a difference in my son's sleep, digestion, headaches and overall well being. Probiotics alone did wonders to help stabilize his digestion.

Diets have been shown to be effective with seizures in some kids. These and other promising treatments can be expensive, and out of reach for many families.



Thank you:

Autism presents our community—and so many individuals families—with great gifts and many complex challenges. I believe your efforts to welcome and incorporate stakeholder involvement in these reform initiatives will continue to be critical for creating effective and safe services.

Respectfully,

A solid black rectangular redaction box covering the signature of the person.

July 16, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

Dr. Mr Godfrey,

On behalf of Vail Place I am submitting these comments to the Medicaid Section 115 Waiver Proposal: Reform 2020 - Pathways to Independence. Vail Place is a community mental health program which provides case management, supportive housing, employment, and other community supports for adults with serious and persistent mental illness in Hennepin County. Thank you for the opportunity to comment on the Reform 2020 proposal.

Vail Place supports the goals outlined in Reform 2020 to:

- Achieve better health outcomes
- Increase enrollee independence
- Increase community integration
- Reduce reliance on institutional level of care
- Simplify administration and access to program
- Create a program that is more financially sustainable

Vail Place has reviewed the proposal and will provide comment on services for persons with serious mental illness.

4.2.1 & 4.2.2: Community First Services and Supports

Providing for an alternative to the PCA program by providing an array of services and supports to provide assistance with maintenance, enhancement or acquisition of skills to complete activities of daily living, independent activities of daily living and health related tasks to help people live in the community

Vail Place has concerns regarding the Community First Services and Supports (CFSS) for people who need to meet Nursing Facility Level of Care (NFLOC). Over the last year, the NFLOC which has focused on physical symptoms, hands on assistance, daily monitoring, and ADL needs. As a result, many people with a serious mental illness who

need a high level of CADI services were determined to be considered “low need”, resulting in lower service funding for individuals. The proposed CFSS services will be using the MNChoices assessment tool, based on the recent revision of the NFLOC, which will further restrict eligibility for people with mental illness.

The proposed program for people who do not need to meet NFLOC will also result in few people with a serious mental illness meeting eligibility as the individual must have a level one behavior or one ADL need. The program will not allow people who have a primary mental illness to meet the criteria as symptoms and interventions are very different from someone who has a developmental disability combined with a mental illness. For example, many people with a primary diagnosis of mental illness have complicating medical issues, but will not meet criteria of having a level one behavior and most people have no ADL concerns. In addition, the cyclical nature of serious mental illness may allow for decrease in symptoms for a period of time only to have high level of symptoms return at a later date, which may affect eligibility.

6.1: Demonstration to Empower and Encourage Independence through Employment Supports

Targeting specific people to provide telephonic navigation, benefits planning and employment support based on the Pathways and Demonstration to Maintain Independence and Employment programs.

Vail Place supports the proposal for Medicaid expansion to people ages 18 – 26 and the emphasis on employment for this group. However, there is concern about the high emphasis on telephonic navigation for these services which is not a good match for young adults with a serious mental illness. For example, a young adult with paranoid schizophrenia is not likely to follow through with telephonic services and will need face to face staff support to be successful. Vail Place is also concerned about the use of the Disability Linkage Line to provide navigation for this program. Young adults with a serious mental illness do not consider themselves disabled and they and their parents usually seek out mental health services as opposed to disability services.

The proposal also outlines using DB101 to manage benefits for people who find employment, however this program does not meet the needs for people who have complicated benefit issues. Also, many young adults may not have a computer or will need to obtain computer access in order to use DB101.

In addition, there is a concern regarding the eligibility criteria that the person must be currently employed, have been employed in the last year or have experience and an employment shift in the last year. The criteria will exclude young adults who want to

work but have not been able to find work and may exclude people who have been attending post secondary schools.

6.2 Housing Stability Services

Provide a new set of benefits to people who have serious functional impairments and housing instability.

Vail Place supports the development of additional housing support services for people with functional limitations. The proposal outlines three components: 1) outreach/in-reach, 2) tenancy support services, and 3) service coordination.

We are concerned about using MNChoices for someone who is homeless as the process will not well for someone in a shelter or on the street. People who are homeless require face to face outreach and personal connection in order to provide an accurate assessment. In addition, it is unclear how MNChoices will assess the ADL or IADL needs of a person who is currently homeless, particularly if they have been homeless for a long period of time.

The proposal outlines an array of front end housing services; however, it does not list ongoing support services which are often needed in order for people to maintain their housing. Currently, there is little, if any funding for ongoing housing support and Vail Place recommends the proposal be expanded to include these services.

7. Anoka Metro Regional Treatment Center Demonstration

Waiving the Institutions of Mental Disease (IMD) exclusion to use MA for AMRTC to allow for continuity of care

The proposal requests CMS to waive the IMD exclusion for AMRTC in order to provide continuity of care for people committed to the hospital. Vail Place is in support of the waiver as it will allow people to move from the community, to the hospital and back to the community without having gaps in Medical Assistance which will be a seamless transition for people as they purchase medications and have doctor and therapy appointments.

We are concerned that the proposal links 1915(i) only to a group of people who no longer meet hospital level of care and are unable to move from the state hospital to the community. Vail Place is in support of DHS reviewing a variety of 1915(i) program options that would assist people in the community, not only at AMRTC.

9.1.4 1915(i) to support individuals with mental illness who are at risk for institutionalization without access to integrated community-based systems of care.

Providing a wide range of services to a select group of people with serious mental illnesses who have co-occurring or complex health care needs and no longer need hospital level of care at AMRTC

Over the last year, there has been a lot of discussion in the mental health community regarding the 1915 (i) State Plan waiver to provide additional mental health services for people with serious mental illnesses. Vail Place supports the inclusion of 1915(I) placeholder language in the overall proposal while further details on the program are developed. We support the

We have concerns regarding the eligibility criteria in the proposal for adults with serious mental illness, which will exclude many people. The proposed current eligibility includes people who have a serious and persistent mental illness and difficulty maintaining community-based services as exhibited by extensive hospital stays, AND exhibits two of the following:

- Assaults
- Verbal aggression
- Active chemical dependency
- Past criminal behavior
- Symptoms that do not respond to treatment and require eight hours of supervision per day
- The presence of another illness, condition or disability that makes it difficult to function in the community

These criteria focus on a small group of people at AMRTC which does not include people who are at risk of being committed or hospitalized. In order to meet this goal, we would encourage DHS to explore additional service models and target population.

In addition, we ask DHS staff to revise Adult Rehabilitative Mental Health Services (ARMHS) to review funded services and billing as well as consider new rehabilitative services and billing units not currently funded by the Rehabilitation Option. Also, DHS would need to determine if this would be a good fit for the 1915(i) program.

9.3.2 MnChoices

Providing a single web-based assessment and planning process tool.

Vail Place recognizes the work DHS staff have made to improve the MNChoices program in order to assess the needs of people with mental illness.

We also feel additional work is needed to improved the assessment for people with serious mental illnesses.

We want to thank you for the work by DHS leadership and staff in developing this proposal which will improve the lives for many people who are elderly and disabled in our state.

Thank you again for the opportunity to provide comment on the proposal.

Sincerely,

Kathie Prieve, CPRP
Director of Community Development
Vail Place



Hennepin County Human Services and Public Health Department

**Administration
A-2303 Government Center
Minneapolis, MN 55487-0233**

**612-348-4806
FAX 612-348-8228**

July 16, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, Minnesota 55164

Dear Mr. Godfrey:

On behalf of the metro counties, I would like to thank the department for all the hard work that is evident in the Reform 2020: Pathways to Independence, federal waiver proposal. Comprehensive reforms that build on client capabilities, support community integration, and recognize the necessary role of housing are essential to sustain our public programs and better serve our clients into the future.

As the “administrators” in our state supervised/county administered system, we have many questions about how things will actually work. We will not fill this letter with all those questions. We recognize the Reform 2020 waiver request is a high level vision and that is appropriate. We do want to emphasize our willingness and our desire to be part of the work plan as you begin to build toward this vision. We want to contribute to and be part of the successful implementation of these proposals.

In general, our questions are in regard to “what is the role of the county?” As the administrators we have questions about operations, administrative burden and financing that may reduce funding to counties or shift funding responsibility to local property tax. In several areas of the RFP we agree with the vision, but we have concerns that arise from our traditional role as the safety net. In the metro area, health plans and contracted agencies have taken on more direct service and case management responsibilities. County staff are no longer the “eyes” in the community to provide oversight of quality and client safety and we no longer receive the service revenues that were used to fund quality and protection functions.

We support the proposal’s goal of simplified, streamlined administration and increased efficiencies. Counties do not and will not have resources to increase staff. We support early intervention, client directed services, and flexible service packages. We have questions about the county social services infrastructure that must be maintained to assist clients, protect clients, support clients to make good decisions in service packages and continue to serve clients who are connected to county services.

We support the proposal's initiatives to stabilize housing as an essential intervention in reducing health care costs. . Our clients will benefit from removal of barriers between programs and services so that our staff or community partners can deliver the right service at the right time. The Hennepin Health pilot and the "in-reach" pilots demonstrate the importance of integration and coordination of health care and social services, medical and behavioral health care providers, and access to housing with appropriate services. Sufficient options for housing with appropriate services, however, continue to be a challenge for both crisis and stable clients.

We support the proposal's initiatives to integrate care, develop health care homes with linkages to county social services, and targeted focus on transitions. Counties that work with health care homes, accountable care organizations, and other community integrated care models know that the greatest barrier to communication and streamlined service delivery is the inability to share data. We want to work with The Department of Human Services to achieve the cost savings and improved care that will result if we can find our way to protect client privacy and facilitate pathways through service delivery locations.

The metro counties are ready to participate with the Department to develop and implement the vision of the Reform 2020: Pathways to Independence. We appreciate the opportunity to comment and we look forward to being an integral part of the process to evolve and move forward our health and social services systems.

Sincerely,

Dan Engstrom
Assistant County Administrator
Human Services and Public Health

Cc: 7-County Metro Director Group

To: Dr. David Godfrey
Medicaid Director
MN Department of Human Services

From: Nancy Schussler, Ph.D., BCBA-D, Licensed Psychologist
President
Behavioral Dimensions, Inc.

Date: July 14, 2012

Re: DHS Reform 2020 draft proposal

Introduction

Thank you for the opportunity to comment on the DHS draft proposal. In responding to the proposal, I draw on my 35+ years of experience working with persons with autism and other developmental disabilities across the lifespan (see attachment for professional biosketch and description of Behavioral Dimensions). My company, Behavioral Dimensions Inc. (BDI), currently employs 95 staff who serve approximately 100 children spread across the state within the seven county metro area as well as Duluth, St. Cloud, Warroad, and Alexandria. Our clients present with an array of mental health diagnoses, including autism, disruptive behavior disorder, depression, anxiety, and stereotypic movement disorder.

BDI scope of services

Our largest group of clients is served in our in-home intensive Applied Behavior Analysis (ABA) therapy program; currently we are serving approximately 85 children with autism in this program. Behavioral Dimensions also offers other tailored interventions for families whose needs are not met by the ABA therapy program. We treat adolescents and pre-adolescents who come to us in crisis—often with a history of psychiatric hospital stays, day treatment, and police involvement. We provide workshop and in-home consultation to families to increase caregiver capacity to independently problem solve using behavioral principles. We also offer life skills training to address sleep and eating disorders and to teach self-care skills such as toileting, which can have lasting implications for placement and cost of care. We provide consultation services in group homes, schools, and job placements for children and adults with disabilities experiencing severe and persistent aggression and self-injury. Finally, we offer continuing education workshops to licensed psychologists and behavior analysts.

Focus of my feedback

Reflecting on the DHS proposal, I would like to draw on these experiences to address the ‘big picture’ rather than provide commentary on specifics of the proposal. The scope, content, and mission of the 2020 Reform document is impressive and clearly positions Minnesota as a national leader in providing services to individuals with special needs. As a member of the MNABA task force I have provided input on the MNABA response to the DHS proposal and the Standards for Behavior Analysis document being adopted by MNABA. I believe that these MNABA-sponsored comments provide ample guidance on specific points in the text of the DHS proposal.

Based on previous meetings and interactions with DHS staff charged with the Reform proposal I believe that DHS is taking to heart the stakeholder feedback which will result in well-coordinated, evidence-based services to the citizens of Minnesota and their families struggling with mental health disorders. I am very interested and invested in the translation of these goals into policy, rather than simply editing the document requesting the federal waiver.

My understanding of the proposal's intent is to break down barriers to effective service delivery across diagnostic categories, service categories, and age groups, so I have organized my response as a series of case studies based on my clinical experiences that might serve to illustrate the opportunities and pitfalls that I see coming from the proposal. They are organized to reflect the various needs and types of service delivery that are necessary and the lifespan impact of the proposed changes. I hope that using this format to provide input will illustrate 'real world' impacts of the reform proposal, rather than line by line critiques of what has been written. These case studies are based on actual clients served by BDI and are chosen because they are representative of large numbers of clients in the general population.

In addition, to assist in finalizing the reform proposal, we are mailing hard copies of resources that we use to guide our services. We hope these research articles and books are useful to you.

Types of clients served and impact of current/ proposed service delivery changes

Fully Recovered Autism

Child: JIM – Recovered autism

Age: 10

Diagnoses: Autism

Skill level at intake: Nonverbal, no functional communication skills; screamed unintelligibly for all needs; high rates of stereotypic, nonfunctional toy play; no receptive communication skills; high rates of tantrums and aggression

Chronology of Services:

- At age 2.5: "Recovery-oriented" Intensive ABA services at 40 hours per week for 3 years (continued at 40 hours/wk until discharged); Successfully completed curriculum skills at age 5.5

Current symptoms: None

Current issues: None. Educational placement in regular education setting full time w/o specialized supports; no longer meets ASD diagnostic criteria.

Future needs: None

What reforms are needed:

- To insure that intensive ABA services are available at the very earliest age autism can be diagnosed and provided at the maximum intensity (in this case 40 hours a week, plus parent training).
- Intensive services were required at "full strength" up to discharge; a requirement to taper hours would have delayed or disrupted treatment efficacy.
- How would changes to 9.1.3 "Initiative to advance coordinated care" and language around comprehensive multidisciplinary assessment impact the speed at which JIM could have accessed high

intensity evidence based intervention? Under current practices a referral from a developmental behavioral pediatrician allowed for nearly immediate service provision.

Autism fully mainstreamed, but needs social skills instruction

Child: CAL – Recovered autism; residual issues

Age: 8

Diagnoses: Autism

Skill level at intake: Delayed communication and language, restricted and rigid behavior patterns, problem behavior occurring during tantrums included: hitting, kicking, pushing others, throwing objects, yelling, screaming. Refused to participate in difficult or novel activities.

Chronology of Services:

- At age 2.5: Received Intensive ABA at 40 hours per week for 2.5 years, required 40 hours a week to fully complete treatment plan; discharged at age 5
- Regular education placement with minor case management support
- At age 7: Family contacted BDI due to peer rejection due to rigidity in play and lack of reciprocity. Received social skills training to remediate these deficits 4 - 6 hours per week with a typically developing peer for 10 months

Current symptoms: Can engage in interactive, reciprocal play with peers across several settings. Continued mild social skill deficits; Normal IQ; No aberrant behavior

Current issues: Still has difficulty in social situations with peers when at peer's house; Still served under Individualized Education Plan for case management but remains in a regular education classroom without direct special education services.

What reforms are needed:

- To insure that intensive ABA services are available at earliest age that diagnosis is possible to help remediate symptoms and to promote placement in a mainstream classroom.
- Intensive services were required at "full strength" up to discharge; a requirement to taper hours would have added months to services potentially reducing efficacy or delay school success.
- Regarding Reform 2020 9.1.2 Autism section: how would language in reform around school case management at age 7 effect access to services and interpretation of medical necessity as social requirements of daily environment change with age?
- How would Reform 2020 allow for post discharge consultation to prevent deterioration or development of maladaptive behaviors as child ages? "Booster training" using evidence-based practice should be available for clients and families throughout childhood/adolescence to remediate and not simply accommodate social limitations that can develop over time, by a) systematically targeting and teaching skills like social skills that expand and change with age, and helping clients master important coping skills despite the anxiety that can develop when encountering new and changing social situations rather than avoiding difficult interactions; and b) supporting and enabling parents to managing these changing skills and issues over time. It can be difficult for schools to provide the individualized and intensive focus on social skills issues that specialized service providers are already equipped to deliver.

Autism not recovered, significant behavior issues

Child: SUE: Autism with dangerous behavioral issues

Age: 8

Diagnoses: Autism

Skill level at intake: Pre-BDI services, at 4 ½ years of age: severe self-injury, aggression, property destruction, elopement, disrobing in public, masturbation using silverware; no functional communication (despite 2+ years of day treatment and speech therapy), Play needed to be continuously monitored for unsafe use of toys/objects.

Chronology of Services:

- Age 3 attended PIE (an outpatient behavioral program), also received some outpatient speech and OT through private providers; Parents requested behavioral support from BDI to provide in home behavioral services in conjunction with PIE's center based parent training to remediate aberrant behavior that was increasing at home.
- Funding mechanism would not pay for two providers; parents decided to forego home-based behavioral services in order to continue to receive center based instruction
- At age 4.5 SUE was referred to BDI again when aberrant behavior had worsened at home. Parents removed SUE from center based services at PIE to receive full time services from BDI. She received 40 hours a week of individual skills training to address skill deficits and to reduce her severe aberrant behavior. Her mother also received 3 – 6 hours of family skills training. BDI trained PCA staff pro bono to ensure consistent interactions across service providers. After approximately a year of service, SUE had made significant progress in reducing aberrant behavior and using an array of functional communication skills. She was also participating in age appropriate play and instructional activities. Her services then had to change because of a serious family event; see next bullet point.
- Following a family tragedy (suicide of father), SUE was placed in a crisis home for 3 months then permanently placed in group home due to her mother's inability to care for her *and* work full time to support her family. In both placements, her mother requested consistent implementation of the effective behavior plan previously used by mother and BDI. Both facilities agreed to this at intake, but then neither followed through, despite repeated meetings to adapt plan to these settings.
- At age 8 SUE's mother is seeking to return her to the family home (see current issues below).

Current symptoms: SUE's headbanging and severe tantrum behavior has not worsened, and in some cases has improved; yet her mother reports that SUE has now pulled out all of her hair—in tantrums or when anxious. When left unsupervised, she continues to engage in dangerous property destruction; often this can occur during the middle of the night when caregivers are sleeping.

Current Issues: In her mother's efforts to bring her home, she is seeking 24 hour a day staffing to care for SUE. This high amount of service is driven by two main factors: 1) SUE cannot remain safely occupied without direct adult supervision at any time of day and 2) she will awaken a number of nights a week and become "quietly" destructive. In order to care for her other daughter, maintain her overall family well-being, and her ability to work, this level of service is being requested by the county. Her mother is also requesting BDI to resume and

coordinate behavioral support with both SUE and caregivers—with the ultimate goal of reducing the intensive level of care needed in the future.

What reforms are needed:

- Funding mechanisms must allow for services to occur in all necessary environments. If SUE had received both home-based and center based mental health services at 3 years of age, it is likely she would have made sufficient gains to be able to remain at home with her single-parent mother.
- Reform 2020 must ensure that PCA services are available at levels that would maintain successful home placement like those proposed for elder care and transition from Anoka Co Treatment facility. While 24 hour care seems excessive, it would avoid costly out-of-home placement; in this case, for a 5 year old. For a child like SUE, specific behavioral training in the child’s Behavior Plan must occur with all assigned PCA’s (as opposed to a specialty-certified PCA) and across all settings; treatment integrity and adherence must be maintained. It is likely that with the addition of evidence-based mental health services directed towards SUE, her need for 24 hour care would reduce over time.
- Mental health services based in applied behavior analysis delivered at home with compulsory implementation by PCA and schools (i.e, beyond sharing ideas and progress updates at a meeting) is necessary to continue to remediate and manage SUE’s mental health issues.
- The full definition of “medical necessity” must be applied to children like SUE—specifically services must ultimately be designed “to restore or maintain enrollees health or prevent deterioration of the enrollee’s condition” (MN Statute on Medical Necessity). Many individuals with mental health disorders can attain a beneficial level of functioning with adequate supports in their lives. Removal of these supports—for many individuals—will result in deterioration. Service models must account for the long term needs of individuals with chronic mental health issues; this includes many children with autism and other mental health diagnoses.

Unrecovered autism

Child: MAT – Unrecovered autism with 5 year old level language

Age: 10

Diagnoses: Autism

Skill level at intake: Nonverbal; limited play skills; low rates of aberrant behavior

Chronology of Services:

- At age 3: Received Intensive ABA services at 40 hours per week for 3 years, had 40 hours a week until school age; was on track for age appropriate skills development (e.g. had learned “3.5 - 4” year level language)
- At school age: Family wanted therapy to continue, but also wanted MAT to be in school full-time; Because his learning rate continued steadily, we continued his ABA services after school for 3 more years in which he finished the language program bringing his receptive and expressive language to a 5 year level, and completed a significant amount of social skills training.

Current symptoms: Continues to show moderate autism symptoms. Spends majority of school day in special education classroom with ‘social inclusion’ during nonacademic classes (e.g. gym, art, lunch). No aberrant behavior.

Current issues: None

What reforms are needed:

- To insure that intensive ABA services are available at earliest age diagnosis possible to help remediate symptoms to promote placement in a mainstream classroom.
- Evaluation of need and outcomes for services under Reform 2020 must take into account long term functional skills development that does not result in full recovery. Intensive services were required at “full strength” up to for three years, and continued with decreased hours for 3 years. This treatment developed 5 year old language skills which enable MAT to progress through a special education program without direct paraprofessional support; as an adult, allows gainful employment in setting with minimal or no support from a job coach; may be able to live in semi-independent living.

Toddler with mental health needs and other disabilities

Child: RAE

Age: 8

Diagnoses: Microcephaly; Blind (she sees shadows only); global developmental delay; autosomal recessive condition, very small stature; stereotypic movement disorder with self-injury; severe disruptive behavior disorder

Skill level at intake: High rates of self-injury (head hitting and head banging), severe tantrums, aggression; no functional communication skills; emerging echolalia, limited and stereotypic play skills

Chronology of Services:

- At age 2, Early childhood special education and outpatient speech and OT
- Age 4, Began behavioral services from BDI, 10 - 15 hours of individual skills and 2 – 4 hours of family skills per week. Discharged at 6 years of age when no longer qualified for Severe Emotional Disturbance diagnosis—per MA rules, (despite not completing important skills remaining on treatment plan). Mental health services provided over these two years not only reduced her aberrant behavior to insignificant levels, but also was able to teach her to speak in short sentences to make requests, clarify her requests, ask questions, and engage in fun, teasing, verbal interactions. We also taught her to understand simple language of caregivers. She also learned a wide variety of age appropriate play skills which were modified for her visual disability.

Current symptoms: unknown

Current issues: unknown

What reforms are needed:

- RAE had learned to control her environment and the people in it though displaying an array of serious aberrant behavior. While BDI’s treatment of her aberrant behavior was so successful that she no longer qualified as having a severe emotional disturbance, given her current array of disabilities, as well as her 2+ year history of controlling her world through aberrant behavior, it is likely that she will need mental health services again in the future. A mechanism is needed to be able to “keep these kids

on our radar” and enable “booster” support to occur more readily and efficiently. How will Reform 2020 create a mechanism to allow preventative consultative services before a child deteriorates to the point of “re-qualifying” for a mental health diagnosis?

- The two years of receiving early childhood and outpatient speech and OT were unsuccessful in addressing her severe aberrant behavior, or increasing functional language use. None of these three disciplines provides an integrated and comprehensive evidence-based treatment package. Because research clearly shows that aberrant behavior can function as a form of communication, speech instruction in the absence of a Functional Behavioral Assessment has been shown to result in neither acquisition of language nor reduction in problem behavior. Programming needs to be developed using the results of a functional behavioral assessment and needs the beginning treatment phases to be carefully tailored to address children’s communicative function of their aberrant behavior.
- Reform 2020 endeavors to develop a coordinated care system for children with autism (Section 9.1.3). This endeavor needs to be extended to children like RAE. The multidisciplinary assessment, if it includes a mental health professional, could have identified the serious nature of her aberrant behavior; and hopefully would have also recognized the missing link in previous services. Appropriate mental health services could have begun at age 2.
- Applying a stronger standard across all disciplines to adhere to evidence-based treatment might have prevented the OT from recommending sensory integration techniques to RAE’s mother as a means of addressing the aberrant behavior (for which there is no evidence). In many cases, sensory integration actually increases problem behavior. A focus on outcome-based treatment might have led the speech therapist to refer RAE to other interventions, since her treatment plan had not developed functional, intentional language in two years of service, nor did it effect a decrease in aberrant behavior. While this may sound harsh, this is the reality of services that families receive, and families do not have the background to second guess recommendations made by experts. Many families are often first steered to early childhood and outpatient speech and OT, when in fact their child’s condition requires the service of mental health professionals.
- The benefits of a well designed team of people to complete a multidisciplinary assessment (again Section 9.1.3.) as close to the first year of life as possible are huge. Reform 2020 must also specify how this will be reviewed and implemented to gain maximum impact from this reform.

Other disorders that result in a deterioration of behavior or functioning

Child: DON

Age: 3

Diagnoses: Smith-Magenis syndrome (a chromosomal disorder) and disruptive behavior disorder

Skill level at intake: typical cognitive functioning, gross and fine motor delays, verbal communication delay (communicated through some signing), sleep disturbance, self-injurious behavior (head hitting and hand biting), aggression, quick to upset/tantrum

Chronology of Services:

- At age 2: Obtained a PCA to assist with care at home; Began Behavioral Services at 11 hours per week, continues to receive OT and speech outpatient services

Current symptoms: Still demonstrating atypically high rates of aberrant behavior (e.g. - self-injury, aggression, property destruction) across many life situations that inhibit quality participation in activities for the child and family. Furthermore, the behavioral symptoms of this child's disorder significantly interferes with DON's potential development and negatively effects family and sibling relationships.

Current issues: This child's treatment plan is focused on developing compliance and cooperation with others and developing independence in functional everyday activities such that aberrant behavior is minimal and easily managed by parents and teachers. Careful teaching and behavioral support is necessary for the child to participate in the simplest everyday tasks, and generalization across people and settings is critical in order to prevent behavioral deterioration and delay the progression of further symptoms.

Future needs: Genetics influence the probability of certain behaviors, but behaviors are still expected to respond to environmental contingencies, so teaching effective communication strategies and appropriate alternative to aggressive or self-injurious behavior is necessary to restore and maintain health. Continued supports through adolescence and access to service are also critical to improve or prevent deterioration of the individual's behavioral condition. A recent study of 21 adults with Smith-Magenis (Udwin et al., 2011) found that without appropriate service none of the adults were able to live independently and were dependent upon caregivers more than would be expected based on their level of intellectual functioning.

What reforms are needed:

- Reform 2020 section 9.1 that discusses the goal to "develop a recovery oriented mental health system" needs to include service categories for children like DON.

Pre-Adolescent with severe mental health needs

Child: KIM

Age: 11

Diagnoses: ADHD, PTSD, PDD

Skill level at intake: Significant aberrant behavior including: leaving home by breaking windows, aggression toward siblings, property destruction (kicking holes in walls), verbally threatening and aggressive to teachers, siblings, parents.

Chronology of Services:

- Repeated in-patient hospitalization for psychiatric disorders and aggressive behavior
- BDI service began with functional behavioral assessment conducted March of 2012. During first two months of service, delivered intensive family skills training to mother and step-father with coaching on responding to upsets and reinforcing positive interactions with siblings and adults and 3 hours per week of individual skills training focused on calmly responding to denials, stopping an activity to complete a task, following instructions. On ongoing basis, is receiving 2 hours of family skills training per week and 6 hours of individual skills training per week.

Current symptoms: Symptoms have lessened, but continues to display verbal disruption, some episodes of property destruction with family, and verbal aggression and noncompliance directed at PCA's.

Current issues: PCA's show high turnover rates and frequent cancellation of shifts without notice. PCA's not trained or willing to implement effective strategies. Inconsistent PCA support significantly contributes to family stress. Significant need for care coordination across providers and with school and county.

Future needs:

- On-going support for all family, caregivers, and teachers to implement effective practices. Current system lacks funding for training and supporting nonfamily members.
- Educational services must be held to the same standards to apply evidence-based practices, and outcome measures. At this child's IEP meeting, teachers said that they did not believe in using reinforcement and felt it was better to discuss problem behavior with child. Parents have little influence with the schools to adopt the same Behavior Plan that has proven effective for their child at home.

What reforms are needed:

- How will schools be held to same standards of evidence-based intervention as mental health providers? (who will mediate disagreements in methods if schools are primary case managers?)
- School personnel are not trained, nor are services configured, to provide psychological or mental health treatment. How will school personnel be trained to provide mental health interventions if needed?

Adolescent with severe mental health needs

Child: TOM

Age: 15

Diagnoses: Bi-polar disorder, autism, post-traumatic stress disorder, anxiety disorder, reactive attachment disorder

Skill level at intake: High use of medications at intake (Lithobid, neurotonin, seraquol, lamictal, nexium, medaformin, topomax, haldol PRN). Medical issues including sleep disturbances, digestive issues, asthma, and hand tremors. TOM required constant parent interaction and attention. Property destructive to home (walls, doors). TOM attacked siblings with knives and found/made weapons. Self-injury involving slamming head on floor during upsets. Several police calls to home resulting in behavioral health unit hospitalizations and emergency evaluations. Parents frequently needed to physically protect sibling from TOM's attacks.

Chronology of Services:

- PCA services at home, emergency psychiatric care, sensory integration invention through school and home, group therapy through school's CTSS program (that discussed violent video games and activities against mother's wishes)
- Out-of-home placement was recommended by the county and TOM was placed in a day treatment educational program before BDI stepped in and began services. Family was unable to retain PCA's due to aggression and noncompliance leaving family with no respite time or time for other siblings.
- BDI conducted a functional behavioral assessment in June of 2011, began intensive family skills training with parents and created crisis plan in conjunction with County, developed reinforcement system and began practicing waiting for parent attention, responding to stressful situations, behavioral contracts, waiting for requested items, asking for help and asking for breaks, refraining from asking for items that

are not available. Currently receives approx. 7 hours per week of individual skills training. Rates of aberrant behavior significantly reduced within 2 months of service.

- Parent removed TOM from school January 2012 due to school's long-term resistance to meaningful collaboration on behavior plan and concomitant detrimental effects of school-designed intervention on TOM's aberrant and academic behavior.

Current symptoms: Outbursts have significantly reduced in frequency and intensity such that out-of-home placement no longer being considered. Now able to travel on family trips and has begun using a debit card to spend money earned through positive behaviors and household chores. Can separate from mother for periods of 45 minutes to 1 hour which allows his mother to complete work from home and to spend one-on-one time with siblings. Actively and cooperatively participating in home-based school-delivered tutoring, which has now successfully transitioned from home to school site. He is also gardening to sell at farmer's market. Hand tremors ended with removal of psychotropic med and dosage reductions. Mows lawn, sorts laundry, and completes other chores that may lead to meaningful future employment skills.

Current issues: Currently receiving home-bound tutoring by a teacher who was willing to applying BDI's treatment plan—TOM is now showing academic success. Plans are being developed to return TOM to school in order to generalize gains to peer settings. Continue ongoing collaboration with medication management team. Continue in-home programming and extend BDI's treatment plan to new school setting and personnel.

Future needs: Family needs the assurance that supports will occur across all of TOM's treatment settings that maintain and extend the treatment gains he's attained over this last year. Supports must continue to insure that behavioral deterioration does not occur in any setting.

What reforms are needed:

- Allowing access to service at the youngest age possible to help remediate symptoms
- Training for PCA's on current behavior plan to maintained learned skills
- Insurance that schools will implement treatment plan—requires funding for careful implementation and monitoring of success in the school setting
- Funding for family training without child present; the presence of many of these older children in family skills is counterproductive during the "didactic" portion of training
- Funding for functional assessment hours—this is necessary to develop a comprehensive treatment plan

Conclusion

Our intent was to comment on a select number of sections in the Reform 2020 document; namely

4.1/4.2.1 PCA services

4.1 Home and Community Based Care

9.1.2 Autism (particularly medically necessity, evidence-based, intensive behavioral services past 7)

9.1.3 Initiative to advance coordinated care for children with ASD: Birth mandate and utilization of

comprehensive, multidimensional assessment to produce service coordination and assign funding responsibility

9.1.4 Mental Illness: develop a recovery-oriented mental health system

I hope the case studies have served to illustrate issues raised in the above sections, and in conjunction with the feedback provided by MNABA and others in the field, will help DHS maximize the impact of the Reform 2020 proposal. Please feel free to contact me with any questions or for any additional materials or documentation as needed. I am interested and available to provide more indepth service to DHS should that be desired. I'm looking forward to seeing the Reform 2020 programs move into implementation. Thank you again for allowing providers to offer feedback.

Respectively Submitted,

Nancy Schussler

Attachment 1: Schussler Biosketch**Clinician/researcher**

My educational experience has reflected my commitment to behavior analysis and services to persons with disabilities. I hold a B.A. from St. Cloud State (1975), and M.Ed from Peabody College at Vanderbilt University (1981), and an MA (1989) and PhD (1995) from the University of Kansas. I am a member in the Association for Behavior Analysis International (since 1974). I have work experience across the lifespan in preschool-based, home-based and group home settings, and in state institutions. Both my academic work and my clinical career have emphasized reducing severe aberrant behavior through positive methods such as teaching functional communication skills.

As a licensed psychologist (since 1991) some of my areas of Professional Competency include comprehensive functional skill, behavioral, and communication assessments, program development, monitoring the effects of proactive approaches to learning and behavior problems, and supervision of psychology students and other psychologists. I am also a Board Certified Behavior Analyst (since 2001) and was instrumental in bringing test sites for this national certification to Minnesota. Twenty of our staff members have had formal behavior analysis training and/or are Board Certified in Behavior Analysis.

I am fortunate to have many talented people working with me at Behavioral Dimensions, who all contribute to the high quality of clinical work being done with our clients. Among them, in particular, are:

Tim Moore, Ph.D., BCBA-D, Licensed Psychologist; President of MNABA

John Hoch, Ph.D. Research Director

Erin Cote, Ph.D., Associate Research Director

Jacki Harth, M.A., BCBA, Licensed Psychologist, Clinical Director

Sarah Roberts, M.A., BCBA, Licensed Psychologist; former president of MNABA

Nancy Rueckl-Jones, M.A., BCBA, Licensed Psychologist

Michael Maus, Ph.D., Licensed Psychologist



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July 16, 2012

VIA EMAIL

David Godfrey, Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164-64998

RE: Comments on “Reform 2020: Pathways to Independence, Section 1115 Waiver Proposal”

Dear Mr. Godfrey:

Thank you for the opportunity to comment on Minnesota’s nine 1115 Medicaid waiver proposals as well as other reform proposals under 1915i, 1915k, and 1915c and other state initiatives. Our office is Minnesota’s designated Protection and Advocacy system which represents children and adults with significant, often lifelong, disabilities, including intellectual and developmental disabilities, mental illnesses, physical disabilities and brain injuries across Minnesota.

1915 Medicaid Waiver Demonstration Proposals

1. Fiscal Analysis

We request the fiscal analysis and background information which has not yet been provided as part of the draft Reform 2020 proposal. We find it difficult to comment on the proposals without clearly understanding the assumed fiscal impact of the various proposals. The following comments are provided without the benefit of the fiscal analysis and may change when we are able to review that information. We do appreciate the complexity of the analyses required and the time pressures involved with such a multifaceted proposal and look forward to reviewing this aspect of the 1115 waiver as soon as it is available.

2. 3. Accountable Care Demonstration, p. 20

Given the requests for waivers of statewideness and freedom of choice under Medicaid, we urge that a description of consumer protections for the accountable care

demonstration be added. How will people learn about accountable care demonstrations and how will they be assigned to such demonstrations? Under what circumstances will a person be able to leave an accountable care demonstration? What appeal rights will the person have if disagreements or mistakes occur?

In addition, we continue to have serious concerns about the integration of long-term services and supports (LTSS) with health/medical care because of the likely emphasis on the medical model of service provision. While we certainly support effective coordination of health care and LTSS, we oppose control over all of one's LTSS services by a medical care provider without experience in housing, employment, transportation and social relationships in the community. Rather than assigning medical entities or health plans the authority and risk for every project, we recommend seeking proposals where the community support providers are in charge and can subcontract for medical services. This would be of particular value for persons with high LTSS costs and average to low medical costs or those whose costs are quite stable year to year.

We think it is essential to assure that persons who need long-term support services to remain as independent as possible in their communities are able to direct their own services based upon a person-centered plan rather than directed by a medical clinic or hospital. We urge that this proposal include clear safeguards, data reporting, appeal rights and disability-relevant outcome requirements for the provider.

3. 4. Demonstration to Reform Personal Care Assistance (PCA) Services, p. 25

- a. We are in strong support of reforming and modernizing Minnesota's personal care assistance (PCA) services program using the 1915k Community First Choice federal authority, under the title Community First Services and Supports (CFSS).
- b. We support the Department's waiver request to use Minnesota's special eligibility rules that apply to our home and community-based waivers for those who meet the level of care of an institution but would remain in the community and receive CFSS services.
- c. We strongly support the proposal to use both the 1915k option and 1915i option in order to continue serving people who do not meet Minnesota's institutional level of care criteria. This is especially important given Minnesota's pending request to make the nursing facility institutional level of care (NFLOC) criteria more stringent, thus eliminating eligibility for important Home and Community-Based Services Waiver Program (EW, CADI, BI) for many people who need assistance to remain in the community.
- d. Other Comments on the proposal to replace PCA services with CFSS.

- i. We urge inclusion of institutions for mental disease (IMD) as an institution for the level of care requirement in CFSS, as allowed under federal law.
- ii. We strongly support the increase in the minimum amount of time for persons who have one dependency in an activity of daily living (ADL) or Level 1 behavior to at least 90 minutes per day.
- iii. We urge that the definition of dependency in Minnesota's PCA program be changed to include persons who need **prompting and cuing** to accomplish activities of daily living and health-related tasks as the program used to permit. Currently, Minnesota's PCA program is discriminatory in that it does not include the type of help often needed by persons with mental illnesses, cognitive limitations or brain injuries. Many individuals with these conditions need prompting and cuing in order to accomplish essential tasks to remain independent in their homes, but are able to physically accomplish these tasks if provided with such assistance. We believe the current PCA eligibility criteria are discriminatory because the service is not being offered without regard to the type of disability as required by 1915k. Minnesota's current PCA eligibility criteria are limited to persons who need:

- (1) **constant cuing and supervision or**

- (2) **hands-on physical assistance.**

These dependency criteria do not meet the federal requirements for the scope of 1915k: ". . . as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands on assistance, supervision or cuing." 42 C.F.R. § 441.500. We understand that there are fiscal constraints and concerns about new participants in a reformed PCA program. We request that DHS consult with external stakeholders on these fiscal matters to assure the broadest consideration of factors affecting future costs and caseloads of a reformed PCA program.

- iv. We urge that the Department of Human Services (DHS) retain the PCA Choice Option by offering three models for CFSS:
 - (1) A fully agency directed support service;
 - (2) An agency service which maintains the beneficial aspects of the PCA Choice Option, such as choosing your staff, training and scheduling and

- (3) The new self-directed option with an individual budget.

We believe that many people currently using the PCA Choice Option will be reluctant to choose the totally self-directed option, at least initially. These individuals will be hurt by losing the self-directed authority they now have and by a reduction in their PCA staff wages. Clearly the pay for PCAs can be higher in the PCA Choice Option because nurse supervision and other administrative costs are lower for the agency. An abrupt decrease in the hourly wage of many PCAs will threaten the well-being of all current PCA Choice recipients.

- v. We are in strong support of the self-directed option under CFSS with an individualized budget. We urge that the budget administrative cost be carefully determined with input of stakeholders so as to provide the maximum amount to the eligible individual for services.
- vi. The 1915k State Plan Amendment Option offers other beneficial aspects, such as skill acquisition, assistance with health tasks and an updated description of instrumental activities of daily living, which includes traveling and participating in the community, as well as communicating by phone or other media, shopping, essential household chores, managing finances, meal planning and other tasks related to maintaining independence in the community.
- vii. In addition, the 1915k option requires that assistance and supports be provided in the most integrated settings without regard to the type of disability, age or type of assistance needed to live an independent life. We strongly support these important requirements and believe that a reformed PCA program can offer more flexibility and assistance in tasks needed for persons with disabilities to remain as independent as possible in their communities.

4. **4.23. Demonstration of Innovative Approaches to Service Coordination (children with CFSS), p. 41**

We urge that DHS find another way to assure coordination with school services for children who have two or more complex health-related needs, receive mental health services or exhibit physical aggression to oneself or others or engage in property destruction requiring the immediate intervention of another person. We do not believe funneling intensive service coordination through school districts is a sound idea for a number of reasons:

- a. Schools do not now provide services 24 hours a day, 7 days a week. While districts could contract with agencies to do so, this is simply not part of the

experience or institutional practice of school districts, and we believe will be inordinately difficult and lead to many gaps and problems for high-need children.

- b. Because schools do not provide services all day, 7 days a week, year round, staff are often unaware of the many needs a child has within the community and within their families. Again, it may be possible for a school district to contract with an agency with this expertise, but we do not understand why such a major shift in responsibility would result in positive outcomes for high-need students in a short time frame.
- c. Many of our clients' families do not want all of their medical information to be shared with schools and teachers. It is important to remember that most students have different teachers and support staff every year. In addition, many high-need students have more than one teacher or other staff person during a school year. The spreading of one's private medical information across the school district is simply not warranted or desired by most families.
- d. Relying on school resources, such as school psychologists, is mentioned as a reason to use the school as a basis for innovative service coordination yet Minnesota ranks low among states in the number of school psychologists across the districts. School psychologists do not have the training required for this level of treatment and service coordination. Our schools are simply not staffed with the professional resources to contribute to this effort.
- e. There is some concern that implementation of service coordination would result in cost shifting from special education services to Medicaid. We are concerned because schools have very strong incentives not to identify a student's needs. With authority over Medicaid, we believe the opportunity for cost shifting is increased. We do not think shifting authority to school districts is a sound method to assure children get both the educational and the health care services they need.

Instead, we suggest a demonstration to provide innovative approaches to service coordination for the children described based in our current human services system and relying upon a range of experienced providers to work closely with school districts to assure common approaches to the complex needs of these children in school, within their families and in their communities. We urge this proposal be substantially changed prior to submission to CMS.

5. 5.2. Demonstration to Expand Access to Transition Supports, Return to the Community, p. 44 and p. 127

We urge that the "Return to the Community" transition supports for people in nursing homes be clearly described as a service available to persons in nursing homes of any age. The emphasis in the description is on seniors but many persons under 65 could benefit from this effort.

6. 6.1. Demonstration to Empower and Encourage Independence through Employment Supports, p. 51

- a. We are in strong support of efforts to increase employment for persons with disabilities in Minnesota. We support statewide demonstration program focusing on five target groups of young adults. We are concerned, however, that the requirements to be employed or to have been employed within the year or to have experienced an employment shift within the past year is too onerous for some of the target groups listed. In particular, targeting 18-year-olds and imposing these employment requirements simply misses the mark. We certainly agree that 18-year-olds in the circumstances described in the five groups could well benefit from navigation assistance, but we are concerned these individuals will not be included because they do not have employment experience. We think it is especially important to target young people graduating from high school for employment supports. The longer a person is both out of school and not working the more likely the person will be to seek the total and permanent disability status of Social Security. We urge that the employment eligibility requirements be expanded to include young persons in their first year after high school graduation in the categories listed, regardless of employment experience.

- b. Recommended changes to disability benefits 101.

While we appreciate the online benefit analysis tool, disability benefits 101 (DB 101), we are aware that the tool itself is not a comprehensive analysis for some people, especially those who benefit from one or another of a long list of local and project-specific housing subsidies. We urge that DB 101 be changed to include information on housing subsidies and the clear recommendation that people with local benefits or other unique types of housing supports be referred to the Work Incentives Connection for a full and individual analysis. It simply is not wise nor fair to attempt a benefit analysis without the full consideration and we understand this may not be possible with an online tool given the variety of unique subsidies available.

- c. 1915i for Employment Supports.

We also urge that the Department work with stakeholders to develop a 1915i state plan option for employment supports for all persons with disabilities who meet criteria to be established with stakeholders. The employment supports should, of course, be individually tailored and follow available evidence-based practices such as individual placement support (IPS) for persons with mental health conditions which has been tested at six pilot sites in our state. The recommendation to develop a 1915i proposal for employment supports as well as the Department's proposals on navigation services both point to the challenge of making necessary changes within a very tough fiscal environment. Any employment supports for persons with disabilities which are successful in

assisting persons with disabilities to work will produce tax revenue and cost savings. However, some portion of such cost savings would likely come not from Medicaid, but from reduced income supports such as SSI or Social Security Disability benefits, food support, housing subsidies and transportation funding. In order to truly account for the benefits of employment of persons with disabilities, savings in all of these other sectors ought to be able to be part of the fiscal considerations in establishing a broad employment supports program in our state Medicaid plan under 1915i.

d. Transition from Corrections Systems.

We are in very strong support of inclusion of Medical Assistance recipients who are transitioning from the Department of Corrections. This group definitely needs services and supports. If well designed and successful this effort will undoubtedly save corrections funding in the future.

7. **6.2 Housing Stability Services Demonstration, p. 58**

- a. We support the demonstration to add housing stabilization and services to our state plan. Again, we strongly support the inclusion of persons leaving correctional facilities, residential chemical dependency treatment and inpatient psychiatric facilities as well as nursing facilities.
- b. We support the request to obtain federal Medicaid match for PATH Critical Time Intervention services (p. 66) for those who have not yet been determined eligible for Medical Assistance because they have been homeless and disconnected from services.

8. **7. Anoka Regional Treatment Center Demonstration, p. 72**

We support the proposal to obtain Medicaid match for Anoka's treatment services so long as these services are intensive, short-term medical services. We also support the exemption from IMD status in order to be able to qualify persons who have received intensive psychiatric services and are ready to return to the community for the Money Follow the Person initiative. We urge more specificity on how the increased funding would be used to both divert persons from Anoka Regional Treatment Center and assist people to return to the community as soon as possible after treatment at Anoka or other psychiatric inpatient settings. We support the request to exempt the state from the IMD exclusion for adults between the ages of 21 and 65 who meet Medicaid eligibility requirements as long as the increased funding is used to divert or assist to return to the community persons with significant mental illnesses.

9. **9.1.4. 1915i To Support Individuals with Mental Illness who are at Risk for Institutionalization without access to Integrated Community-Based Systems of Care, p. 82**

- a. We strongly support the development of a 1915i state plan option to provide services which are flexible in terms of type, such as in-home services, employment supports or other therapeutic services and flexible in terms of intensity. The criteria for qualifying for the proposed services, however, is very restrictive. We support broadening a 1915i state plan proposal in order to provide services to persons before they end up in psychiatric hospitals, prisons, jails or nursing facilities.
- b. Our specific concerns regarding this proposal include:
 - i. The SPMI definition in the Mental Health Act has been viewed in the mental health community as too restrictive for a long time. It does not cover many individuals with severe anxiety related diagnoses who are unable to function without a high level of supports. It does not recognize severe functional disabilities related to a combination of diagnoses or conditions. Use of SPMI criteria will make many “first onset” individuals without extensive hospitalizations ineligible for very beneficial services.
 - ii. The targeting of behaviors that are “specifically related to symptoms of the person’s mental illness” is confusing and needs to be clarified. (p. 84). For example, if a person has schizophrenia, must the person exhibit symptoms of schizophrenia that are listed in the DSM to qualify? What about maladaptive behaviors that have been learned over a lifetime of living in institutional settings? These are not specifically related to the symptoms of the mental illness, but are likely the reason the person needs more intensive services and supports.
- c. Another reform needed to improve Minnesota’s services to persons with mental health conditions living in the community is to make changes to adult rehabilitative mental health services (ARMHS). We understand from a number of providers and have seen with some clients that the service limits are too low and inflexible and understand the rates are very low as well. Also, we have seen variable authorization of ARMHS’ services so that people do not seem to be treated consistently across the state. Finally, providers are either dropping or having to subsidize ARMHS, which is not a sound trajectory for an important mental health service which has been found effective in stabilizing individuals for successful living in the community.
- d. The criterion in “f” (p. 85) of “inability to function in the community or inability to find supportive services in the community” should not be limited to persons who have a mental illness and a co-occurring other illness, condition or disability. This criterion should also be applicable to persons with severe functional limitations due to their mental illness alone, but who may not meet the “eight hours per day of supervision” requirement of 2(e) (p. 84).

- e. Will the MNChoices assessment tool be used to determine eligibility for this state plan option? If so, MNChoices needs to be carefully analyzed and amended as needed to make this service accessible and viable for those who need it.
- f. We also recommend that DHS work with stakeholders to develop a 1915i for children. Certainly this is needed for those 16 and older, who may be subject to commitment. It can also be a good mechanism to fill gaps in children's mental health services in a cost effective manner.

10. 8. Adults without Children Eligibility, p. 76

We oppose the requested waivers to make eligibility for MinnesotaCare adults without children more restrictive by imposing a durational residency requirement of 180 days and establishing an asset limit of \$10,000 for Medicaid eligibility for adults without children who have incomes under 75% of the Federal Poverty Level.

11. 9.12 Services for Children with Autism, p. 79

- a. 1915i state plan service for young children with ASD, p. 80.
 - i. We support the proposal to develop a 1915i state plan amendment for a range of intensive services for young children with autism.
 - ii. We also support the proposal to ask CMS for technical assistance to assure that children from families with income over 150% FPL qualify for Medicaid under TEFRA or HCBS waivers because they meet those criteria for MA eligibility for children with disabilities in families above the required MA poverty levels. However, we urge that this issue be carefully reviewed with stakeholders given the pending changes to the nursing facility level of care (NF-LOC).
 - iii. We urge that a stakeholder group be convened as soon as possible to develop this package of services, eligibility criteria and provider standards.
 - iv. To support and augment this proposal, we urge that DHS support a private insurance mandate for coverage of the variety of medically necessary treatments and services for children with autism.
 - v. Another related effort, which will support the proposal, is to assure that behavior analysts are recognized as a professional category within our state Medicaid program. Use of the national certification standards should be required and used as the basis for this effort.
- b. 9.13 Related Policy Initiative for Care Coordination for Children with ASD, p. 81.

We have serious concerns about several statements in the description of the 9.1.3 related policy initiative. While the title and some statements do indicate this is an undeveloped idea to be worked on over the next two years with stakeholders, there are several other statements which have led many parents to conclude that their child with ASD would not be able to access medical services outside of school after the age of seven. The problematic statements include:

- i. “Minnesota will develop a time limited early intervention service set that tapers off as progress is made **or that children age out as they transition to school.**” Page 81, top of page;
- ii. “In addition, services for children who are over age seven would generally be included in the child’s IEP and could be informed by HASC’s recommendations in this regard.” Page 81, end of paragraph before bold new section;
- iii. “After age seven, it is expected that children would be enrolled in school and receiving any services they are entitled under an IEP, which could include medically-related services in addition to educationally-necessary services.” Page 82, last sentence before bold title for 9.1.4.

The combination of these three statements can be understood to lead to the conclusion that this proposal would mean that after age seven children could no longer be able to access intensive, medically necessary health care services except through the school. Given the dismal school experience of many families of children with ASD due to lack of individual consideration, no choice of treatment approach and, in some instances, use of prone restraint, this prospect has been frightening indeed.

We recommend that this proposal be changed to reflect a general idea to be developed with a stakeholder group over the next two years to assure that children’s rights to a free and appropriate education be assured and that medically necessary services be available depending upon individual need. We certainly agree that school districts have obligations to these children for educational services, but often are ill-equipped and unable to provide those services in the context of intensive behavioral or other services a child needs. Consequently, other ways for school contributions to the child during these intensive treatment periods should be explored and developed.

12. **9.2 1915i for Adults with Co-occurring Developmental Disabilities/Cognitive Impairments/Serious Mental Health Conditions and Diagnosed with a Sexual Disorder and/or Antisocial Personality, p. 85**

David Godfrey, Medicaid Director

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We support the development of a 1915i service for this population to better design effective services and community supports for this population.

13. 9.3.2 MNCHOICES, p. 88

Since the MNCHOICES' assessment is proposed to be used for a number of new services in this document, in addition to all HCBS waivers, nursing facility, ICF/DD, DD case management and Private Duty Nursing (PDN) services, we urge that special care be taken to assure proper consideration of those who have needs due to mental health conditions. The current assessments do a poor job of assessing the need for services and supports for those with mental health conditions. The ways in which the new MNChoices' assessment will assess the impact of mental health conditions on one's eligibility for services should be clearly communicated and available for all to understand.

14. 9.3.4 Strategies for Integration of Long-Term Services and Supports with Other Initiatives, Health Home Demonstration, p. 93

We strongly support our state seeking funding under the Health Home Demonstration authority to include services for people with mental illness and physical or other complex health care needs.

15. 9.3.6 Enhancements to 1915c Waivers, p. 95

- a. We urge the Department to improve the opportunity for self-directed services through the Consumer-Directed Community Supports (CDCS) Option. The current discount of 30 percent over what a person would otherwise use in traditional services defeats many people who would be able to put together a self-directed service plan with more targeted and flexible services. We believe many more individuals would be willing to do this if the discount were reduced to 10 percent.
- b. Quality management and a state quality council are discussed on page 97. Minnesota has a very long way to go in developing adequate quality assurance/improvement for our home and community waiver programs. Recent experience in working on the advisory group to change the current aversive and deprivation rule (Rule 40) has revealed that our state does not have data even on emergency use of restraint or 911 calls during which occur during HCBS services. We strongly support a robust effort to collect and analyze outcome data as well as incident reports in order to understand trends and improve services.

16. Service Coordination/Case Management /Care Coordination

There are numerous provisions and descriptions in the 144-page document which refer to service coordination and navigation. We are quite concerned that the proliferation of efforts to coordinate services for individuals will lead to confusion on roles and authorities. We request more details on how people would access these new or reformed types of case management service coordination and what choices they will have in so doing. Today some individuals have more than one case manager/service coordinator

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which too often results in duplication of effort and conflict. We urge a serious effort across divisions and agencies to thoroughly examine service coordination/care coordination/case management/navigation in order to avoid duplication, confusion and conflict.

17. 9.7 Children under 21 in Residential “IMD” Facilities, p. 103

We share the concerns expressed in the description of this issue on pages 103 and 104 and urge the Department, in consultation with stakeholders, to develop some solutions to this issue as soon as possible and certainly in time for the next legislative session should such action be necessary.

In sum, we thank you for the opportunity to comment. We also appreciate the Department’s efforts to provide information and inform the public about the many different proposals contained in the Reform 2020 document. We look forward to the fiscal analysis for the 1115 waiver requests and the final submission for CMS.

Sincerely,

Anne L. Henry
Attorney

ALH:nb

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Monday, July 16, 2012 3:30 PM
To: *DHS_Reform2020Comments
Subject: Don't cut autism coverage

Dear Mr. Godfrey:

We are writing to express grave concern regarding certain provisions of the new "Autism Benefit Set" proposed by the Department of Human Services. **Limiting access to these benefits to children under 7 would be a terrible blow to older children and their families who desperately need these services. Not all children are diagnosed with autism as toddlers; many are diagnosed much later, especially minority children. These children CAN STILL benefit from evidence-based therapeutic treatment delivered in a one-on-one environment. Relegating these services to a child's school IEP is simply not enough.**

As a whole, the Autism Benefit Set does offer good ideas. However, expecting that these services should be delivered by schools after age 7 is an impossible fantasy. There is simply not the time or the staff required to help these children learn the skills that will ultimately help them live more independent, productive lives.

Intensive, one-on-one treatment such as ABA (applied behavioral analysis) that has been clinically proven to help autistic children function at a more independent level is **impossible in a school setting**. Even in classrooms taught by the best autism specialists, students cannot get the kind of effective, rigorous, evidence-based intervention that ABA provides.

This benefit limit would hit our family in a destructive way. Unfortunately, despite repeated questions from us regarding the possibility of autism, our daughter's pediatrician resisted the diagnosis, and ultimately delayed our daughter's diagnosis until she was **5 1/2**. Months of arranging insurance, medical assistance and finally, therapy providers delayed the start of her individual ABA services until she was **nearly six**. Now, our lovely daughter is **7 years old**, and after just one full year of ABA, we can say without any hesitation that our daughter has made progress beyond our wildest dreams.

Under your new provisions, our daughter would not have access to the same services other children who were diagnosed early get.

Once psychologically assessed as "perhaps retarded", we have seen our daughter's ability to communicate what she knows absolutely explode. Through painstaking, tireless, consistent and tedious therapy, our daughter's skills have ballooned. In addition to that, our daughter's therapists have worked to help us, her parents, learn how to deal with her difficult behaviors.

The difficulty of teaching special needs children such complicated yet basic tasks as dressing oneself may not be obvious to people unfamiliar with disabilities. Our daughter just learned--**at age 7**-- how to put on her own pants. This was a triumph to our family, and would absolutely not have happened without the help of her ABA therapists. Our daughter needed months of one-on-one direction to learn this simple task. We needed the therapists' help in knowing how we could help her. We see this one simple triumph as a small step towards her living a more independent life.

Our family desperately needs these services to continue. Please don't derail our daughter from a path that has already delivered such triumphs. **Do not cap at age 7 the Autism Benefit Set. Services should be delivered based on need, not age.**

Thank you for your time.

Sincerely,

[REDACTED]

[REDACTED]



July 16, 2012

To: Minnesota Department of Human Services

From: Randall Bachman, Executive Director, AXIS Healthcare

Re: Reform 2020, Input for Public Comment

The Reform 2020 proposal is an ambitious effort to reform Minnesota's Medicaid system that has significant implications for all Medical Assistance beneficiaries, their families, providers, and other stakeholders. It contains many elements of reform that have been proposed by consumers and advocates. It also builds upon the current system of community supports that Minnesota has developed over the years.

While the proposal raises a number of issues and concerns, AXIS Healthcare generally supports the direction and philosophy contained in the proposal. However, as evidenced by feedback in recent public hearings, the proposal raises many questions regarding the details of implementation. We are pleased that an Implementation Council with significant input from consumers and other stakeholders will be established, and hope that this mechanism, as well as other opportunities for feedback, will inform DHS's policy development and practices.

AXIS Healthcare was created over a decade ago as a joint venture of the Sister Kenny Institute of Allina Healthcare, and Courage Center, two well-respected rehabilitation providers in the upper Midwest. The objective was to help working age adults with disabilities or chronic and complex medical conditions maintain their health and live in the community. This is achieved through care coordination and case management by nurses, social workers, and other community support staff with expertise in disability services. Through our work we have demonstrated a reduction in avoidable hospitalizations and re-admissions, successful relocation of persons in facilities back into the community, prevention of recurring conditions that are common to persons with disabilities, and coordination and management of services and supports that help people live healthier lives and allow them to remain at home or in another setting appropriate to their needs.

AXIS Healthcare was the provider of care coordination services with the now defunct Minnesota Disabilities Healthcare Option (MnDHO) program. This program integrated the services of health care coordination and case management under the Medicaid Waivers for persons with disabilities. Unfortunately, for a variety of reasons, including inadequate reimbursement on the Medicare side, the program was terminated at the end of 2010. While the program ended, our Agency has continued on providing care coordination with contracts with health plans under the Special Needs Basic Care program, and through contracts with counties for waiver case management services. We point out this history to underscore our expertise in collaboration with our stakeholder partners, and in disability health care coordination and case management. We hope that DHS takes advantage of our expertise as we have learned a lot about what works and what does not, and pitfalls to avoid.

AXIS Healthcare supports the core values reflected in the proposal: community integration; person-centered services; self-direction and choice; independence and recovery; individual planning; and quality outcomes. Accordingly, we support the direction toward more consumer-directed services, in accord with the My Life My Choices initiative, with the caveat that there needs to be continued strong support for persons who cannot self-direct sufficiently and need assistance. In order to truly achieve these values and direction, however, it will be necessary to focus on effective implementation. This will require a candid assessment of shortcomings and barriers from all parties with the intent of redesigning and streamlining the current infrastructure to make the systems more efficient and effective.

While there are many aspects of the proposal that could impact our agency and the persons we serve, we will limit our feedback to three areas: 1. Service Coordination; 2. PCA changes; and, 3. Infrastructure, including Information Systems.

1. Service Coordination: References to service coordination being the key to effective implementation are numerous throughout the document. As an agency that provides health care coordination and waiver case management services, these references are very germane to our business. The proposal notes that there are people who are eligible but do not get connected with the appropriate service and others who are accessing many services across multiple systems that are not well coordinated. The dilemma of having too many coordinators, yet needing the different areas of expertise that each coordinator or case manager brings to the table, is also described.

While we support the consolidation of service coordination where it makes sense, we are concerned that it not be assumed that one case manager can handle it all and still be effective. For example, staff who manage waiver services in the community may not necessarily have the expertise or background to provide health care coordination for persons with disabilities or complex medical conditions.

The proposal would broaden the availability of home care service coordination to persons not enrolled in managed care and not receiving waiver services. Our hope is that there will be a mechanism for persons with disabilities on Medical Assistance who are on fee for service and not on waivers to access health care service coordination from a community-based provider as well.

2. PCA Changes: DHS proposes to transform the current PCA system to Community First Services and Supports (CFSS). We understand that the intention is to make the system more efficient and accountable, and also expand services to those not currently eligible for PCAs.

While we support the expanded access provided by CFSS, what are the ramifications for an already under funded PCA program? Our hope is that there will be adequate funds to support this expansion.

Finally, we hope that this reform will eliminate accounting for PCA and skilled nursing in an individual's waiver budget when the waiver does not pay for those services.

3. Infrastructure Changes: We understand that DHS will be planning for necessary IT changes in the spring of 2013. Our hope is that work could start now on upgrading their MMIS system. A start would be to survey stakeholders who have direct experience with the capacities and shortcomings of the system to identify the issues and barriers in preparation for this planning.

Under Vision for the Future, 3.3.2, the document refers to new integrated provider organizations and the need for accurate and timely information:

“These new integrated care provider organizations will need the capability to receive data from the state and share data among their members’ providers (health care and non-health care) to better manage care for their populations they serve. This includes data analytic capabilities and storage capacity for reporting that potentially use a combination of health care claims, electronic medical records, and social service data to help providers better understand the care their populations are receiving and evaluate outcomes and care model strategies. Organizations must have the capabilities to stratify populations by need and develop appropriate models of care based on those needs.”

Our hope is that DHS with the support of stakeholders will give this objective priority. It is unclear to us whether or not there is funding to make the necessary systems upgrade. However, without modernizing the IT system, the reforms under this proposal will be greatly hindered.

Regarding other infrastructure changes, the document states on p. 29:

“The system evolved over a long period of time and now is quite complex and increasingly difficult to manage. Simplification would make it easier and more efficient for participants and providers to navigate and for lead agencies and the state to administer.”

While we certainly support simplification, it is not clear to us what will be simplified and how it will be accomplished. We would like to know more about how this simplification will occur and what mechanism will be used to identify what needs to be simplified.

AXIS Healthcare appreciates the opportunity to provide feedback on the Reform 2020 proposal. Notwithstanding our concerns, we believe that with strong consumer and stakeholder input we can work together with DHS to bring the vision of these reforms into reality. We look forward to participating as a partner in this effort.



Center for Elder Justice & Policy

July 16, 2012

To: David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

From: Iris C. Freeman
Associate Director, Center for Elder Justice & Policy
William Mitchell College of Law
875 Summit Avenue
St. Paul, Minnesota 55105

Comments to the Department of Human Services on

Section 1115 Waiver Proposal

State of Minnesota

Reform 2020: Pathways to Independence

This statement is submitted on behalf of the Vulnerable Adult Justice Project (VAJP), an elder justice collaborative that has been administratively housed at William Mitchell College of Law since 2007. Participants in the VAJP include professionals from adult protection agencies, public advocacy organizations, elder and disability organizations, health care providers, law enforcement, city and county attorneys, private attorneys, and other government organizations. The group provides a forum for experts who work with and for vulnerable adults to weigh, debate, and ultimately advocate for policies and safeguards that better protect vulnerable Minnesotans.

The Vulnerable Adult Justice Project strongly endorses the Proposal's Section 93.9 to create a statewide, centralized system for Reports of Vulnerable Adult Maltreatment.

The VAJP launched a successful legislative effort in 2009 with two focal areas. One was adding tools for the identification and response to cases of financial exploitation. The other was the centralization of the Common Entry Point for reports of maltreatment. The policy for the latter was enacted that year. No funds have been granted for the purpose since that date.

Minnesota Statutes Section 245A.655

FEDERAL GRANTS TO ESTABLISH AND MAINTAIN A SINGLE COMMON ENTRY POINT FOR REPORTING MALTREATMENT OF A VULNERABLE ADULT.

(a) The commissioner of human services shall seek federal funding to design, implement, maintain, and evaluate the common entry point for reports of suspected maltreatment made under

Minnesota Statutes, section 626.557. The purpose of the federal grant funds is to establish a common entry point with a statewide toll-free telephone number and Web site-based system to report known or suspected abuse, neglect, or exploitation of a vulnerable adult.

(b) A common entry point must be operated in a manner that enables the common entry point staff to:

(1) operate under Minnesota Statutes, section 626.557, subdivision 9, paragraph (b); and subdivision 9a;

(2) when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; and

(3) immediately identify and locate prior reports of abuse, neglect, or exploitation.

(c) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) develop a system to manage consumer complaints related to the common entry point.

(d) The commissioner of human services may take the actions necessary to design and implement the common entry point in paragraph (a). Funds awarded by the federal government for the purposes of this section are appropriated to the commissioner of human services.

History: 2009 c 119 s 19

Our advocacy for the foregoing policy is ample evidence of our commitment to establishing a “statewide toll free hotline with 24/7 response and triage to receive reports of suspected maltreatment of vulnerable adults and determine the need for investigation,” as described in the waiver request. We further endorse the “public outreach campaign to raise awareness of vulnerable adult abuse and educate mandated and voluntary reporters on the new reporting system.” Streamlining the reporting system is essential to encouraging those who suspect maltreatment to come forward and make a report. Our current patchwork of county-specific daytime and nighttime numbers allows complexity to inhibit reporting. With a centralized entry point and public awareness efforts, Minnesota will strengthen its commitment and effectiveness in responding to the abuse, neglect, and exploitation of vulnerable adults. This is an essential facet of an increasingly localized system of services and supports whose benefits are also marked by the risks of isolation.

Thank you very much for the opportunity to comment. The Vulnerable Adult Justice Project stands ready to serve as an ally in the work to simplify the reporting system and amplify public awareness.

Dooley, Lea M (DHS)

From: Aki Yoshino <ms_yoshino@yahoo.com>
Sent: Sunday, July 15, 2012 3:42 PM
To: *DHS_Reform2020Comments
Subject: Do Not institute an arbitrary age cutoff of autism therapy benefits

Dear David Godfrey...

Please do not cap autism benefits arbitrarily for children over the age of 7.

Specifically, here's why:

- all children enrolled in Medical Assistance are entitled to coverage for medically necessary treatment prescribed by their treating clinician
- coverage for health care should be based on medical necessity
- if a treatment is evidence-based – such as intensive early intervention behavior therapy or applied behavior analysis, then it should be included in the “Autism benefit set”
- if a treatment is a generally accepted practice, like “social skills therapy” then it should be included in the “Autism benefit set”
- treatments, supports and services should be based NEED, not age
- treatments, supports and services should be based on need, not LABELS
- children who have autism need choices for different treatments, as well as choices for different providers
- don't limit school-age children to receiving treatment from ONLY schools
- Yes! Please do look at outcome measures – in fact, please look at them NOW — before you make long lasting policy decisions about what types of treatments to cover!
- DHS should provide formal opportunities for members of the autism community to provide input before finalizing policy changes! Specifically, DHS should obtain input from the health care professional who treat individuals who have autism! DHS should also hear from individuals on the spectrum and their friends and family.

best regards,

aki yoshino
2553 brighton ave ne
minneapolis, mn 55418
6122029908

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Sunday, July 15, 2012 3:38 PM
To: *DHS_Reform2020Comments
Subject: The MA reform proposal should be rewritten to clarify that there will be NO REDUCTION in MA coverage for children in Minnesota.

Dear David Godfrey...

I am a parent to an autistic child here in Minnesota, active voter and regular tax payer. I'm hoping you'll hear my plea to not arbitrarily cap autism health benefits at age 7.

Specifically, here's why:

- all children enrolled in Medical Assistance are entitled to coverage for medically necessary treatment prescribed by their treating clinician
- coverage for health care should be based on medical necessity
- if a treatment is evidence-based – such as intensive early intervention behavior therapy or applied behavior analysis, then it should be included in the “Autism benefit set”
- if a treatment is a generally accepted practice, like “social skills therapy” then it should be included in the “Autism benefit set”
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- DHS should provide formal opportunities for members of the autism community to provide input before finalizing policy changes! Specifically, DHS should obtain input from the health care professional who treat individuals who have autism! DHS should also hear from individuals on the spectrum and their friends and family.

best regards,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

TO: Minnesota Department of Human Services

DATE: July 14, 2012

RE: Comments to Reform 2020

FROM: [REDACTED] and [REDACTED]

Our concerns as a parent of a child with a rare, complex and chronic health condition and as citizens concerned about taking care of the most vulnerable among us are many. Our main concern is that Reform 2020 will operate as a significant cut to current levels of service and leave many kids and families without services or supports during the demonstration project and beyond.

The stated goals of clarifying and streamlining services are laudable goals, but we urge policymakers to prioritize accessibility and availability of all treatment options for persons with autism and related conditions. The proposal should clearly state that the intention is not to cut current services, but to make treatments more accessible, more accountable, and individualized to the needs of the person seeking services through the state health plan.

It is a health plan, so all medically necessary treatments should be covered period. Clearly state there is no age limits on any treatments or therapies, or any other limits except documented medical necessity as determined by a qualified provider and his or her patient.

It is a health plan, so expecting another system to provide medically necessary treatments after a certain age is not reasonable or feasible. The federal government has clearly stated that ABA therapy in particular is medical treatment, not education.

Although officials are quick to point out that the current MA statute does not specifically authorize behavioral therapies such as ABA therapy, practice has been for this therapy to be covered with prior authorization for many years. Our son has benefited from intensive in-home ABA therapy for the last several years and continues to make gains with this therapy. Without therapy, he would likely need a much more restrictive placement than home with his family.

Although ABA has not cured our son of his diagnosis or mitigated all of his symptoms, it has afforded him the opportunity to be integrated into his family, school and community. It has taught him how to learn from the environment and valuable skills of how to ask for help or do what the group is doing or speak to a peer. These all are things we take for granted as they come naturally to many people. For people born with autism or related conditions, these skills are not learned unless the child is taught through intensive ABA or equivalent therapy.

We are very grateful that when [REDACTED], our insurance company, denied covered for the ABA therapy that our son's doctor recommended, we were able to get Medical Assistance through TEFRA. We were even more grateful that officials considered ABA therapy skills training covered under the current statute and paid for this expensive therapy that has resulted in life changes for our son and our family.

At 7 1/2 , he still has areas of lagging development, especially in the social emotional area. Yet we see gains still and know his development is accelerated by ABA therapy and speech therapy and other therapies that have been recommended for him over the years. He just finished kindergarten in a private school classroom with typical peers, with his one-one behavioral support and an adaptive schedule. Without the therapies that his providers recommended and that we were able to afford because of his MA coverage, the community and learning he experienced this year would not have been possible.

We have learned through experience how over burdened and under funded the public school system is in Minnesota. They were not able to provide the supports our son needed to attend and be successful at school. Although coordination between the education and the health care system is a laudable goal, it is not enough for the health insurance system to simply stop covering services when a child reaches an arbitrary age and expect the school system to start providing medical treatments to these children. The school system is not qualified, funded, or likely to do so effectively.

Children and adults with autism and related conditions deserve access to all reasonable medically necessary treatments for autism and related conditions, just as children and adults with any other chronic medical condition deserve access to treatments to mitigate symptoms and improve functioning and quality of life. There is no age cap on treatment of diabetes or asthma or cancer. There should not be on autism or related conditions either.

Thank you for your consideration. Feel free to contact us if we can provide any additional information.

Sincerely,

[REDACTED] and [REDACTED]

St. Paul, MN

Parents of three children, one of whom has Smith-Magenis Syndrome and ASD (and many other diagnoses)

July 12, 2012

Mr. David Godfrey
Medicaid Director
Minnesota Department of Human Services
Elmer L. Andersen Building
540 Cedar Street
PO Box 64998
St. Paul, Minnesota 55164

RE: Reform 2020: Pathways to Independence, Section 1115 Waiver Proposal

Dear David:

On behalf of the Minnesota Governor's Council on Developmental Disabilities, I thank you for the opportunity to provide comments and feedback on the above identified Waiver Proposal. Following are our comments, organized according to specific sections in the Section 1115 Waiver Proposal:

Overall General Comments:

This is a very comprehensive proposal that will allow the State of Minnesota to negotiate with the Centers for Medicare & Medicaid Services (CMS). According to CMS, the key elements of a Section 1115 waiver are to provide for "experimental, pilot, or demonstration projects which are likely to assist in promoting the objectives of the program" while being "budget neutral for the federal government."

The flexibility to work with CMS during such a pilot or demonstration period can be critical in learning more about the effects of reform measures on specific populations of individuals and making the necessary adjustments to assure that the goals envisioned are the goals that can be reasonably achieved. We applaud the Department for undertaking such a broad reform effort.

Overall Comments about New Service Design:

Because of the length and complexity of the proposal, it is difficult to sort out the specifics of the design of each experiment/pilot/demonstration and then also find

assurance of budget neutrality. Perhaps during this comment period, the proposal can be strengthened by creating some type of framework to address the following:

- 1 A process to ensure end user or recipient input, needs, requirements, and expectations was not always apparent in the Section 1115 Waiver Proposal. It may be helpful to emphasize this consumer input in the discussion about each new service/service area.
- 2 The specific breakthrough or innovation that is being piloted was not always clearly articulated. We suggest clarifying the breakthroughs or innovations in each section since they seem to be pivotal to many of the reform measures presented.
- 3 The context or information about the market environment, current delivery system, or current capabilities was not always included. Adding this would provide greater understanding about the reform measures being proposed for each service/service area.
- 4 Include a very specific statement that describes the service or product design point in terms of how to access the service, the particular usability features, operational performance specifications, and cost controls or how budget neutrality will be maintained. These design features are not always evident and would contribute to meeting the key CMS elements for the Section 1115 Waiver Proposal.
- 5 A description of a test team to validate the specifications of the product or services, operational performance requirements, timelines, the back-up systems, and the testing cycles would seem to be a necessary component. It appears that the Partners Panel may be used to answer some of these questions for one part of the waiver proposal but it's not clear that the Panel would be assuming this role and responsibilities throughout the waiver proposal. Clarification may be needed.
- 6 A description of the external review of all design specifications and the method to certify that the service is ready for release is not apparent and a critical component that needs to be added. This step is not obvious.
- 7 In some instances, projections about the number of users by month, quarter, and year was given or caps were mentioned. Those data were

not included consistently across all parts of the Section 1115 Waiver Proposal and would seem helpful and necessary to add.

- 8 The business case in terms of costs to design, operate, maintain, and update were not given, and should be established and included if possible.
- 9 Provider standards are mentioned throughout the proposal but not all aspects are mentioned. A list of suppliers that are capable of delivery under the Section 1115 Waiver Proposal should be established and include design specifications, internal quality improvement system, financial viability, and other supplier qualifications. This aspect may come later in the process.

Overall minor editing suggestions and typos:

In reviewing the Section 1115 Waiver Proposal, we came across the following:

Page 43: Last sentence beginning at the bottom of the page, please recheck the language in this sentence, "With federal support, Minnesota could serve more consumers in nursing homes...." Is this a correct statement?

Page 52: Under 6.6.1 First Phase, item 1: Medical Assistance is repeated twice; could this be a typo?

Page 53: Third bullet; should this maybe read, "Have experienced an employment shift?"

Page 56: The last bullet at the top of the page; should this read, "Integrated planning and screening tools...?"

Page 86: Typo in the first paragraph – the word should probably be "effective;" and in the second paragraph, the word should probably be "lessened."

Page 91: First line in the first paragraph, the word should probably be "demonstration." Is "First Contact" correct or is this a typo?

Definitions Section:

- 1 Throughout the proposal, technology and assistive technology terms are used interchangeably. Is this accurate? Should a single term be consistently used throughout? Can a definition be added?
- 2 Throughout the proposal, person centered planning and person centered plans are mentioned but no definition is provided. Other terms are used throughout the proposal for a variety of plans. Can each plan be specifically identified and can that term then be used consistently throughout the Section 1115 Waiver Proposal?
- 3 There are language changes throughout the Section 1115 Waiver Proposal for developmental disabilities and intellectual disability, and there's one mention of mental retardation on Page 79. We believe that a single term should be used consistently throughout the Section 1115 Waiver Proposal. Please remove mental retardation from the proposal.
- 4 **Pages 25 and 26:** There is no definition of "most integrated setting." Since CMS and the Department of Justice are working closely on Olmstead issues, it might be helpful to include a definition.
- 5 **Page 25:** The use of the terminology personal care attendants, personal assistants, and personal care assistants dates back to 1962 and Ed Roberts. When the terminology is 50 years old, there must be some attention paid to an information campaign to inform Minnesotans about the change in language. People will continue to use PCA to describe the person who is an assistant.

Perhaps CFSS is being proposed only as a means of communicating that type of service with CMS and not a change in the actual terminology within Minnesota. Can this terminology be clarified?
- 6 In reading across the entire Section 1115 Waiver Proposal, there are several terms mentioned that refer to service coordination and case management, including home care service coordination, service coordination, case management, school service coordination (school employees). Definitions may be necessary

and should be helpful to the reader to understand what specific term is used and what it means in a particular environment.

Regarding the new Community First Services and Supports (CFSS) program:

Page 26: CFSS is described as a less costly option –

Can data be inserted into this page or this section that supports that statement?

Is the cost comparison between the proposed CFSS program and the waivers or with institutional settings? Can this be clarified?

If CFSS is a PCA program that includes training and technology, will the cost savings come from moving people from the waiver to the new CFSS service? Clarification here would also be helpful.

Page 27: There is reference to legislative changes in 2009 that resulted in 170 people losing access to PCA services and that 22,000 people are currently on the PCA program –

Is there any description about those individuals who lost access to PCA services? Did they experience mental health issues?

How many people lost services and were reinstated after appeals?

Are there any additional planned reductions in the future that might not be mentioned here?

Under 4.1.2 What We Want to Change :

Page 29: There is a list of problems presented to support the need for the proposed CFSS program, including not receiving necessary services, not achieving optimal outcomes, and the high cost services that could be avoided. We fully support this description.

As a result of this list of problems, CFSS is proposed as “the right service at the right time, in the right way.” Is it possible to add “at the right cost with the right staff with the right skills?” As you may know, the Department of Defense (DOD) used a very similar phrase to fulfill their GPRA goals, stated as follows:

"Our security depends on our defense being in the right place at the right time with the right qualities and capacities to protect our national resources"

Minnesota may want to distinguish itself from that DOD approach by adding a few more phrases.

Page 30: The Section 1115 Waiver Proposal states that people who want technology and home modifications would go on the waiver since that is the only way to access those services –

Can data be inserted here to document this trend?

What types of technology and what types of home modifications are being sought and approved under the waivers?

Page 31: The Section 1115 Waiver Proposal states that 10 percent of people who are currently using PCA services along with a variety of other services will have higher

emergency room visits and hospitalizations along with the associated higher costs when all of those services are not well coordinated –

Is there any additional information about this subgroup?

Are these individuals experiencing mental health issues? If so, can that be stated?

Did this subgroup help with the redesign of PCA into the CFSS program and, if so, how?

Pages 31 and 32: A long list of problems refer to the waivers and the state plan as being out of alignment and creating "administrative challenges" -

What part of the Section 1115 Waiver Proposal will bring any or all of the waivers and state plan back into alignment?

Pages 32 and 33: CFSS is described here as PCA + skills + assistive technology (not just technology) + environmental modifications + transitions which will lead to greater self-determination, individualized service budgets, greater fiscal management, greater quality assurance, and greater direction.

These are worthy goals and outcomes that we can definitely support and the Department should be commended for incorporating these into the Section 1115 Waiver Proposal. We suggest that this statement come earlier in the Proposal since it is so well stated and can lead this section.

Page 33: There are several issues presented on these pages that discuss PCA services and additional details may be needed to distinguish between the various PCA options and other related issues.

First, a lengthy list of issues around providers are mentioned including skill set, certifications, training, provider regulations, and quality assurance, but there are few details about training, oversight, and implementation.

On the previous page, page 32, the PCA Choice program is mentioned along with the fact that there are hundreds of PCA Choice providers but 15 fiscal support entities for people who choose CDCS - a complex system to manage administratively and monitor for quality assurance.

Then, on page 34, one service coordinator is mentioned to plan and support the individual across all services, with CFSS having fewer providers and yet greater capacity for quality assurance. However, everyone in Minnesota should have the choice of at least 2 fiscal entities.

Under the CFSS program, will there be more providers or fewer providers?

If there are fewer providers, how is that reconciled with everyone having a choice of at least two fiscal entities?

Will there be more standards and assurances, or fewer, and how will these be determined?

Pages 34 and 35: There is a long list of initiatives identified on these pages but it's difficult to track the current status of each, start or launch date, who is affected, and how they will be effectively and efficiently coordinated within the Section 1115 Waiver Proposal. More specifics would be helpful to better understand the connections and give a clearer picture of how individuals who may be receiving services under one of more initiative can navigate a new system.

Page 35: Home Care Case Management (HCCM) is presented as an interim step in the redesign of case management services but a description about this component or program is missing –

Who and/or what is HCCM?

What is the role and relationship to current case management services?

Who will be providing HCCM services, how many HCC managers will be available across the state, and what area(s) will they serve?

What training will be provided?

How will any potential conflict of interest be resolved? It is our understanding that CMS is concerned that service coordination be independent.

Consultation, training, and technical assistance are mentioned and that all services will be coordinated in a single plan. A description about the specific consultation services and technical assistance that will be available, and training that will be offered/provided, would be helpful to add here.

Page 36: The need for a large number of changes occurring at the same time is discussed but the need to phase in changes is also presented. It's difficult to understand how these seemingly contradictory approaches can be reconciled. Clarification is needed to better understand how these initiatives will all be implemented without disruptions or gaps in the delivery of services.

The statement that the reasons for applying for a 1915 (i) and 1915 (k) waiver under the Section 1115 Waiver Proposal are to learn, to mitigate risks, and to offer one set of assurances are very laudable goals. However, the desire to build services that align with 1915 (k) because "we are requesting to receive enhanced federal participation," would seem to require a discussion about who would be covered, the potential number of people being considered, and where they currently live.

There are also conflicting references to 1915 (k). In one part of the Section 1115 Waiver Proposal it is discussed for those individuals not meeting an institutional level of care while later in the Waiver Proposal, on page 41, section 1915(i) is discussed for the very same group of individuals. Clarification may be needed.

Waiver definitions are contained at the end of the Section 1115 Waiver Proposal. It may be helpful to move them or also include them here.

Page 37: On this page, the statement is made that the Section 1115 Waiver Proposal will provide participants in home and community based waivers with the option to

receive CFSS as part of their waiver. The very next sentence, however, is in direct conflict –

“To avoid duplication of services, HCBS waiver participants may not receive CFSS” (emphasis added).

At the bottom of the same page, the statement is made –

“We intend to end our current PCA program and replace it with a more flexible set of services, which we are calling Community First Services and Supports (CFSS).

Are we to understand that CFSS is an option under the waiver, or that CFSS is only offered through the state plan?

If the current PCA program ceases to exist, are PCA services still available but only through the waiver and then only as defined under the state plan versus how they may be defined under CFSS?

CFSS is also discussed as limited to settings of not more than four people; and not in settings owned, leased or controlled by the same provider. We fully support and commend the Department for taking this direction.

Page 38: Budget is based on need, Budget will be set for CFSS and can include "assistive technology" and home modifications. There is no mention of most integrated setting on this page.

Page 39: The term “community support plan” is first used on this page rather than a person centered plan but there is also reference to a “person centered Coordinated Service and Support Plan.”

A person centered planning process is mentioned on the previous page, page 38.

If there is a difference, what is the difference?

Are three different types of plans really intended?

Clarification is needed about setting individual service budgets –

Is MnCHOICES being proposed for setting the budget?

If so, can more details be provided?

Two service models are presented, a self-direction model and an agency-provider model. If self-direction is selected, a fiscal management entity (FME) is required with an RFP process used to limit the number of FMEs. If an individual must be given a choice of at least two FMEs but the total number of FMEs will be limited, please explain or clarify how this process will work. How will adequate state coverage and choice be assured?

Pages 39 and 40: Budgets and budget protocols are discussed for CFSS and based on the "LT home care rating." The formula to determine a budget, units of services, and hours seem complicated when, overall, the direction and justification of the Section 1115 Waiver Proposal seem to be on ease of use for individuals needing and using services; and efficiency and effectiveness from an administrative standpoint. The Waiver Proposal is then proposing five years to analyze, evaluate, and create individual service budgets. Can this item be discussed in greater detail?

Page 40: Under Provider Standards, more information is needed about provider training, including what will be included in the core curriculum and who will be providing the training, number of training hours and delivery methods, ongoing training requirements, how training will be evaluated and how evaluation results will be used to improve future trainings and competencies.

Page 41: Regarding individuals who do not meet an institutional level of care, section 1915 (i) applies; for individuals who do meet an institutional level of care, section 1915 (k) applies. If the data are correct, that 90 percent of individuals currently using PCA services meet an institutional level of care, then only 10 percent of this group of individuals would meet section 1915 (i) criteria or less than an institutional level of care.

If CFSS would be available for all of these individuals, would existing waiver services be available or would these individuals no longer be eligible? See questions and needed clarifications on page 37 above.

School Proposal Section:

Pages 41 and 42: We are concerned about a demonstration project under the Section 1115 Waiver Proposal to test the coordination of school based services for several reasons (We maybe misunderstanding this section because we have been unable to attend the public meetings)-

The success of a demonstration would require school staff to be available year round and, presumably, that Medical Assistance (MA) eligible students under age 21 would also be receiving extended school year services.

School staff would have to assume care coordination responsibilities in order to bill for the MA services they would be providing, which could be a district contracting issue.

Each school district does not likely have a full complement of related services staff so it would be necessary to consider how itinerant or services shared across school districts would be available in the selected school districts.

Eligible students also have to access CFSS but, because of the waiver/CFSS conflict noted above on page 37, it may be difficult to identify 1500 students who would meet the criteria from school districts willing to participate

In this part of the Section 1115 Waiver Proposal, cultural competence is not mentioned (especially Somali community).

According to most advocates, most school staff (psychologists, nurses, and social workers) have little or no knowledge of autism or medical conditions and most school staff are unfamiliar with DHS programs and/or how to be a service coordinator.

Additional details may be needed to describe the avoidance of "conflict of interest" issues that CMS has about case managers or service coordinators not being associated with provision of services, as well as how these pieces result in less complexity.

Employment Proposal Section:

Page 52: Pathways to Employment is mentioned as developing policies that focused on employment and consumer directed initiatives. Can this section be expanded to include a discussion on what specific policies were developed, what initiatives grew out of those policies, and what were the results?

Page 53: Add numbers for each of three subgroups identified. Are there data about these groups or information about how these particular groups were selected?

Page 54: The Waiver Proposal states that navigators will be part of the Disability Linkage Line. This seems duplicative of the efforts of the Workforce Centers and Work Incentives Connection.

What are the differences and what distinguishes the services that would be offered by the Disability Linkage Line?

Are these new navigators trained in person centered planning, the full range of employment issues and employment programs, or life planning?

Are data available about DB101 - who is using this resource, the numbers of people using, evaluation results to date, and Return on Investment?

Page 55: Evaluation questions about employment services are listed here but these questions are not repeated in the evaluation section, pages 105 to 111 at the end of this proposal nor is there any reference back to these questions.

If the Disability Linkage Line is now doing job placements, how will these services complement, supplement, or enhance what Vocational Rehabilitation Services provides?

The data collection items listed here, that are currently being collected by the Disability Linkage Line, don't match the evaluation questions in this section. Can more information or details be provided to make a direct connection between the evaluation questions and the data collection process?

Page 56: What is the anticipated reduction in use of SSDI, medical services savings, and increased taxes? Are there any projections available and, if so, on what are those projections based?

Has there been any testing of the idea that the Disability Linkage Line is now providing employment and job placement services? Have any data been collected or what data will be collected and how?

Page 57: What is the wraparound option that will be included in a future health insurance exchange?

Page 58: What specific "existing relationships" will be leveraged with DEED, the Department of Education, and Corrections?

What are "medical providers" going to be doing with employment?

What research will they be conducting and what is the purpose of that research?

Under 7. Anoka Metro RTC Demonstration :

Page 73: The footnote states that there are 12 beds for individuals with mental illness and “intellectual” disabilities.” Are these the individuals who were transferred from METO/MSHS to Anoka? If so, they come under the Jensen Settlement Agreement and that should be mentioned.

This section discusses the need to redesign the relationship between the Anoka RTC and Medicaid, since individuals residing there are not Medicaid eligible but would be Medicaid eligible if services were available in the community.

Please clarify: Would a demonstration under the Section 1115 Waiver Proposal allow individuals at Anoka RTC to become Medicaid eligible and could they then transition to the community under the Money Follows the Person initiative?

Is this what is keeping them from moving or are there other barriers?

The length of stay is mentioned but are there data on the range of stays?

Page 75: Is there an estimated number of individuals for whom a section 1915 (i) waiver would apply? What is the target for a section 1915(i) waiver here?

The discussion on Page 36 above (Page 8 of our comments) regarding Section 1915 (i) and Section 1915 (k) waivers would suggest that, since these are individuals meeting an institutional level of care, would not a section 1915 (k) waiver apply here?

Under 7.2.1 Evaluation:

Page 76: Are there any specific questions regarding people with developmental disabilities?

Under 9. Context of Reform: Current and Proposed Initiatives:

Page 78: A section 1915 (i) waiver is mentioned for individuals with autism spectrum disorder (ASD), mental illness plus other disabilities plus behavior and committed at Anoka and unable to return to the community; and for people with developmental

disabilities and mental health issues and sexual disorders. Would a section 1915 (i) waiver apply to individuals with multiple disabilities and complex conditions?

Section 1915 (i) and Children with ASD:

Page 79: The statement is made that, despite the rise in the incidence of ASD, Minnesota lacks a system of coordinated care. But there is considerable discussion about several agencies and programs that are involved with this issue and are currently providing services.

There seem to be two separate issues and neither is the cause of or leads to the other. A separate discussion about each issue would be helpful.

A section 1915 (i) waiver may give children with ASD better access to a broader range of services that are actually available. A coordinated system of care is another issue. Could these distinctions be made?

Page 80: In the second paragraph, reference is made to children “ages 0-7.” Can this be changed to read birth to age 7.

The goal of developing one program that can provide an integrated set of services for Medicaid eligible children with similar diagnoses and functional needs is quite worthy and ambitious, but it’s not clear how the Section 1115 Waiver Proposal will be able to achieve that end result.

Pages 80 and 81: The services listed in a specific benefit set for children with ASD include service coordination, behavior intervention, counseling, and respite among other (page 80) but page 81 states that the benefit set has yet to be defined. Clarification is needed.

Page 81: Standards, assessment tools, protocols, and learning collaboratives are proposed. How will these activities be connected with a single program, fully integrated benefit set of services, especially when the scope of services is pending?

The statement is made that Minnesota does not currently have any established guidelines for medically necessary, evidence based, early intervention services. The Health Services Advisory Council (HSAC) was assigned by the Legislature to look at efficacy of treatments. Does HSAC have the necessary expertise to make this judgment? What is the specific scope of their work and what is the time frame?

The Department of Human Services will propose benefit and service utilization criteria but will have to meet Legislative deadlines which may not be in sync with HSAC's work. What are the reliability and validity data for the Comprehensive Multi-Dimension Diagnostic Assessment tool? How does this connect to the MnCHOICES assessment tool?

Can this proposal expand on and allow greater opportunities for the input of families, educators, health care professionals, and advocates?

Page 82: Service coordination of special education services (Individual Education Programs), Preschool Special Education (Part B), Infant and Toddler Intervention (Part C), Medical Assistance-IEP benefits, CTSS, and school linked mental health are all mentioned. These are diverse and specialized services. What qualifications will be needed to do this work?

Sex Offenders:

Page 85: The Section 1115 Waiver Proposal states, "There are 134 people with developmental disabilities, and mental health issues, sexual disorders and/or anti-social personality disorders but only four sex offender day treatment providers. Day treatment is not the right service."

This section does not mention the report from the Office of the Legislative Auditor, "Civil Commitment of Sex Offenders," and the specific recommendations about individuals with developmental disabilities and sex offenders who are not benefiting from the Minnesota Sex Offender Program (MSOP).

There is no mention of the MSOP lawsuit or the Jensen Settlement Agreement that affects people at St. Peter.

The term "intellectual disability" is used in this section.

Under 9.3 Redesign Home and Community Based Services:

Page 87: Several initiatives are listed to suggest an emphasis on person centered planning including earlier intervention services; the integration of LTSS, behavioral, and physical health care; enhancements to 1915 (c) waivers; case management reforms; crisis intervention and protection protocols; and health care reforms. The list, however, does not necessarily connect to person centered planning principles.

Page 92: The proposed Home and Community Based Services Report Card is an exciting initiative. Several services are listed here that have not been mentioned previously including day training and habilitation, assisted living, and corporate foster care. What level of effort will be needed to collect, and analyze data, and create report cards across the service system?

Page 95: People first language should be used in all waiver descriptions.

Page 96: Anticipated waiver changes are mentioned including a new menu of services for all five home and community based waivers, more options for home of your own, changes to “provider standards,” a “universal worker,” and “technology to support the person in lieu of staffing.” Can each of these be clarified and more details provided?

The term “technology” is used. Should this read “assistive technology?” If technology includes assistive technology, that should be specifically stated. How will current definitions be updated and what changes are being proposed? It is not clear that technology as used here includes devices as well as services.

The redesign of a new financial management structure is presented in connection with a section 1915 (j) option but details are needed. What specifically prompted a redesign? What has been learned from the current financial management structure that will be included in the redesign and what were the sources of that learning?

Page 97: Assisted Living is mentioned but it’s not clear who would be moving into assisted living. Can that information be added?

Regarding the statement that “[t]he state has established a consistent quality management structure across all waivers,” what specifically is this referencing?

Page 98: Under Provider Standards, it is mentioned that recommendations will be provided to the 2013 State Legislature regarding “a new licensing and quality outcome system for home and community based services.” What specific recommendations are being considered?

Rule 40 committee work is mentioned briefly but there’s no mention of positive behavioral supports. Can more information about the Rule 40 Advisory Committee be included here?

A long list of problems and solutions about case management are identified. Is there any information about priorities or data that will be used to prioritize the reforms?

Page 99: Under Crisis Intervention and Protection of Vulnerable Adults, a long list of solutions for crises are identified, including positive behavior training, person centered approaches, technical assistance, mobile crisis intervention, and increased crisis capacity; along with indicators to avoid use of emergency room, civil commitment, and law enforcement. Information is missing about numbers, costs, what is actually being planned, and how these solutions will intersect with the Jensen Settlement Agreement. Can these additions be made to this section?

A statewide, centralized vulnerable adult reporting system is proposed. Can more information be added here -

When will the system be implemented?

What will be the reporting process and what kind of reports will be available?

What training will be provided and who will provide?

How will the system be staffed?

How will data collected and reports produced be used to prevent problems?

What analysis will be done to identify patterns so that abuse can be prevented?

Re: Money Follows the Person (MFP): In Minnesota, a total of \$187.4 million in MFP grant funds will be received across five years, and \$13.4 million in the first year -

Where is this money being spent and how?

What are the results to date?

Is there a strategic plan in place?

What information has been communicated about this effort to date and how?

Under 9.4 Promote Personal Responsibility and Reward Health Outcomes:

Page 100: How will the diabetes prevention program intersect with people with disabilities?

What is the Community Living Mini-Assessment that will be conducted by Dr. Greg Arling? How is this connected to MnCHOICES?

Under 10. Evaluation:

Pages 105-118: The evaluation design section could be strengthened if there are individual designs for each part of the Section 1115 Waiver Proposal but with an overall design offered. For example, providing an outline of sample numbers, targets and comparisons, and how samples will be drawn would contribute to the collection of data and outcome measures that are more closely matched with the envisioned reforms for each of the initiatives.

Page 108: Increased community integration is mentioned in connection with the CFSS and Service Coordination Demonstration. The concept of community integration seems to run through much of this proposal and should be a primary indicator in the overall evaluation design

What are the data sources for personal level outcomes?

We appreciate the time and effort invested by the Department in the preparation of this Section 1115 Waiver Proposal. Thank you again for the opportunity to be involved in this review and comment process.

Cordially,

Colleen Wieck, Ph.D.
Executive Director

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Saturday, July 14, 2012 10:47 PM
To: *DHS_Reform2020Comments
Subject: ABA Services for Children with Autism

Our daughter is 7 years old and has been receiving ABA therapy since she was 4 1/2. Prior to enrolling her in the ABA program, she spent a school year in the public school special ed classroom. She was lost in the background in that classroom and made no progress in that year.

In March this year we enrolled in public school again and again it was a disaster. The schools do not have the capability to provide these children the resources necessary to give them the individual programming necessary for them to be able to learn and have a chance to be successful in the community. We are back in an ABA program and feel that it is imparative that she is able to get these services if she is to have any chance to learn, make progress and succeed.

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Saturday, July 14, 2012 5:38 PM
To: *DHS_Reform2020Comments
Subject: MEDICAID REFORM 2020 RESPONSE

RE: Medicaid Reform2020 Response

Hello:

Saw your website today & felt I must reply. Medicaid has been a "sore spot" with me. I am an older disabled person dealing with major health issues.

And am apparently not qualified for Medicaid. My income is strictly disability from 3 sources. Well below what I use to earn. My long-term disability insurance will end at retirement age (quite awhile from now), so a big drop in income in future.

But right now, I have to pay all my transportation myself, (MetroMobility) about \$300/month more or less. Have mandatory medical treatment sessions several times a week (to keep alive), and between that, clinical visits. I take alot of medications (can't get social security help with that) and since I'm not quite retirement age, and unable to work, have no transportation help from family/friends, I find this a burden.

Why do Medicaid people get their transportation paid for? When I seem to have more health expense than they do? Medicaid seems to go by income, rather than actual expenses vs. income. WHY? Had to sell my old car 8 yrs. ago couldn't afford gas/repairs.

I'm not rich by any means. I pay rising market rate rent for my tiny studio apartment I've lived in for 20+ yrs. And food, etc. is constantly rising. Isn't there any help for people like me? I don't qualify for things like food stamps, yet I'm on a special diet with more food expense. I don't have kids for welfare help. It's a shame that people who never paid into the system seem to get alot of help, while we who have paid taxes for years can't get a grant or something to help with burdensome health-related costs.

THANKS FOR CONSIDERING MY INPUT! [REDACTED]

Anyhow, I hope this helps your Medicaid Reform2020 initiative. I probably won't be around to see the final product, but want you to know there are others like me out there that aren't getting help.

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Saturday, July 14, 2012 8:52 AM
To: *DHS_Reform2020Comments

To Whom It May Concern:

I have a grandson who is on the autism spectrum. He receives assistance in school and outside of school. As he has gotten older and more demands are made upon him, he needs the assistance in and out of school for his continued functioning and adaptation. Services provided now will pay off in the long term as his functioning and meeting the demands that society requires of him. Please do not cut out the out of school services which my grandson needs.

Sincerely,

[REDACTED]

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Autism Spectrum and Neurodevelopmental Disorders Clinic

*Clinic Location:
717 Delaware Street SE
Suite 340
Minneapolis, MN 55414*

*Main: 612-625-3617
Fax: 612-625-3261*

July 11, 2012

Dear Deputy Assistant Commissioner Wagner and additional Members of the Department of Human Services Waiver Proposal “Reform 2020” Committee,

We in the Autism Spectrum and Neurodevelopmental Disorder Clinic at the University of Minnesota are pleased with many aspects of your proposed Reform 2020 waiver. The proposed waiver will help many young children with autism spectrum disorder (ASD) more easily access evidence-based, medically-necessary treatment, behavioral intervention and family supports.

We do have concerns about uniformly requiring transition into the school system at age 7. While the majority of children we see are transitioned into school by age 7, there are without a doubt children and families who greatly benefit from short term, family centered behavioral intervention and in some cases more intensive behavioral services after that age. Addressing significant problem behaviors that occur in the home clearly is beyond the purview of school systems. We believe that by developing outcome criteria that can objectively assess response to intervention at any age, an age cap would not be necessary; children of any age who are showing measurable benefit addressing their needs related to ASD and their ability to function more adaptively in the community should continue to receive evidence-based and medically-necessary intervention services. Similarly, for those children at any age who are not demonstrating measurable gains, other evidence-based intervention approaches and/ or educational services should be tried.

As you state in your proposal, “The Department will work with providers, medical experts and clinicians to develop agreed upon standards, assessment tools and protocols for objectively measuring progress.” We are in a unique position to assist with the development of agreed upon standards, as we are not providers of intervention services, yet we routinely and objectively assess core symptoms of ASD and co-occurring conditions, monitor response to intervention, and make medically necessary treatment and educational recommendations. We would welcome the opportunity to work with you on these matters.

Thank you for your continued efforts to serve children with autism and their families.

Sincerely,

Robin K. Rumsey, Ph.D., L.P.
Pediatric Neuropsychologist
rumse002@umn.edu

Amy Esler, Ph.D., L.P.
Psychologist
esle0007@umn.edu

Michael Reiff, MD
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Care Coordinator
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Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Friday, July 13, 2012 9:53 AM
To: *DHS_Reform2020Comments
Subject: Regarding the "autism benefit set"....

I am a grandmother of a boy with autism. I am also a retired educator who has worked with children ages 10 to 18 with this disorder. My love for my grandson and my experience with students compels me to write and challenge the notion that services/funding could be cut after the age of six. Ridiculous!
Parents and school districts alike are ill-equipped to face the challenges presented by autism without the financial support offered by MA coverage.

Please reconsider your stance on this critically important issue for families, children, and community.

Sincerely,

[REDACTED]

Please keep me informed of any continued discussions or decisions.

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Friday, July 13, 2012 8:52 AM
To: *DHS_Reform2020Comments
Cc: [REDACTED]
Subject: Proposed MA "Autism Benefit Set" Concerns

Good afternoon,

I am writing in response to the Department of Human Services' proposed changes to MA coverage for people with Autism Spectrum Disorder via an "Autism Benefit Set."

As a parent of a child with ASD, the DHS proposal is most striking to me because the "Autism Benefit Set" would only extend through age 6 and my son just turned 7 last month.

It is incorrect to assume that MA, and other services which can be obtained with it, are no longer needed after age 6.\

While early intervention is critical, most children on the Autism Spectrum are not diagnosed before the age of **two**, and their needs often increase as they get older. This is what I have found with my son. As he starts to navigate the world on his own, he simply requires more support and services.

It would be a devastating blow to pull the rug out from under so many families when their children with ASD reach the age of 7, as well as cripple the school districts that are already struggling with reduced budgets.

Please reconsider this change. I found out about the public hearings after the fact, but hope that there will be other opportunities to voice my opinion. My contact information is below if you would like to discuss this over the phone.

Sincerely,

[REDACTED] | [REDACTED]



Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

Date: July 12, 2012

To: David Godfrey
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, MN 55164

From: Patti Cullen, CAE
President/CEO
Care Providers of Minnesota
(952) 854-2844
pcullen@careproviders.org

Gayle Kvenvold
President/CEO
Aging Services of Minnesota
(651) 645-4545
gkvenvold@agingservicesmn.org

Re: Comments on *Reform 2020* Section 1115 Medicaid Waiver

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 "*Reform 2020: Pathways to Independence*" Section 1115 Waiver Proposal.

General Comments:

Intent

We are pleased to see the statement for the next step which infers significant changes to the current segregated approach to health care and long term care:

"The next step for Minnesota's service delivery system is expanded full and partial risk sharing at the provider level, using prospective, global or population-based payment structures that include the costs of providing traditional health care and other Medicaid covered services in addition to costs outside of the traditional health care system that impact a Medicaid enrollees' health and outcomes (e.g., social services and public health services). This will provide an incentive not to shift the cost of services on to other parts of the health care and long-term care system, as well as other county and social service systems, while also allowing providers flexibility in managing upfront resources and making needed infrastructure investments under a prospective payment."

That is a laudable goal that we hope the Department of Human Services (DHS) can continue to focus on, moving ahead to a fully integrated system. Having said that, it appears that the waiver request is a collection of programs, concepts, and initiatives to move the state forward without a specific action plan for each of the items. It is difficult to comment specifically in areas where there is no action plan, or data to support the specific initiative. We do appreciate the forward thinking of the state, and we are looking forward to continued discussions in the areas identified in the proposal.

Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

However, before moving too far down the path, we do want to highlight some general areas of concern for each of the categories below.

Waiver Requests

We support two of the three waiver requests. First, the specific request to waive statewideness is appropriate, and we support that particular request. We urge the state to consider the specific needs of rural communities when developing sites for their demonstrations, where access to certain services is difficult due to distance and/or operational challenges with fewer numbers of enrollees. We also support the request to facilitate data-sharing. Our experiences with care transitions in particular support the need for data sharing across the “lines” of services to avoid duplication, negative consequences, and fragmentation of care and services. We do have concerns, however, about the third waiver request: the waiver of freedom of choice of provider as a blanket waiver request. Consumer protection, especially for the frail elderly and persons with disabilities, needs to be a built-in feature yet the proposal was virtually silent on consumer rights. Currently it appears the only consumer protection is the ability to “walk”—to leave one program/provider and move to another. By removing choice of vendor, consumers, especially in rural communities where options may already be limited, are particularly vulnerable.

Section 2.2: Long-Term Care Realignment Waiver

As we have stated in the past when the state agency submitted the long-term care realignment waiver, we continue to have concerns about individuals who will be displaced when this is implemented. Since this waiver request is referenced as a related reform initiative, we must remind the state agency about our overriding concern. We would summarize our concerns as being critical of the proposed policy for what we believe will result when the state begins to implement the new level of care criteria. 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 shifting responsibility for such seniors; and conflict between seniors and their family members. A further concern we have relates to the responsibility for transition for those newly ineligible for Medicaid or Elderly Waiver services. The lack of infrastructure and services in many rural areas of the state will make this transition very problematic.

Federal Matching Funds for Alternative Care Program and Essential Community Supports Program

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 strongly suggest that the state increase 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.

Section 2.3: Duals Demonstration

We also submitted a response to the duals demonstration proposal, concerned that expanding the current health plan-centric model does not allow for true integration of acute and long term care services and supports. We believe that overall there is likely enough total money in the current system, assuming you consider acute, post-acute, ancillary, end of life and long-term care services,

Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

to effectively serve the dual eligible population, but current funding is poorly distributed and divided up between providers based on a “silo mentality” that does not focus on how to use resources to achieve the best outcomes. The duals demonstration has the potential to make great improvements in care but only if the financing is designed with incentives to provide the most appropriate and least costly option for each recipient.

Section 3: Accountable Care Demonstration

We are generally supportive of the proposed accountable care demonstration, particularly to the extent that it focuses on a fully-integrated model that is similar to Program of All-Inclusive Care for the Elderly (PACE), where all payment streams are combined and the incentive is to provide the most appropriate care for the least cost, with rewards to providers who are able to do that. As with many of the concepts in the reform proposal, there are not enough details at this point to know for sure whether an accountable care demonstration can achieve these goals and be workable for providers and consumers, but we view it as a positive step that is worth investigating.

Section 4. Community First Services and Supports (CFSS)

While we understand that CFSS is intended to replace all/part of the current Personal Care Assistance Services (PCA) the proposal is lacking the data to determine the full impact of the proposal. It is unclear since the PCA services do not align with the level of care criteria who will be eligible to receive CFSS and who will not. It is also unclear if the proposal will increase or decrease the numbers of participants in the future. Additionally, it appears that CFSS will cover the services an individual may need but will not pay for their housing needs, so how is the CFSS program going to intersect with the housing demonstrations to ensure that affordable housing is targeted to those individuals qualifying for CFSS without a “family home”?

Section 5: Demonstration to Expand Access to Transition Services

The premise of this demonstration is that transitioning individuals to their own home is always in their best interest, and we believe that is not always the case. The concept of “right service-right place-right time” is important especially if the state is seeking to follow the health reform “triple aim”. There are circumstances where living in a single family dwelling with all of the necessary home care services is not only the most expensive option, but it may also have a diminishing quality of life impact given the research about isolation and depression with seniors in certain circumstances. We strongly encourage the state to take a few additional steps before expanding transitional supports and level of care criteria further:

1. Evaluate the per person cost benefit of current transition initiatives;
2. Utilize latest research on effective transitions for persons with Alzheimer’s disease and their caregivers;
3. Using surveys and focus groups, analyze the current population in both nursing facilities and assisted living setting both on what their needs are but also why they chose to move to those settings; and
4. Identify the total costs for transitions over time to include acute care costs, social service costs, long term care services and supports.

Section 6.2: Housing Stability Services Demonstration

We have been experiencing over the past few years an increase in the numbers of younger individuals with serious and persistent mental illness and/or chemical dependency with a health condition being admitted into nursing facilities and assisted living establishments. We hope that

Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

this demonstration can include a special focus on this population because we acknowledge that the current setting for services is not the most appropriate setting. Often times the placement is made because there are no other options in the community; or because the options for housing focus only on their mental health needs without addressing health conditions such as skin wounds, untreated diabetes, etc.

Section 9.3.2: MnCHOICES

We applaud the process the Department of Human Services has been using to develop and test this comprehensive tool, which will be a key mechanism in the future to ensure that individuals receive the long term care services and supports they need. What is not included in the discussion to date, however, are the details about financing. Currently the long term care consultation is financed through nursing facility rates and we believe there needs to be a transition away from that mechanism. There are also other vehicles that fund current screenings. We are also unsure about the use of MnCHOICES in primary care/health care home settings and urge further discussions about how the integration into those settings will be funded.

In addition, we ask DHS for more detail on the transition to MnCHOICES from the current LTC Consultation assessment tools and the Customized Living tool. We assume that modifications will be needed to the Customized Living tool, and hope that these modifications will improve the ability of case managers to identify the need for interventions for behaviors, redirection, coaching, and general oversight/supervision. We also hope that any revisions to the CL tool will result in more realistic identification of time necessary to complete needed tasks. Currently, many case managers are authorizing inadequate amounts of time for various EW services.

We also support the statewide assessor training and certification in hopes that it will bring greater consistency in treatment of waiver clients. Currently there is great variation among lead agency staff in the way they gather information—with some refusing to communicate with the clients' current providers who know their needs best. In addition, we have found that some lead agencies, especially certain counties, have set policies regarding what services they will and will not authorize--sometimes in contradiction to DHS policies. For example, some counties refuse to authorize EW Customized Living for housekeeping and laundry services when a client has a need for that service, even though those services are clearly eligible under the EW CL waiver program.

We also hope that having the assessment and other data in electronic format—allowing the audit function to be standardized and automated—will also improve the consistency of assessments and authorized services and will result in a more fair system to waiver clients.

Section 9.3.3: Home and Community Based Services Report Card

We acknowledge the need to provide consumers with information to help them make informed purchasing decisions and we encourage the state to move ahead cautiously in that endeavor. Unlike the development of the nursing home report card, where the services delivered are very homogenous, the home and community based services delivery system is varied and flexible to meet consumer needs. Even within a subsection of services—housing with services—there are significant variations with sizes, settings, and services available. Minnesota has established a unique model of separating the housing from the services, which has ensured maximum flexibility to meet consumer needs and interests. Because of that variation, the establishment of a uniform report card that is both consumer friendly and objectively based will be very challenging. We

Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

encourage the state to establish a process for input, testing, and discussion and an extended timeframe to accomplish their goals.

One major concern is that there is little uniform data available for assisted living programs or housing with services establishments. The little data DHS currently has is only for MA waiver clients, who compose a small proportion of the residents being served in these settings. Collecting additional data needed to provide a comprehensive picture of these settings will be a costly and challenging task for both the state and for providers. Similar data challenges exist for other HCBS that may be the subject of future report cards.

We also do not believe the project, as stated, is actually measuring outcomes per se, but is focusing on provider descriptives. Because of this, we wonder how this "report card" that simply describes the services and costs will be an improvement over the Uniform Consumer Information Guide (UCIG) that Housing With Services (HWS) providers must now make available to prospective HWS residents. There has been no evaluation to see if this 7-page document is even useful to consumers, and it is unclear how another document that "educates consumers about differences" among HWS would help consumers in their decision-making process. Moreover, given the decentralized nature of HCBS and the associated pricing and service models, we doubt that DHS will be able to collect meaningful and universal data on the descriptives identified. Even now the UCIG only presents a general picture of services and costs. In order for a prospective HWS resident to fully understand what services may be available to meet his/her needs and what the cost will be is to have the on-site RN complete an assessment and develop a proposed **individualized service plan**. A generic report card will not provide that detailed information that a prospective resident may need when making decisions about housing and service options.

Section 9.3.4 Alzheimers Health Care Home Demonstration

Consider the addition of the following parameters to the existing parameter which states "*build on the physician's algorithm for early identification of dementia to implement a fully integrated primary health and community service model for patients with Alzheimer's disease and their caregivers*":

- Comply with Health Care Home certification standards regarding dementia and documented care approaches that use dementia as an organizing principle of care;
- Establish and document referral paths to and partnerships with community based services organizations that provide some or all of the supportive services identified in the Practice Algorithm (e.g., cognitive and physical function, caregiver support, emotional and social supports, safety, planning, etc.); and
- Implement care management and care transitions support that evidence establishes are effective in dementia populations.
- Establish and implement policies that incorporate specifically trained primary caregivers in the care of persons with Alzheimer's and related dementias

In addition, we recommend that this demonstration effort should coordinate with the work being done by the various working groups that are part of the Preparing Minnesota for Alzheimer's 2020. These groups are doing work on early identification of Alzheimer's/dementia, curriculum for medical professionals, etc.

Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

Section 9.3.5: Critical access study for home and community based services

As part of the critical access study for HCBS, we urge DHS to consider both current and future workforce issues, particularly in rural areas. While maintaining waiver clients in homes scattered throughout their communities may be a laudable goal, "windshield time" due to long distances and decreasing numbers of available workers may have a significant impact on the ability to provide HCBS to persons in rural areas.

Section 9.3.5: Redirect Residential and Nursing Facility Services

We are concerned that the proposal includes an expected outcome of planning and analysis before conducting the studies, especially when it comes to critical access study of core services. We have experienced what happens when portions of the infrastructure for a given population are reduced and/or removed, as is evidenced by the increasing number of younger individuals with mental illness and health needs entering nursing facilities. Until core infrastructure needs-- such as affordable housing, crisis response services, health care in supportive housing settings--are

addressed, there will be populations that are disenfranchised and that won't be served due to increased level of care criteria. It is important for the state to first implement and evaluate the implications of the first level of care changes before increasing the service eligibility threshold again. Not only do we need better data to measure the impact of these changes; we also need to involve social services, public health and others in the discussion to be certain communities are ready and able to respond with services to fill in the gaps created by these redirections.

Section 9.3.6 New In-home Support and Technology

While we agree that using technology to assist people living throughout the community can be useful—particularly if they have a family caregiver who can help fill in some of the gaps—we recommend that DHS consider how to make better use of technology also for those waiver clients who live in housing with services. For private pay residents, especially those with dementia, monitoring technology has been proven to improve outcomes by identifying problems (e.g., UTI) before they become severe enough to require hospitalization. As DHS re-visits the current waiver requirements, we hope you will make changes to make it easier for providers and their clients to access funding for various types of technology to improve clients' outcomes.

Section 9.3.6: New Budget Methodology to Serve Medically Complex Seniors

We are pleased the state acknowledges the fact that the rate setting methodology for the Elderly Waiver program is insufficient to meet the needs of certain individuals. We have two recommendations for this initiative: First, that they look beyond the limitations of "ventilator dependent" and focus instead on the clinical needs of individuals who need the higher threshold of nursing and therapy services. Secondly, we encourage the state to calculate total costs when determining which setting is the lesser cost for comparison purposes.

In order to achieve long-term cost savings, we would also recommend that DHS reconsider some of its policies related to Customized Living/24-hour Customized Living. These waiver packages do not pay for any licensed nursing time other than medication set-ups. By allowing some flexibility to pay providers for some licensed nurse visits—for example when an EW Customized Living client has returned from the hospital or when the client has the flu—this could potentially eliminate some transportation/clinic costs, or even avoid unnecessary hospitalization. While some health plans are now have Nurse Practitioners or even physicians on-site in some HWS settings, another way to

Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

avoid more expensive services would be to allow RNs and LPNs that know their residents/clients well to take a more active role in providing early interventions to avoid more expensive care later.

Section 9.3.6: Threshold for Accessing Residential Services.

As waiver clients are required to meet increasing thresholds for residential services (e.g., HWS), we urge DHS to consider how to assist private pay residents who may have lived in the residential settings for a long-time prior to becoming eligible for waiver services. While the Level of Care criteria do include some considerations—such as whether the individual will have certain risk factors and will be living alone—if a resident has lived in a HWS setting of their choice for several years, made friends and had their health stabilized as a result of the meal plan, socialization, etc., significant amounts of assistance may be necessary if they can no longer receive needed services if they continue living in that setting.

Section 9.3.7: Rate Methodologies

We want to state on the record that the Customized Living (CL) tool may have made some improvements in rate setting, it has not resulted in "fair" and "consistent pricing across the state." Counties and other lead agencies are still administering the tool inconsistently; for example, with some lead agencies refusing to authorize CL for housekeeping and laundry, which are clearly eligible services under DHS' policies and the waiver. In addition, the tool has not resulted in services individualized to a particular client's needs. We know that case managers are using standardized approaches—such as using a flat five minutes for each medication administration task no matter whether the client has 2 or 12 medications. In addition, rather than try to be creative in terms of bringing in volunteers or other agencies to meet all of a client's assessed needs, case managers often simply reduce the time allowed for the CL provider for all services in order to stay within a client's service rate limit, while still expecting the CL provider to provide all services in full without appropriate reimbursement. As DHS develops the rate methodology for disability services, we hope there will be adequate testing and evaluation of the methodologies and that that information will inform changes needed to the EW CL tool.

Section 9.3.8: Redesign Case Management

We agree that it will be an improvement to separate the administrative functions that have been assigned to case managers from the services of case management, and hope that this frees up case managers to spend more time in responding to changes in client's needs and in revising service plans as needed. As DHS looks to improve case management functions, we urge DHS to consider the important case management function played by providers' nurses and other health care professionals who work directly with waiver clients. In Customized Living services, the on-site RN plays the primary day-to-day role of case management in contacting the physician about changes in condition, side effects of medications, etc., yet there is no reimbursement for this valuable service. We hope as the case management system is redesigned, that this important function that providers fulfill will be recognized by lead agencies with resulting improvements in outcomes for clients.

Section 9.3.9: Statewide, centralized system for Reports of Vulnerable Adult Maltreatment

Minnesota plans to establish a statewide toll free hotline with 24/7 response and triage to receive reports of suspected maltreatment of vulnerable adults and determine the need for investigation. While we are supportive of a more streamlined approach, during the past two years, a collaborative initiative known as the Vulnerable Adults Justice Project (VAJP) has been discussing similar

Comments on the Reform 2020: Pathways to Independence: Section 1115 Waiver Proposal

concepts, along with the need for simplified reporting. If the state moves ahead with this change, we encourage you to build off of the work that is already underway with VAJP. In addition, if there is a major initiative that changes the current reporting system, we encourage the state to look ~~and~~ at training, resources, and expectations to local officials to address the growing challenge of financial exploitation of the elderly.

Section 10: Data, System and Evaluation Criticisms

In general, it is disappointing that much of the evaluation proposal focuses on process without addressing how care and the associated healthcare outcomes for a specific client are to be measured. The work on the duals project assumes that care will be virtually organized, but doesn't specify how providers will do so. The CFSS, Redirect Residential and Nursing Facility Services, New Budget Methodology to Serve Medically Complex Seniors, Demonstration to Expand Access to Transition Services, and other areas speak to how DHS will manage the new system, but are silent on how providers will improve the health outcomes under these new constructs. For example, the fact that medication listings and reconciliation, which is a key problem area for successful transition, is not mentioned, leads one to think this is not focused on the consumer, and on consumer outcomes.

Furthermore, this appears to be a theoretical construct at this point. No evidence is provided that by aligning payments, needs, and services that better health-related outcomes will be achieved. On this, it is disappointing that none of the waivers and programs discuss how eHealth technology and the sharing of data will be incorporated and used to improve and measure health outcomes.

Finally, in general, the evaluation laid out seems to rely on old ways of measurement, not newer and more client-related. Are we avoiding hospital stays? Are people managing their specific diseases or conditions better? What are the expectations for providers and care coordinators to communicate and coordinate? How often are care coordinators and case managers meeting with their clients?

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 12, 2012 1:05 PM
To: *DHS_Reform2020Comments
Subject: Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

Dear Dr, Godfrey,

Kids don't grow out of autism by age 7, so why should the state end the funding? These kids deserve every opportunity to get help and I want my tax dollars to help these kids. I am doing this for [REDACTED]-Age 8. He is a non-verbal kid with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

It is frightening to me that these kids would stop getting much needed help at Age 7. I have a very good friend whose son is in the public school system with autism, and they don't have the resources to help him. This is wrong!

Please do not take away the basic right of proper care for these children. Please do the right thing and DO NOT pass this waiver.

Kindest Regards,

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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July 11, 2012

David Godfrey
Medicaid Director
Minnesota Department of Human Services
PO Box 64998
St. Paul, MN 55164

Dear Mr. Godfrey:

On behalf of the National Alliance on Mental Illness of Minnesota (NAMI Minnesota) I am submitting these comments to the State's Medicaid Section 1115 Waiver Proposal – Reform 2020: Pathways to Independence. NAMI Minnesota is a statewide grassroots organization dedicated to improving the lives of children and adults with mental illnesses and their families. Nearly 100% of our board and staff either live with a mental illness or have a family member with a mental illness. We appreciate the opportunity to comment on such a far reaching proposal.

NAMI Minnesota supports the purpose of the Medicaid reforms to:

- Achieve better health outcomes
- Increase enrollee independence
- Increase community integration
- Reduce reliance on institutional level of care
- Simplify administration and access to program
- Create a program that is more financially sustainable

Medicaid, or as it is called in Minnesota, Medical Assistance (MA), is an invaluable program for children and adults with mental illnesses and their families. For many, it is the **only** way to obtain access to treatment and supports. We believe it is important to remind the department that the health care system for children and adults with mental illnesses continues to this day to discriminate against people needing mental health treatment and supports to achieve wellness and recovery.

Mental health treatment is not currently mandated for self-insured plans. Over 40% of Minnesotans are under self-insured plans. Companies that self-insure can legally not cover mental health and substance abuse treatment. Individual policies, under Minnesota law, can exclude coverage for mental health treatment. Nearly 8% of Minnesotans have coverage under individual policies. Thus, nearly 50% of Minnesotans that are insured may not have access to mental health treatment.

If mental health treatment is covered under private insurance, what is covered is variable. Few private plans cover the model mental health benefit set which is included under MA and MinnesotaCare. Final federal parity regulations have not yet been adopted and so it is not clear how major components of the law to ensure equity and parity will be implemented. People continue to struggle with obtaining insurance coverage, particularly with non-quantitative treatment limits and medical necessity.

Even under MA, discrimination exists. The TEFRA program (Katie Beckett Waiver) is different for children with mental illnesses than for children with developmental disabilities. These children have to meet a higher standard – hospital level of care – resulting in far fewer families being able to access the TEFRA program for the services that their children need to remain in their home.

This background information is important. When people cannot access treatment and supports that are needed for their mental illness they often turn to publicly funded programs – like MA. The coverage and eligibility criteria for mental health treatment and supports, becomes hugely important since there is no where else to turn for help.

Great progress was made in 2006 and 2007 in expanding coverage for effective treatment and supports (model mental health benefit set) and in expanding access by increasing rates for mental health providers. During the past two years, NAMI has seen these specific programs held largely harmless, but have witnessed the legislature and department make drastic changes to other MA programs that have significantly negatively impacted people with mental illnesses and thus greatly reduced people's ability to access needed supports to live well in the community.

The most detrimental changes are ones made to the Nursing Facility Level of Care (NFLOC), the PCA program, and the CADI program. Changes to these programs will or have resulted in countless people with mental illnesses being tossed out of programs that provide the in-home supports they need to live at home in their communities.

The NFLOC proposed changes: 1) require hands-on assistance thus eliminating eligibility for people who may need cueing to meet their daily needs; 2) require daily monitoring thus eliminating eligibility for people who need only weekly injectable medications or medication checks; 3) no longer mention disorientation which could have included someone experiencing delusional thoughts or psychosis; 4) no longer include safety which in the past could have included people who were suicidal or had self-injurious behaviors; 5) refocuses on physical symptoms and no longer includes aggression, recent hospitalizations, cutting or otherwise hurting oneself, or even self-neglect. The reason it is important to remind the department about the NFLOC changes is that it will result in far fewer people with mental illnesses being able to qualify for the CADI program. Of people currently on the CADI program, 34.1% have a serious mental illness and 25.8% have a serious and persistent mental illness. The NFLOC changes will result in thousands of people with a mental illness no longer being eligible for this waiver. Medicaid Reform must address the loss of eligibility for services.

Eligibility for the PCA program was changed to be more restrictive so that many people with a mental illness, particularly children, were no longer eligible or had their hours reduced drastically to roughly half-hour a day. These cuts especially impacted children from communities of color. Medicaid Reform must address the loss of eligibility for services.

The CADI program was changed last year by reducing funding for people with “low needs.” Many of those people were people with a mental illness since the assessment tool did not adequately assess needs related to mental illnesses. It is easy to understand that someone who cannot bring a fork to their mouth needs assistance. It's harder to understand that someone's

symptoms may make it difficult to leave the house to purchase groceries and cook may need assistance. But either way, without assistance, neither will eat. Yet, the latter person would be deemed “low needs.” Thus many mental health providers lost 10% of the funding and some people were faced with losing services.

The MNChoices program, which is a universal assessment tool, still does not adequately assess the needs of children and adults with mental illnesses. This will result in them not being eligible for programs and not having their needs addressed.

Even before these changes, we have seen the poor outcomes for children and adults with mental illnesses— 70% of youth in the juvenile justice system have one or more mental health diagnoses, over 25% of our prisons and 60% of our jails are filled with people with mental illnesses, more than half of those who are homeless have a mental illness or chemical dependency, and over 500 people die every year in Minnesota due to suicide. The current Medicaid program isn’t totally working for people with mental illnesses and it will only get worse. The only time NAMI has witnessed significant positive changes to the mental health system was in 2006 and 2007 with the passage of the Mental Health Initiative, where we used MA funding for specific services that had evidence to prove their effectiveness and that were designed to explicitly meet the needs of people with mental illnesses.

The components of the Reform 2020 proposal are, therefore, extremely important since children and adults with mental illnesses are being pushed out of current home and community-based MA programs and if the NFLOC changes are approved, even more will lose their supports. NAMI Minnesota is very concerned that the Reform 2020 will not create the programs needed to support those who will no longer be eligible for the CADI and PCA programs.

NAMI Minnesota unequivocally supports the development of a waiver specific to the needs of children and adults with mental illnesses and that does not tie eligibility to facility level of care or multiple hospitalizations.

In reviewing the proposal NAMI specifically looked at changes that would worsen the situation for people with mental illnesses and identified lost opportunities for actually improving the lives of children and adults with mental illnesses.

3.2.2: Accountable Care Demonstration Project

Establishing Hennepin Health, providing an integrated health delivery network for people under MA expansion.

NAMI supports the department’s request for waiving state-wideness for the Hennepin Health project. Hennepin Health builds on the Preferred Integrated Network project in Dakota County and has the potential to provide better coordination of treatment and supports. Starting in one county and learning how to do this effectively before going statewide makes sense.

4.2.1 & 4.2.2: Community First Services and Supports

Providing for an alternative to the PCA program by providing an array of services and supports to provide assistance with maintenance, enhancement or acquisition of skills to

complete activities of daily living, independent activities of daily living and health related tasks to help people live in the community.

The main problem that NAMI has with the current PCA program is the limited half-hour per day (two units) of services and the lack of appropriate training of PCA providers. The proposal does include provider standards which may help address the current problem related to lack of training on mental illnesses. This new program will use the MNChoices assessment tool, which we believe is still flawed, and eligibility will be based on the new NFLOC. This will result in many people with mental illnesses not being eligible for services under CFSS. When the changes were made to the PCA program by the legislature many of those who no longer qualified for the program or who lost all but 30 minutes of day of service had a mental illness, were children and were African American or from other culturally specific communities.

There is a second program for people who do not meet the NFLOC but who have one ADL or a level one behavior. Due to the definition of a level one behavior, we do not believe we will see people with mental illnesses who were cut from the program be able to come back on to it. Exhibiting a behavior once a week is not really relevant to people with mental illnesses who may go for several weeks without a serious symptom and then have several difficult days or weeks in a row. The proposal will increase the number of units per day to 90 minutes, which is certainly much better than 30 minutes.

NAMI hopes that the some of the service options under this program will aide with coordination. The ability to include CFSS services as part of a waiver could certainly help with this aspect.

4.2.3: Demonstration of Innovative Approaches to Service Coordination (Children with CFSS)

Providing service coordination through a limited number of school districts.

Children with mental illnesses clearly need more supports than are currently provided under MA. This has been noted in the Intensive Needs Report which showed that roughly 10% of the children used over 50% of the inpatient bed days and were receiving community-based services - but at the same intensity as other children. Due the recent passage of a law governing the use of seclusion and restraints in the schools, we now understand that the use of prone restraints on children is intrinsically tied to lack of access to intensive mental health services. In fact, the 2012 Legislature is requiring the MN Department of Education to convene a group to study how to reduce the use of all seclusion and restraints by looking at a number of factors, including access to mental health services. Thus, NAMI strongly supports a better and more intensive care coordination model.

There are, however, several problems with this specific proposal. The first is that you have chosen schools to be the agency providing care coordination. Many schools do not operate year round. Many of the personnel in schools that the application refers to – school psychologists, social workers, school counselors – are not licensed mental health professionals and are not clinicians. Few districts are true CTSS providers, providing the full range of services, including day treatment. They largely provide skill building. Most importantly, the proposal makes no mention of how this new service will interact with what has become an extremely effective program – school-linked mental health services.

One of the reasons that the Mental Health Action Group (MHAG) chose mental health providers to be the recipients of the school-linked mental health grants is that they have licensed mental health professionals, operate year round and are able to bill all insurance providers. Additionally, when a child changes schools (voluntarily or expulsion) the provider can continue to provide services to the child – their care is not interrupted.

For many children with a serious mental illness, they are neither on the TEFRA program nor on a CADI waiver. For those that are, they often also have private insurance. Schools are required to bill their private insurance first since MA is the payer of last resort. When services are provided by the schools, parents can deny permission to bill their private insurance for these services due to FAPE. You will be making the situation more difficult than it needs to be by placing this service with the schools.

NAMI Minnesota does not support the schools being the lead agency for this new service and urges the department to revise this proposal with direct input of the current school-linked mental health providers and children's mental health advocates.

6.1: Demonstration to Empower and Encourage Independence through Employment Supports

Targeting specific people to provide telephonic navigation, benefits planning and employment support based on the Pathways and Demonstration to Maintain Independence and Employment programs.

People with a serious mental illness have the lowest employment rate of any disability group. Less than 15% are employed. And yet, employment is an evidence-based practice – it actually helps people get better. Theoretically, NAMI Minnesota supports efforts to include employment programs under MA. However, we are perplexed as to why IPS, an approach based on research and proven to be effective in helping people with serious mental illnesses obtain and retain employment, was not included in this proposal.

IPS, also known as evidence-based supported employment, helps people in community mental health service systems to become a part of the competitive labor market. IPS is nearly three times more effective than other vocational approaches in helping people with mental illnesses to work competitively. IPS is cost-effective when the costs of mental health treatment are considered. Several studies have found a reduction in community mental health treatment costs for supported employment clients, while other studies have found a reduction in psychiatric hospitalization days and emergency room usage after enrollment in supported employment. Service agencies that have replaced their day treatment programs with IPS have reduced service costs by 29%.

People who obtain competitive employment through IPS have increased income, improved self-esteem, improved quality of life, and reduced symptoms. Approximately half of the people who enroll in IPS become steady workers and remain competitively employed a decade later.

DHS is proposing a program targeted largely at young adults with a serious mental illness who are in MA expansion, MA-EPD, or MFIP, or young adults exiting foster care or people transferring from the Department of Corrections. And yet, the department is not proposing to use

an evidence-based practice for people with mental illnesses. Instead the department is proposing to carry out activities that have absolutely no evidence behind them.

The proposal is to conduct outreach, provide navigators, use the Disability Linkage Line and utilize DB101.

While we have not done extensive research, nor contacted the department directly due to time constraints, we have not been able to find data demonstrating that the approach used under Pathways was successful in reaching young people with mental illnesses. The last report we could find was from the first quarter of 2011 and it did not contain outcomes or data.

In looking at the Minnesota Demonstration to Maintain Independence and Employment (DMIE) Report published in February 2010 there is data, but it should be analyzed more closely before using this approach. First, is the low response rate of 16% and the fact that only half of them were approved, leaving just 8% of the total mailing. Granted, this is higher than most market research efforts; however, in terms of reaching people to prevent them from going on to a variety of disability programs, we believe it is low. Outreach to enroll people under the new proposal includes mailings and phone calls - to people who do not have stable home addresses and who may not have cell phones. Will reaching fewer than 8% be viewed as successful?

In looking at why people were denied access to the DMIE program, 45% were not working and 13% did not complete the diagnostic screen. The data also show that 65% of pending cases had “not responded to outreach efforts to schedule their appointments or had not attended scheduled appointments...The number of missed appointments was high enough...to prompt DHS to establish a policy of issuing a denial letter if an applicant missed three scheduled appointments.”¹

This demonstrates lack of engagement, which is particularly hard for young adults. Will a phone call be enough?

What is particularly noteworthy is that 58% of the participants were over the age of 35 and depressive disorders were the most common psychiatric illness (52%) followed by anxiety disorders. We were not able to fully analyze the data to learn if the people who did not complete the diagnostic screen were under the age of 35. It would be even more helpful if we could look at the date for those between the ages of 18 and 25. Further analyzing the impact of this program on those under the age of 25 would provide greater insight as to if this program will truly be effective with young adults.

One of the important components of the IPS model is to conduct a rapid job search within one month. Under the DMIE program, at one point there was a delay of 63 days before their first encounter with a navigator. It can be assumed that the job search happened much later. The most common referrals after meeting with the navigator were for employment supports, mental health services and medical care and 33% needed more intensive employment supports.

¹ DMIE Report, page 12

Of the 1494 people that were randomized into the program, 26% dropped out – mainly due to being not employed or failing to pay the ongoing premium. This leaves under 6% of those that received the initial mailing being in the program. This information is critical to the development of the eligibility criteria for this new program and its components. The eligibility criteria that is proposed will greatly limit access by requiring that someone currently have a job, have had reduced hours or pay, or not worked in a year or less. Especially in light of the economy, why would you exclude people who have not worked in more than a year or who haven't had reductions in hours or pay but would like to do better? The DMIE program lost over a quarter of its participants due to this requirement.

The components of the program should also be changed. While we would prefer that you fund the IPS model, instead of funding a “middleman,” at the very least changes should be made to make it easier for someone to obtain an assessment and to not penalize those who miss appointments. For people with a criminal background, you need to address the impact of collateral sanctions.

For anyone who has any type of complex issues, DB101 is not helpful. We have heard from many mental health providers who do not recommend that their clients use DB101 because it is not accurate and does not look at all the benefits someone will use. Additionally, it is rarely used by the individual. People who do not own computers only have about 30 minutes on a computer at the library which is not sufficient time to obtain a meaningful response through DB101. Even on DB101 there is a reference to the Work Incentives Connection, recognizing that people need individual benefits planning – yet there is no funding for them to complete these assessments.

The Disability Linkage Line is not a “natural” resource for people with mental illnesses. People with mental illnesses and their families do not look up disability related sites or programs – they look for mental health or health care. Our community won't know to go there.

In the proposal the word “navigator” is used, which could be very confusing when the health care exchange is up and running and navigators are used to help people access insurance through the exchange. The qualifications for “navigators” is very high and don't line up with current definitions of mental health practitioners or mental health professionals, making it more difficult for agencies to figure out if they have qualified staff. The requirement that an organization have mental health professionals yet not be required to provide mental health services such as under IPS does not make sense. We have few too mental health professionals to be using them for nonclinical positions.

NAMI would recommend that you change this section to fund IPS. If the department proceeds with its proposal as is, at the very least it should alter the eligibility criteria, add components, and use the evaluation criteria for IPS so that you can compare the efficacy of the two programs.

6.2 Housing Stability Services

Providing a new set of benefits to people who have serious functional impairments and housing instability.

NAMI Minnesota supports developing more services to support stable housing. Stable, safe, affordable housing is an important component for achieving recovery. The department has

proposed three components: 1) outreach/in-reach, 2) tenancy support services, and 3) service coordination.

Eligibility will be based on assessment through MNChoices. NAMI questions the applicability of MNChoices to people who are homeless. We do not believe that you will obtain an accurate assessment of someone's needs nor will it be easy to conduct this type of assessment on someone who is homeless.

NAMI is concerned with how the department is defining qualified service providers of housing stabilization services. Some of the very best people who provide outreach and support to people who are homeless would not meet these criteria. We would like a "reality" check in the field to make sure that some of our most successful providers of housing stabilization services are comfortable with these criteria.

NAMI is equally concerned with the eligibility criteria for these services in that it looks at ADLS and IADLS of people who are living on the street or are couch hopping. How can you even know if someone needs help getting around an apartment or needs assistance with meal planning or managing finances when they are not in housing?

NAMI does support the fact that the eligibility criteria includes people transitioning from institutional level of care, such as a jail or prison, since so many people with a mental illness are housed in the corrections system.

The benefits that will be provided do not go far enough. The proposal funds outreach activities, so that people know what options may be available. It funds assistance with finding housing and setting up a household. And it funds service plan development and coordination. What are missing are the actual services to maintain people in safe affordable housing.

The Substance Abuse Mental Health Services Administration (SAMHSA) views supportive housing for people with a mental illness as an evidence-based practice. As an evidence-based practice it requires a service plan to be developed specific to the individual and does not require a list of services for a specific location. SAMSHA does recommend that staff be available 24/7 and that services be available such as psychiatric, medical, relapse prevention, ADLs, money and medication management, education and information-sharing groups and activities, along with independent living skills, Illness Management, employment, and substance use services.

They also recommend the following supports for new tenants and tenants who may need ongoing support to maintain their housing: Tenant orientation; Tenant councils; Case management; Psychosocial assessment; Service planning; Counseling; Referrals; Crisis intervention; Peer mentoring; Support groups; and Recreational and socialization services. They also identify additional services that can be helpful such as: Legal assistance; Transportation; Nutrition; Art and music therapy; financial assistance; Money management or representative payee services; Furnishing units; and Assistance with dispute resolution (including negotiating payments for delinquent rent or resolving lease violations).

The problem that NAMI has heard in talking with providers is that the services that are needed to support someone in their home are not currently funded. This proposal only contains a partial list of the recommendations from the supportive housing community. NAMI recommends that the full list be included in order to achieve the envisioned and desired outcomes.

6.3 Project for Assistance in Transition from Homelessness and Critical Time Intervention Pilot.

Providing services to people are homeless or at-risk of being homeless and live with a serious mental illness and/or substance use disorder.

NAMI Minnesota supports this section.

7. Anoka Metro Regional Treatment Center Demonstration

Waiving the Institutions of Mental Disease (IMD) exclusion to use MA for AMRTC to allow for continuity of care.

The department seeks to waive the IMD exclusion for the Anoka Metro Regional Treatment Center (AMRTC). NAMI certainly believes that AMRTC is more like a short-term intensive hospital program in the community than it is an institution, particularly when compared to other state's institutions. In this respect it should be able to receive MA funds for the care and treatment provided. NAMI does not, however, view this section separately, but rather tied to the entire Reform 2020 proposal and how this section fits in to what else is being proposed to serve people with mental illnesses.

We are concerned that the section of the proposal to develop a 1915(i) for people with mental illnesses is not robust enough to prevent people from entering into AMRTC in the first place. Also, if we are to look at how to use our existing resources most effectively, NAMI believes that DHS must look at the Community Behavioral Health Hospitals (CBHHs) and their inability to be at capacity – using all 16 beds. When most of our other providers are full or have waiting lists, we simply cannot have beds that are not used. With the NFLOC and CADI changes, NAMI cannot support this section of the proposal without changes made to section 9, including an assurance from DHS that they will seriously consider developing a program to meet the needs of people who are experiencing their first episode of a serious mental illness.

9.1.4 1915(i) to support individuals with mental illness who are at risk for institutionalization without access to integrated community-based systems of care.

Providing a wide range of services to a select group of people with serious mental illnesses who have co-occurring or complex health care needs and no longer need hospital level of care (at AMRTC).

NAMI Minnesota has been strongly advocating that the department develop a 1915(i) specifically for people with mental illnesses, especially since people with mental illnesses having been using programs that are not designed to meet their needs and are now being pushed out of the PCA and CADI programs. If they cannot meet an institutional level of care, especially the new NFLOC, then new programs must be developed to meet their needs. Thus, we are pleased that there is a placeholder for this type of program.

We do, however, have several concerns. The first concern is that there is no 1915(i) for children with a serious mental illness. Over and over again we hear that we simply do not have adequate

intensive supports for children. Data and reports back this up, including the Intensive Needs Report and the Transformation Advisory Committee Report. Key services that could be included would be IDDT for adolescents, supported education, peer specialists, parent peer specialists, respite care, a more intensive residential service, clinical case consultation and more intensive care coordination. NAMI strongly urges the department to create a proposal for children.

Our second concern is that the criteria for adults with mental illnesses are very limiting. The department is requiring that to be eligible, people have a serious and persistent mental illness and difficulty maintaining community-based services as exhibited by extensive hospital stays, AND exhibit two of the following:

- Assaults
- Verbal aggression
- Active chemical dependency
- Past criminal behavior
- Symptoms that do not respond to treatment and require eight hours of supervision per day
- The presence of another illness, condition or disability that makes it difficult to function in the community

NAMI Minnesota's concern is that interventions and specific services are being provided after the outcomes are poor – after people have ended up in the jail or prison, after people have had multiple hospitalizations. If the mental health system is going to continue to be transformed, then we must be intervening earlier – not later. We do want to support those who are having the most difficulty, those with the most complex needs, those who are not able to leave AMRTC because there are not intensive enough services in the community.

But, NAMI believes, especially in light of MA expansion, that the state should target people who are in the early stages of their mental illness, particularly immediately following the first episode of psychosis. Intervening effectively and intensively through coordinated and aggressive treatment during the earliest stages of mental illness could fundamentally change the trajectory of people's lives and produce the greatest outcomes – that people would not become permanently disabled by their mental illness. It takes an average of nine years from the first symptoms to an accurate diagnosis and treatment. This is unacceptable.

In the Minnesota DMIE Report published in February 2010, it states that “SSDI beneficiaries with psychiatric disabilities are the fastest-growing and largest disability group, they become disabled at a young age and remain on the rolls for many years, and they are the most costly population in the SSDI program.” According to a 2008 GAO Report entitled “Young Adults with a Serious Mental Illness” the main psychiatric illnesses of young adults on the SSDI or SSI program were schizophrenia, paranoid, and other functional psychotic disorders and affective mood disorders, such as depression or bipolar disorder.

The GAO Report also found that these young adults required multiple supports from a variety of agencies. The agencies and programs often have differing eligibility criteria – including age, income and definition of mental illness – making it even more difficult to navigate the system and on top of the fact that these young people may have, according to the report “fewer interpersonal and emotional resources with which to do so.” Families often end up being the

case manager, care coordinator and advocate, at a time when they are just learning about the illness and the various systems. Four states have targeted programs to young adults with a mental illness: Connecticut, Massachusetts, Maryland and Mississippi. The state should investigate the type of services that were offered and the approaches they utilized to try to meet the needs of these young adults. Again, intervening early, with enough intensity, is paramount to reducing costs long term.

There are several demonstration projects funded by the National Institute of Mental Health (NIMH) that could inform these reform efforts. One is called Recovery After an Initial Schizophrenia Episode (RAISE) and the other The Early Treatment Program (ETP). In Minnesota both Northpoint and the Human Development Center are involved with ETP and Spectrum Community Mental Health and the U of M at Fairview have experience in first episode programs. Vail Place also has a young adult program.

Dr. Recht, from Northpoint, and his team have been working with this model as part of the RAISE ETP study for approximately two years. They use a four component, team-based approach to working with clients. The four components are as follows:

- 1) **Psychiatry.** Specifically using a new model (not yet publicly available) known as COMPASS which using computer images in conjunction with more traditional clinical work to determine what will have the most immediate and effective impact of psychotic symptoms. He described it as identifying psychosis as early as possible and "hitting it with all you can."
- 2) **Supported Education and/or Employment Services.** This involves one-on-one mentoring to help people find and/or maintain work or education activities to help people re-engage with the community. The service is designed to help eliminate any obstacles to success. It is designed to meet the person where they are at and can include everything interview coaching, skill building,
- 3) **Individual Therapy.** Specifically using an "individual resilience therapy model" similar to cognitive therapy and motivational interviewing. It is designed to meet people where they are and help develop skills for coping with their symptoms and understanding what underlying factors can lead to symptoms and how to deal with those.
- 4) **Family Education.** Family involvement, with family defined by the person receiving care, is paramount to the model. The family education is very similar to the education the individual receives in therapy. It is designed to help the family better understand their loved ones illness, provide support, help reduce stress in the home environment as well as recognize when symptoms may be coming back and what to do.

These services work as a menu of options and are dictated by the preferences and interests of the person receiving care. The person receiving the care is involved in the decision making process every step of the way. While ideally all four services can be delivered simultaneously, individual services can be started and stopped as the situation dictates.

Dr. Recht stressed the strong team-based approach to the work as one of the greatest assets this model provides. While the study is on-going and closed to new participants Dr. Recht's team

continues to use this model on any new clients who would otherwise meet the criteria. "We feel very good about what we're doing" he said.

Dr. S. Charles Schulz, who is the Donald W. Hastings Endowed Chair, Professor and Head of the Department of Psychiatry at the University of Minnesota Medical School, believes in the "importance of coverage in the recognition and treatment of first episode psychosis and related serious psychiatric illness." He points out that there is now significant evidence that early recognition of schizophrenia can significantly reduce poor outcome in these young people.

The following paragraphs are taken from a letter Dr. Schulz sent to NAMI.

Several studies have demonstrated that if there is early recognition of psychotic disorders that the outcome over the next number of years is improved. This improvement is not only a reduction of psychotic symptoms – hallucinations and bizarre thoughts – but also in functioning. Furthermore, a pilot study done in collaboration between Yale University and Norway has demonstrated a reduction in suicide rates in early recognition programs. I would like to note that all of these studies have demonstrated a highly statistically significant relationship between early recognition and outcome. I would be pleased to provide you with those articles as needed.

Related to the improved outcome of an early recognition program, I would also like to note the importance of health plans – both public and private – to recognize and provide comprehensive treatment for young people with serious psychiatric illnesses such as schizophrenia, bipolar disorder, and severe depression. It is noted in the medical world that the recognition of cancer and diabetes at an early stage is considered an important way to lead to much better outcomes. It is very important for these serious psychiatric illnesses to be treated in the same way – without prejudice or stigma.

The success of helping the seriously ill young patient includes much more than just covering a brief initial hospitalization. In order to have a highly successful outcome, services such as family psychoeducation and support groups, group therapy for the young patient, and day treatment for those young people who require it after a hospitalization is crucial to maintaining the therapeutic alliance with the young person and their family. Furthermore, I know you are fully aware of the importance of family psychoeducation in not only reducing the risk of relapse but also in providing support for the very difficult impact of a family's child coming down with a serious illness.

It is important to note that the treatments following an initial hospitalization or an initial outpatient evaluation are crucial in the reduction of relapse of these young patients. I have visited Anoka State Hospital and reviewed with the doctors there how many young people in their early 20s have already had repeated hospitalizations because of inadequate support. There is emerging evidence that each relapse following the initial stage of schizophrenia requires more effort to bring the young person back to remission.

In summary, I would like to note that our public and private healthcare system needs to develop early stage of psychiatric illness programs in order to:

- *improve outcomes in both the short- and long-term*

- *reduce the morbidity and mortality of psychiatric illness*
- *reduce the cost of healthcare by providing early connection with the patient and by reducing relapse.*

In summary, I strongly believe it is important to intervene at the early stages of serious psychiatric illness and to provide appropriate subsequent treatment. Further it is judicious to not ignore serious psychiatric illness which can be present for up to a year before treatment. Third, I strongly believe that the impact of such programs will not only improve the outcome of these young people but will also provide a more economical healthcare system.

Generally, the model for first episode programs integrates medication, psychosocial therapies, family involvement, rehabilitation services, cognitive enhancement therapy and supported employment. There are also certain medications that are viewed as having greater success, namely Clozapine.

The third concern is that the services that are listed under this section need to be expanded and have more detail. NAMI recommends that the department refer back to the model mental health benefit set adopted by the Minnesota Mental Health Action Group. Only some – not all – of the recommendations were included in the 2007 Mental Health Initiative. Additional services recommended included clinical case consultation, IDDT, disease management and education, and supportive housing. Since then, more evidence-based practices have been developed and supported by the Substance Abuse Mental Health Administration. In checking SAMHSA’s website today, there are more than 230 listed.

In addition, the department needs to seriously review Adult Rehabilitative Mental Health Services (ARMHS). This is an excellent program; however, the low rates combined with limited reimbursement of activities have led to many providers dropping out of the program. The pros and cons of including ARMHS under a 1915(i) or leaving it as a separate service must be thoroughly explored and discussed.

NAMI looks forward to working with the adult mental health division more closely on this section to fully develop the service options and eligibility options.

9.3.2 MnChoices

Providing a single web-based assessment and planning process tool.

NAMI Minnesota appreciates the efforts that DHS has made to make changes to the MNChoices program to more accurately assess the needs of people with mental illness. NAMI believes, however, that more work needs to be done.

9.3.6 Enhancements to 1915(c) Waivers

Enhancing the current waivers (including CADI) to provide the right services at the right time.

NAMI Minnesota has been a part of the group looking at developing a common service menu. We strongly encourage the department to make sure that a “universal worker” has the skills and education needed to work with people who have a serious mental illness. In addition, your description of supported employment as a service should include IPS and not simply Pathways to

Employment services. The provider standards should also include the option to specialize in working with people with mental illnesses.

9.3.9 Crisis Intervention and Protection of Vulnerable Adults

Expanding crisis services to people with disabilities and seniors living in the community.

NAMI is wondering how this program will intersect with the current mental health crisis teams.

9.6 Intensive Residential Treatment Services

Integrating mental health and health care services in IRTS.

NAMI Minnesota has been a strong supporter of IRTS programs. Most recently there have been concerns raised about the need for more health care providers, such as nurses, to be able to be reimbursed through IRTS programs. This proposal, however, really only references the IRTS under State Operated Services and not those in the community. NAMI believes that this is a grave error and that we must allow the private IRTS providers the opportunity to meet the needs of people in their community.

9.7 Children under 21 in Residential IMD facilities

Addressing the IMD issue in children's residential facilities and increasing the intensity of care.

NAMI Minnesota supports efforts to address the IMD issue in children's facilities and to move forward our efforts to develop psychiatric residential treatment facilities.

Conclusion

This concludes the comments of NAMI Minnesota. We thank the department for the obvious amount of effort from numerous staff to develop a proposal that is this extensive and far reaching. We appreciate the leadership of the commissioner, assistant commissioners and the Medicaid Director in developing this proposal. Our comments are provided to help improve the proposal and to ensure that the needs of children and adults with mental illnesses, who heavily rely on Medical Assistance for treatment and supports, are met. Thank you again for the opportunity to comment.

Sincerely,

Sue Abderholden, MPH
Executive Director

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 12, 2012 11:39 AM
To: *DHS_Reform2020Comments
Subject: Please do not change this coverage.

To David Godfrey, Medicaid Director:

Kids don't grow out of autism by age 7 so why should the state end the funding? These kids deserve every opportunity to get help and I want my tax dollars to help these kids. I am doing this for [REDACTED]-Age 8. He is a non-verbal kid with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

I am [REDACTED] aunt and know that he has a lot of potential. He needs more help than the school system is equipped to give him. They are pushed to the limit with so many special needs children. Please help the families give these kids the extra help that can make such a big difference. And the more help he receives now, the less help he will need later in life. That is our hope and prayer.

Thank you for your attention.

[REDACTED]
Concerned Aunt and retired teacher

[REDACTED]
[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 12, 2012 11:27 AM
To: *DHS_Reform2020Comments
Subject: Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

Dear Dr, Godfrey,

Kids don't grow out of autism by age 7, so why should the state end the funding? These kids deserve every opportunity to get help and I want my tax dollars to help these kids. I am doing this for [REDACTED]-Age 8. He is a non-verbal kid with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

It is frightening to me that these kids would stop getting much needed help at Age 7. I have a very good friend whose son is in the public school system with autism, and they don't have the resources to help him. This is wrong!

Please do not take away the basic right of proper care for these children. Please do the right thing and DO NOT pass this waiver.

Sincerely,

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 12, 2012 10:58 AM
To: *DHS_Reform2020Comments
Subject: STOP Reform 2020 Section 1115

To Whom It May Concern to Make a Significant Impact:

Kids don't grow out of autism by age 7 so why should the state end the funding? These kids deserve every opportunity to get help and I want my tax dollars to help these kids. I am doing this for [REDACTED]-Age 8. He is a non-verbal kid with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

Sincerely,

[REDACTED]

Human Resources Manager

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 12, 2012 10:36 AM
To: *DHS_Reform2020Comments
Subject: Autisim - ³Reform 2020 Section 1115 Medicaid Waiver,²

Kids don't grow out of autism by age 7 so the state would be making a major mistake by ending the funding? These kids deserve need support and I am supportive of my tax dollars going to help these kids. I am doing this for [REDACTED]-Age 8. He is a non-verbal child with autism and he deserves and needs all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

Thank you.

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 12, 2012 10:02 AM
To: *DHS_Reform2020Comments
Subject: Please stop Reform 2020 Section 1115 Medicaid Waiver, from limiting our kids

Dear State Representatives:

Kids don't grow out of autism by age 7 so why should the state end the funding? These kids deserve every opportunity to get help and I want my tax dollars to help these kids. I am doing this for [REDACTED]-Age 8. He is a non-verbal kid with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

Thank you.

[REDACTED]

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 12, 2012 9:59 AM
To: *DHS_Reform2020Comments
Subject: Please Don't Change Autism Funding

I have several friends who are raising children with different levels of Autism.

I cannot say enough how much of an affect it would have on their lives at home and their ability to help their children grow if this funding is taken away after the age of 7.

These kids deserve every opportunity to get help and I want my tax dollars to help these kids.

I am writing this specifically for [REDACTED]-Age 8. He is a non-verbal child with autism and he deserves all the help he can get. Please do not limit these kids by their age. Look at what they need! Please stop "Reform 2020 Section 1115 Medicaid Waiver," from limiting our kids.

[REDACTED]

[REDACTED]

Dooley, Lea M (DHS)

From: Jami Moon <jmoon@btsofmn.com>
Sent: Wednesday, July 11, 2012 8:42 PM
To: *DHS_Reform2020Comments
Subject: Autism

To whom it may concern:

I have been touching lives of children and families with Autism for several years now and I am truly appalled that these children could be essentially told "I am sorry you are over 7years old there is no hope for a future. Good luck in an overcrowded school system where you may not survive because you were not given the proper tools to do so." Shame on you for giving up on any child's future. What if it were your child?

Could you look them in the eye knowing you put an age limit and funding limit on their success? I do not support what this state is trying to do to this population. They deserve a fighting chance. They are worth the money at 2 years old and at 13 years old. At no age should a child be given up on. What does that teach them? They are people too, just because they may not be able to advocate for themselves does not mean we should throw them away. I hope legislation takes a good look at their proposal and realizes that this is a disgrace to Minnesota.

Sincerely,
Jami Moon

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Wednesday, July 11, 2012 7:44 AM
To: *DHS_Reform2020Comments
Subject: Autism coverage should NOT be age based

Dear Mr. Godfrey:

In May, we received the letter all autism parents fear: our private insurance [REDACTED] would no longer cover our son's ABA therapy. We were grateful that he also had medical assistance so that he could continue his treatment. Just weeks later we learned that since [REDACTED] is 7 MA proposes to eliminate coverage for this same therapy.

With both private insurance and MA eliminating coverage for autism treatments such as MA we--and many families--will be left with no options other than our public school district. As a teacher, I know first hand that schools are not prepared for the influx of children with autism, especially those like my son who are non-verbal. Even in a quality district, [REDACTED] day will be spent primarily with an aide who likely has no training in autism. For most students, the sole focus is on behavior. As long as a student is compliant, they will receive little individual attention by someone qualified to create programs to meet his needs. Special education is little more than babysitting.

This is a sharp contrast to services [REDACTED] currently receives at [REDACTED], which is worth the 45 minute drive from our home. From the leadership who have master's degrees and create programs tailored to his needs to the therapists who work with him one on one, everyone is trained not only in autism but on [REDACTED] specifically. This is not a "one size fits all" program. Kids at [REDACTED]--and other autism treatment programs--have a huge range of skills and needs. [REDACTED] can meet this needs on an individual basis, which would not happen in our underfunded school systems.

Placing an age cap on autism treatment is bad for our kids and our public schools. It will have long term impact not only on our family, but on our society as children with autism will grow up with less skills and ultimately need more long term support. I urge you to reconsider this portion of the Reform 2020 proposal.

Thank you-

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 10, 2012 6:57 PM
To: *DHS_Reform2020Comments
Subject: Autism needs to be covered no matter what the age of the child

We need to stay focused on making sure that treatment for kids will not be disrupted. Both private and public health insurance should cover medically necessary care for autism. Children who have autism benefit from different types of treatment and services - our daughter is proof of that. She has benefited from early intervention. She is currently receiving ABA and intensive early intervention behavior therapy (IEIBT). Those services have made a difference for both her and our family! Children need autism services regardless of age.

Thank you for your consideration.

[REDACTED]

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 10, 2012 4:39 PM
To: *DHS_Reform2020Comments
Subject: Autism Wavier 1915i comments from [REDACTED] family

Minnesota department of Human Services do not cut Autism coverage David Godfrey

1 message

To David Godfrey (Medicaid Director) & TEAM-

My name is [REDACTED]. My husband [REDACTED] and I have a three in a half year old Son [REDACTED] who has Autism.

I went to Regina Wagner's Question and Answer Session and shared my story in May 19th, 2012. I was one of the five parents who was chosen to speak.

I know that Proposal Children with Autism would be routed into a 1915i waiver to access treatment services. Limiting treatment with Autism after the age of 7 should not even be a consideration. ***PLEASE ALL CHILDREN WITH AUTISM SHOULD HAVE AFFORDABLE ACCESS TO EFFECTIVE MEDICALLY NECESSARY TREATMENT.*** Please change the waiver 1915i so all Children get the therapy's that they need.

My Husband [REDACTED] and myself like many other new parents started going to ECFE classes with our 2 month old son [REDACTED]. He was in a class of 0-12 months Babies. By the time the six month ages and stages questioner came around to filling it out when [REDACTED] was six months old he was already falling behind. When he was 9 months old the School District which we lived in [REDACTED], MN at the time took us aside and asked if they could do a evaluation for [REDACTED] through ECSE program. We started have the school district come out to our house 1 time a week for 45 minutes which averaged 3 times a month. At [REDACTED] 9 month appointment [REDACTED] Doctor also told us to get him into PT, OT to see if that would help his development Delay that he was in. By 12 months he kept falling behind and Behind. At 15 months we started taking him to a kids therapy program for OT, Speech in [REDACTED]. When [REDACTED] was 16months My husband finally had enough, [REDACTED] was not able to put rings in a bucket which the school district was working on since he was 9 months old, [REDACTED] was swiping food across any table, and [REDACTED] was a runner. He would run Miles down sidewalks and I could not physically hold his hand because he was getting stronger or he would bite me. At [REDACTED] 18 month appointment [REDACTED] doctor diagnosed [REDACTED] as having Autism after conducting a couple of tests on [REDACTED]. She wanted him to be seen at the [REDACTED] Clinic ASAP. She said it would take a few months to get in but try to work on getting some intensive behavioral Health Treatment. At that time I had no idea what that was. The [REDACTED] called 2 months later and since he was so young they wanted to get him in right away for testing and get [REDACTED] going on some other services. When [REDACTED] turned 2 he has a very limited ability to communicate would scream all day long, was overactive and over stimulated, had NO SELF CARE SKILLS and was preoccupied with self-stimulating behaviors (Known as Stimming). [REDACTED] stimming behaviors included mouthing everything, running back and fourth on lines or seems along the floor or ground. [REDACTED] inability to process different sensations made wearing clothes that had tags, raised seems, or too loose fitting a constant annoyance for him and would cause him to scratch himself so much that it interfered with the ability to play and learn. [REDACTED] would scratch himself until he would bleed. [REDACTED] struggled to learn the simplest skills and had no meaningful vocabulary. He would act so aggressively and bite. For example when [REDACTED] went from infant size shoes to toddler shoes we could not get the exact same shoe.

We would be a stride Ride and I would have Bite marks all over my necks, arms, hands, and I would be bleeding just to try to get a new pair of shoes on [REDACTED]. I also held back tears because I didn't understand why it was horrible for [REDACTED] to get a new pair of shoes. I always enjoyed going shoe shopping as a child and for many other normal children it is just the case. Once we started ABA through [REDACTED] in January 2011 we saw almost an immediate change in [REDACTED] behaviors. He learned to sit in a chair with in one month. He was learning how to play with toys and control his urge to put objects in his mouth. His biting decreased significantly and he started to play with people. He was making great gains with full time therapy. Last November 2011 I took [REDACTED] back to Stride ride and I can say I was able to find a pair of boots for the first time in his life that he would accept and wear with no biting or scratching me. I was so excited.

Then in November 2011 [REDACTED] progress slowed do to low hours and no funding. See when we started ABA therapy our [REDACTED] policy picked up all the hours, they would not pay for all of the hours so then we had to apply for MA- Tephra. By December 31.2012 we were do happy to start up Therapy again full time. [REDACTED] during the six weeks he had reduced hours and started regressing in his Independent play skills. Now we are in July of 2012 and we are started to work back up to the 10 minutes of [REDACTED] playing indepently for 10 minutes by himself without any behaviors such as mouthing, biting, or stimming.

The Doctor's and medical community not only recognize the effectiveness of this therapy but recommend it.

In focusing on the uniqueness of Autism it is important not to forget what Autism has in Common with other conditions. Autism is a brain disorder, a condition where genes and environment combine to cause a disability. As Autism shares the same biological ground as other brain disorders, it should share the same legal space in the Affordable Care act. Science can not justify placing behavioral health treatment for Autism outside behavior health treatments for other mental health and & substance abuse disorders. Behavioral Health treatments help to reinforce wanted behaviors and reduce unwanted behaviors. the treatments are critical for individuals affected by Autism, Down Syndrome, and a variety of other disorders. They can help a child communicate and care for themselves: they can help that child from stopping him from hitting himself and those around him, the can enable a child to attend regular education classes, rather then special education classes; they can enable a child to live at home, rather then an institution. All of these alternatives save money in the long run, and this effort to decrease long-term health costs. Effective health is often beyond the reach of individuals on the Autism spectrum.

According to the 2005/2006 National Study of Children with Special needs.

ALL CHILDREN WITH AUTISM SHOULD HAVE AFFORDABLE ACCESS TO EFFECTIVE MEDICALLY NECESSARY CARE FOR AUTISM. DHS SHOULD ACT TO ENSURE THAT BOTH PUBLIC HEALTH CARE PROGRAMS AND PRIVATE INSURANCE COVER TREATMENT FOR AUTISM.

Please change the 1915i waiver SO THAT ALL CHILDREN CAN GET THE THERAPYS THAT THEY NEED. LIMITING TREATMENT SHOULD NOT EVEN BE A CONSIDERATION.

PLEASE DAVID GODFREY and TEAM LOOK AT THE PROPOSAL AND CHANGE HOW MEDICAL ASSISTANCE MA/MA-TEPHRA COVERS AUTISM. I am writing this letter to you today because my Son [REDACTED] is TREMENDOUSLY BENEFITING FROM IEIBT TREATMENT otherwise known as Skills Training.

Thank You for your time today to read this email.

[REDACTED]

You have the patience, the strength and the passion, to achieve your ambitions, your goals and your dreams. All you need to do now, is try.

[REDACTED]

[REDACTED]



Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 10, 2012 9:04 AM
To: *DHS_Reform2020Comments
Subject: Autism Benefit Set Concerns

Hello,

I would like to thank you for the opportunity to allow me to share my story with you, and ask that you please consider the changes that you are about to make to the services that children require MA. My name is [REDACTED], and am the mother of two beautiful daughters, one of whom was diagnosed with autism in January at the age of 2. Watching my happy, smiley baby lose all of her language and expression was horrible. I knew something was wrong, for months, but everyone told me she would catch back up. That was an awful time. After 6 months, when I was finally able to get an appointment with a developmental pediatrician to voice my concerns, and the subsequent testing leading up to the diagnosis was devastating. All of these things helped to shape one of the darkest times in my husband and I's life...but it got even worse. We dealt with the diagnosis, and decided we would do whatever we had to to help our daughter. Then we figured out how hard these families have it.

My husband and I are highly educated, and work long hours at well respected jobs. Our professions allow us to see Autism from both the medical and educational facets that it holds. I work as a nurse at a large hospital in town and have wonderful health insurance. My husband is a full time teacher at a large catholic high school and also carries full health insurance. We soon learned that NONE of the suggested therapies for our daughter would be covered, despite the fact that we were both paying almost \$700 a month in insurance premiums. [REDACTED] would not cover my daughters speech therapy (she is non verbal) because they deemed it to be a habilitative therapy and not a REhabilitative therapy. The ABA therapy that my childs doctor so strongly recommended was also not covered, and in our denial letter, we were told "sorry, we do not cover this service" but were not given any sort of alternatives! She receives speech therapy from the school district, one hour per week, with no more time allowed. That is not enough. These kids need hours of hands on, consistent therapy. The school district has a large case load (in fact our district outsources our child to another district because they do not even offer birth-2 services)

Through my job I see blatant welfare abuse from patients. Patients that know how to work and abuse the system. Patients who have Iphones and fancy purses and clothes, yet insist they need prescriptions for Ibuprofen because they cannot afford it. To save the state money, I suggest the state look into allowing health care providers to report such abuse, and look into how badly the system is taken advantage of in some cases. We are not trying to abuse any system. We are trying to get our children help from the only place we can.

MA through TEFRA has made this therapy possible for us, and my daughter started just over a month ago. We are early in the game, but feel it holds so much promise for her. Please, the system is so broken for our parents. ABA therapy is one of the most studied, and effective forms of treatment for these kids. Please keep it as an option for those of us that have no other options. Autism is devastating enough, we need help and support because this is how the system has been set up. The state allows the insurance companies to deny us coverage, and we have NOWHERE left to go. I don't know when insurance companies gained all of the power, and why the politicians allow it, but we need help! The fact is without these therapies our daughters future will only be a shadow of what it could be. Help to pay for these kids now, or pay for them later as the non productive adults they will become, because of the skills they have not gained. 1 in 88 children, likely to be many of your children and grandchildren over the next few years. The diagnosis is hard enough, please, please don't make this any harder for us!

Thank you so much,

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Monday, July 09, 2012 11:45 PM
To: *DHS_Reform2020Comments
Subject: Minnesota department of Human Services do not cut Autism coverage David Godfrey

Hello -

Please read this email. All Children with Autism should have affordable access to effective, medically necessary care for Autism. DHS should act to ensure that both public Health Care programs and private insurance cover treatment for Autism. I know that DHS has issued a proposal to change how Medical Assistance (MA) covers Autism. Under the Proposal Children who have Autism would be routed into 1915i waiver to access treatment, services, and supports. Early Intervention would be available only to children under the age of 7. Once Children turn 7, children would have to access therapeutic treatment through their public school district. I am writing this because my Great Grandson [REDACTED] is benefiting Tremendously from IEIBT--- My Grandson insurance policy covers a lot of hours for therapy but not all. They have to use MA-Tephra to cover the rest. They could NEVER afford this on their own. My Grandson who is 3 years old is gaining hundreds of skills and improves Daily. Limiting early intervention and putting age limits would be detrimental and shouldn't even be a consideration.

When I was a kid my friends and I would spend all day in the yard, and when we got hot enough we'd run to the back patio, open the water spigot, get down on our hands and knees and open our mouths up for a drink of water that splashed all over our faces. Like me you probably hope for a life that would exceed your dreams, but those dreams collapsed along the way. You simply settled into your routine in a culture of ungrace. That is not a word but it should be. Ungrace pulsates in our offices, communities, schools, homes, and the media and it tells us that regardless of what has happened we must do more!!! We must be better, look better, and make ourselves better. But to love someone regardless of their quirks and mistakes is a breath of hope in a world that turns more upside down than right side up. That is a gift of grace.

At some point, life blindsides us with something, (Autism), Abuse, Foreclosure, disease, unplanned divorce, death, job, loss, or financial collapse that takes our breath and buckles our knees. But isn't there more? We still need to have Joy after the Diagnosis of Autism, and still have hope after day after day or redirecting behavior in hopes that it will get better. With What strength you have left, turn your face up toward the spigot of Grace and let it splash all over you.

A friend of mine shared this story with me and I thought I would share it with you in a Autism point of view. (When I was a kid my friends and I would spend all day in the yard. (In a Autism world my grandson does not understand Friends, and could not be left alone in a backyard with other kids). My grandson is afraid of Water Spigots which is something ABA therapy is going to help him with not to be afraid of Water coming out of a hose, bathtub, sink, a loud toilet flushing in a public bathroom, elevators, loud sounds and the other sensory issue's that my Great Grandson is currently working on. My Grandson is afraid of Water being splashed all over his face. My Grandson and Granddaughter have a tight routine they do with my Great Grandson [REDACTED] and don't have much free time to go off on their own. They love their son [REDACTED] regardless of his quirks and silly things he does each day because he has Autism. They take a deep breath and hope that their world will turn right side up and they will have the medically necessary care needed for [REDACTED]. All of the other things that were mentioned Abuse, Foreclosure, disease, unplanned divorce, Job Loss, and Financial collapse is all things that families with Autism deal with each Day, Month, Year.

PLEASE ALL CHILDREN WITH AUTISM SHOULD HAVE AFFORDABLE ACCESS TO EFFECTIVE MEDICALLY NECESSARY TREATMENT. PLEASE CHANGE THE WAIVER 1915i SO ALL CHILDREN CAN GET THE THERAPY'S that they need. My grandson is No longer a runner, and is making huge gains each day he does his the therapy. Limiting treatment should not even be a consideration. Please David Godfrey and your team please looks at the comments that I am making and other families who deal with Autism on a ongoing basis as well.

Thank You



Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Monday, July 09, 2012 3:11 PM
To: *DHS_Reform2020Comments
Subject: DHS changes to autism care

Dear Mr. Gregory,

I am unable to be at the July 11th meeting where Reform2020 issues related to services for children with autism is being held. But I did want to inform you of my thoughts and observations.

Our dearest friends have a grandchild who was diagnosed at age 2 and a half with autism just this last spring. He is currently enrolled at the [REDACTED]. The strides he has made have been remarkable to me--where there was NO eye contact, now there is a great deal of it. He is beginning to learn sign language, and has developed some ability to repeat words. The changes in just a few months seem nearly miraculous to those of us who know this sweet little guy! And we know the early intervention has been an extremely important part of that.

I am a retired nurse, and know that funding in these times is so critical, and everyone has the desire for funding for their "pet" issue. Considering the huge and alarming increase in the numbers of children with autism in the last 20 years, it truly seems crucial to me that we as a society find a way to serve these children and give them the chance to be able to join the "mainstream" by virtue of early and intense intervention.

Thus, I am writing to ask that DHS allow choices in services for these families in need, and for as much funding as possible to support these families who want nothing more than an opportunity for their children to thrive and learn, and one day, to be very productive members of our society. To leave them behind would be a travesty.

Sincerely,

[REDACTED]

--

"A settled plan to deprive the people of all the benefits, blessings, and ends of the contract, to subvert the fundamentals of the constitution, to deprive them of all share in making and executing laws, will justify a revolution."

John Adams, Novanglus Papers, 1774

Dooley, Lea M (DHS)

From: Adella Usher <arusher1@comcast.net>
Sent: Monday, July 09, 2012 1:18 PM
To: *DHS_Reform2020Comments
Subject: Autism Coverage

I support that the DHS proposal be revised to reflect Reggie Wagner's June 22 statement. If DHS does not intend to reduce coverage for treatment, services and supports for children who have autism, then they should say so in writing. The MA reform proposal should be rewritten to clarify that there will be NO REDUCTION in MA coverage for children in Minnesota.

Adele Usher

Dooley, Lea M (DHS)

From: Mary Richards <richards.mej@gmail.com>
Sent: Sunday, July 08, 2012 11:23 AM
To: *DHS_Reform2020Comments
Subject: Autism coverage suport

I support that the DHS proposal be revised to reflect Reggie Wagner's June 22 statement. If DHS does not intend to reduce coverage for treatment, services and supports for children who have autism, then they should say so in writing. The MA reform proposal should be rewritten to clarify that there will be **NO REDUCTION** in MA coverage for children in Minnesota.

Mary Richards
13502 Postier Dr.
Oronoco MN 55960



July 6, 2012

To: Alex Bartolic, Director of Disability Services
Reggie Wagner, Deputy Direct of Chemical and Mental Health Services
Jean Wood, Director of Aging and Adult Services

Re: Reform 2020 – Home and Community Based Services Redesign

Dear Alex, Reggie, and Jean,

The executive council of the Minnesota Northland Association for Behavior Analysis (MNABA) has reviewed the proposed redesign of Home and Community Based Services (HCBS) and would like to offer our comments and suggestions. The Minnesota Northland Association for Behavior Analysis is an organization of practitioners, academicians, and others who use Applied Behavior Analysis (ABA) as an evidence-based foundation for data-driven assessment and intervention practices. Our members use ABA in many professional arenas (ranging from weight loss programs to family therapy) but in this response we draw on our collective experience in the treatment of developmental and mental health disorders. Indeed, in recent years, ABA therapy has been primarily associated with our approach to comprehensive early intervention for children with autism and positive behavior support [PBS] for people with a range of developmental and mental health disorders.

In our review we identified three general themes: 1) strong ideas and opportunities for moving the state forward in its capacity to provide high-quality outcomes for people with developmental and mental health disorders, 2) gaps that risk leaving people underserved, and 3) potential roles for MNABA and our constituents to embrace the opportunities and help to fill the gaps. We address strengths, gaps, and potential roles for MNABA in each of the sections below (in parallel with the sections of the draft reforms and the powerpoint presentation to the HCBS Partners Panel on June 18, 2012).

Overall

Strengths:

- Values and vision: flexible and responsive services in support of a meaningful life for each person.
- Emphasis on treating functional impairment rather than disability categories.
- Focus on outcomes vs. process
- Promotion of person-centered planning

Gaps:

- The emphasis on improved outcomes is excellent but should not be limited to those who currently have high costs and cross-systems needs that are not well managed (as currently written). We are hopeful that the waiver will serve as a pilot and will be extended across the HCBS system.



- Limited reference to the necessary empowerment of natural/incumbent support systems to assist each individual in reaching their goals within a meaningful life at home and in the community. People with significant needs who succeed using HCBS funding do so in part because their support systems are adequately trained and empowered to meet the needs and provide an environment that promotes development toward identified goals.
- References to person-centered planning (PCP) are throughout the document with no specifics on current best-practices in PCP, who would be responsible for conducting the PCP, and what qualifications the person would need to demonstrate to be considered qualified to conduct a PCP and support the stakeholder group to carry the plan forward. In other words, meat needs to be on the bones put forth in this proposal. This is concerning because of the assumption held by many practitioners that they subscribe to/practice person-centered principles and practices when in fact their work is far from best-practice in this area. It is unclear whether the PCP components of the MnCHOICES assessment are consistent with current best practice in PCP.

Roles for MNABA:

- Promoting and serving as a resource in the development of flexible and responsive services. ABA providers are prototypes for the translation of this value and vision into measurable outcomes through individualized, tailored treatments for each person, and responsive, frequent data-driven adjustments to supporting progress towards the meaningful life they and their stakeholders identify.
- Promoting and serving as a resource for treating functional impairment vs. diagnosis. Applied Behavior Analysis is a non-categorical approach, so this emphasis is consistent with our assessment and intervention methods.
- Provide leadership in the establishment of individualized data collection and tracking, as well as formative and summative data analysis for decision-making. We are among the standard-bearers for individualized quantitative service outcomes and laud the suggested reforms in this area.
- Together with our constituents we can work with the state and individual providers to integrate ABA technology into person-centered plans. ABA-based interventions occur within person-centered planning approaches as a behavior change technology to support people with complex needs to reach their dreams and visions. For people with significant challenges, person-centered planning is necessary but often insufficient to achieve the life they've articulated.
- Offer trainings in ABA-based mediator models of service delivery. ABA-based interventions, especially our mediator models of service delivery (e.g., caregiver training) are designed to be high-impact and minimize cost. These models are collaborative and result in sustainable skill sets for caregivers and a high level of contextual fit.
- Provide leadership in the establishment of individualized data collection and tracking, as well as formative and summative data analysis for decision-making. The detailed formative data gathered in the context of ABA-based services allow providers and caregivers to make necessary and appropriate clinical adjustments very quickly, and our summative data allow for accountable outcomes for consumers, funders, and other stakeholders. Our ongoing use of observable, quantitative behavioral data allows caregivers to effectively communicate about key needs and



the impacts of interventions across all of a person's providers, which enhances the efficiency of the use of Long Term Services and Supports resources.

Demonstration Project: Reform Personal Assistance Services

Strengths:

- Emphasis on the skills of teaching, coaching, and prompting
- Support plans will align services with goals, outcomes include skill gains
- Scaffold towards self direction of services
- Emphasis on high-impact services and decreased reliance on costly services

Gaps:

- No articulation of the professional competencies and continuing education requirements of people hired to provide CFSS. People with complex needs require providers with specialized skill sets – it is unlikely that better service coordination for people with complex needs will result in better outcomes, only better service coordination.
- No reference to mediator models (training caregivers to provide ongoing behavioral support) of service delivery to achieve sustainable outcomes through incumbent supports (rather than ongoing costly services)

Roles for MNABA:

- Provide training for people providing direct behavioral support via CFSS. These people must achieve a minimum level of competence in behaviorally-based interventions in order to be effective. Indeed, without a minimum level of competency a well-meaning individual providing CFSS may unknowingly exacerbate the very problems he or she was hired to manage. Two national organizations have outlined standards for practice for direct support professionals (likely the class of professional who would be a CFSS provider in Minnesota: the National Association for the Dually Diagnosed (NADD) and the National Alliance for Direct Support Professionals (NADSP). Both organizations emphasize a minimum level of competence in positive behavior support and list competencies. In addition to requiring a nationally-recognized credential for direct support professionals involved in CFSS, the State of Minnesota should leverage the expertise available through MNABA and its constituents to provide additional training and competency evaluations for CFSS providers.
- In addition, well-trained CFSS providers should be required to consistently improve upon their skill sets, as in other professional disciplines. The expectations of this class of professional should be high. The Minnesota Northland Association for Behavior Analysis and its constituents should be leveraged as a helpful source for continuing education for these providers.

Demonstration Project: Innovative Approaches to Service Coordination

Strengths:

- Coordinating care across environments will create consistency for the child and ensure systematic communication between providers, parents, and school.



- Systematic coordination for the transition of effective practices from early intervention context into the school building which would lead to better outcomes

Gaps:

- It is unclear how schools will interface with ABA-based providers and incorporate effective ABA-based treatment methods into their practices. Despite statewide adoption of Positive Behavior Interventions and Supports, and demonstrated efficacy of ABA with individual students, schools have historically not adopted ABA-based procedures. A true coordination model must clarify the steps and roles for the transfer and maintenance of effective practices, incorporating the effective form and dose of ABA-based treatment into the school building.
- The role of the parent is not clearly defined. The parent must be empowered as a decision-maker in this model in order for maximum impact.

Roles for MNABA:

- Provide inservice training and technical assistance to districts participating in this demonstration program on application of ABA. The Minnesota Northland Association for Behavior Analysis has a productive working relationship with the Minnesota Department of Education's Positive Behavior Interventions and Supports team which could be leveraged here. The Minnesota Northland Association for Behavior Analysis should be part of the feedback loop in this demonstration project that will inform mental health professionals about the role of home and community supports in classroom success.
- Provide in-service training and technical assistance to districts participating in this demonstration project on data collection and evaluation tools that assist in communicating about behavior between home, community, and school settings. Empowering the parent as a data collector and competent communicator about the child's performance at home and in the community enables more productive contributions around the IEP table, to allow parents to communicate effectively with the professional team.

Demonstration Project: Empower and Encourage Independence through Employment Supports

Strengths:

- Focus on building independence and stability in community-based employment

Gaps:

- No reference to the ongoing problem of people with mental illness + intellectual/developmental disability languishing in sheltered workshops, and the need to employ these people meaningfully in the community at jobs consistent with their interests and skill sets.

Roles for MNABA:

- Training and technical assistance for provider partners in this demonstration project to design sufficient behavioral supports for competent job performance in a preferred/meaningful community position, especially for the most behaviorally-challenging individuals.



Demonstration Project: Anoka Metro Regional Treatment Center

Strengths:

- Articulation of the necessity to arrange the home/community environment to better support the person after transition from AMRTC treatment (i.e., the person will not be ‘fixed’ at AMRTC and return home and function successfully).

Gaps:

- No intentional connection between this initiative and the person-centered positive behavioral supports emphasis described among the values and vision of the reforms
- No description of the challenges inherent in consistent implementation and evaluation of multiple treatment modalities (medication, counseling, behavioral supports, etc)

Roles for MNABA:

- Together with our constituents, we can provide training and technical assistance to AMRTC administration and clinical leadership, community-based provider partners, and county human services in:
 - o Person-centered PBS addressing challenging behavior and instructional technology to address skill deficits
 - o Establishing behavioral baseline data to evaluate the individual and combined effects of multiple treatment modalities/multi or inter-disciplinary treatment. Applied Behavior Analysts are uniquely positioned to leverage the strength of single-subject experimental design in treatment evaluation.

1915(i) Waiver for Children with Autism Spectrum Disorders

Strengths:

- Functional impairments in pivotal developmental skills primary criteria for access to services
- Focus on evidence based practice and Response to Intervention (RTI) approach to outcomes monitoring
- Focus on comprehensive interventions that address core impairments in ASD.

Gaps:

- Current language creates grey areas that could result in services being denied
 - o E.g. “department may initially propose benefit and service utilization criteria...and **will consider** amending...**if changes are deemed necessary...**” Does this refer to client-by-client benefits/utilization or by overall service-type benefits/utilization?
 - o How will early access to services be ensured? Currently, most referrals come from physicians and psychologists who provide early diagnostic services.
 - o Will coordination and non-categorical emphasis be codified to allow or require special education based early childhood services to incorporate empirically-supported services, such as ABA, when sufficient outcomes are not being produced?
 - o Age specific language (e.g., references to age 7, and 0-7) has a potential to be interpreted as an age cap and conflicts with person centered treatment approach advocated in the



introduction. Some children show therapeutic gains in early intervention but continue to require additional years of support to achieve functional communication. Many of these children display a constellation of mental health concerns that rises to the level of a “serious and persistent mental illness” and should receive the array of services to address such (as discussed in section 9.1.4). The waiver must clearly state children over the age of 7 may continue to receive medically necessary mental health services as long as their symptoms require.

- It is unclear whether the waiver will fund medically-necessary services for doses (i.e., hours per week) determined by mental health professionals, or arbitrary dollar caps will be set.
- Section 9.1.3 Schools serving as primary case managers
 - School special education services are not overseen by DHS except where districts are billing mental health services. If schools are to become the primary case managers for both educational and mental health services, how will DHS ensure compliance with evidence based standards statewide in school settings? The current language “...would generally be included in the child’s IEP and **could be informed by...**” suggests that mental health providers will be held to evidence-based methods and to produce outcomes, but the school programs are only ‘informed by’ evidence based practices.
 - School based services currently often rely heavily on both non evidence supported practices (e.g. sensory integration treatments) and contraindicated intervention protocols (e.g. restraint and seclusionary time out). It is unclear how better (and positive) evidence-based mental health practices will be driven into the school system.
 - Unclear whether ABA providers be reimbursed for coordination time with school teams (e.g. IEP meetings, assessing school contexts)
 - School staff are not trained to provide psychological or behavior analysis services to children.
 - Revisions to IEP requirements have continued to de-emphasize specific behavioral goals and data tracking toward these goals.
 - Identification and assessment procedures differ as well as terminology between educational and mental health arenas.
 - Unclear how will DHS train and supervise IEP goals that involve mental health aspects?

Roles for MNABA:

- Training DHS staff to evaluate ABA outcome measures. Since many ABA providers are cross trained in educational psychology programs, MNABA can help bridge educational and psychological service delivery systems.
- Consulting with DHS on indicators of quality programming and provider standards
- Developing specific language to ensure continuity of care and that implementation remains consistent with stated aims of waiver.



- Workforce development and outreach to create access to treatment in underserved populations and geographic areas.

Provider Standards

Strengths:

- Recognized need to protect the public by articulating professional standards for qualified and competent practice in a way that would protect the public.

Gaps:

- The language used in this section of the proposal indicates a movement towards specification of criteria for competent practice with respect to diagnosis rather than functional impairment, which is inconsistent with the stated objectives of these reforms in other sections of the document.

Roles for MNABA:

- Provide training and technical assistance in the non-categorical application of behavior analysis and positive behavior supports for specific functional and behavioral impairments of people with developmental and mental health disorders regardless of diagnostic category.

Crisis Intervention and Protection of Vulnerable Adults

Strengths:

- Recognized need to improve competence and quality of services for adults living in the community who experience behavioral crises.

Gaps:

- There is a missed opportunity here to articulate the need for improved Positive Behavior Support (PBS) for people with a history of challenging behavior to avert the need for crisis services, and the need for providers who serve adults who experience behavioral crises to receive additional training and technical assistance from experts in PBS and/or ABA.
- The term ‘positive behavior training’ used in this section is not specific to any recognized professional discipline such as PBS or ABA. The language should be improved to reflect the need for DHS and provider agencies to leverage the available expertise in PBS and ABA in the state.

Roles for MNABA:

- Together with our constituents, we can provide training and technical assistance to agencies serving adults with a history of challenging behavior (and to those who encounter the need for crisis services, in order to improve their capacity to better proactively serve the needs of their consumers in the future so crisis services are required less frequently).

In summary, MNABA sees the proposed reforms as a set of ambitious and important goals that have the potential to create great positive change for the people that our constituents serve. The data-based intervention practices and processes of Applied Behavior Analysis (and Positive Behavior Support – an increasingly common framework within which ABA is applied) offer a unique perspective and resource for translating these goals into reality. Our evidence base demonstrates the power of ABA practices to generate extraordinary outcomes across categorical and diagnostic lines. Using formative data evaluation



to guide interventions allows Behavior Analysts to create individualize and highly successful interventions that can evolve with client needs and preferences across the lifespan. The Minnesota Northland Association for Behavior Analysis is pleased to see that the waiver sets many routine operating practices of Behavior Analysts (including and especially the use of rigorous outcome data as the primary indicator of good practice) as goals for the HCBS waiver system. We are looking forward to working in partnership with DHS to do the difficult work of creating better outcomes for people in Minnesota.

On behalf of the MNABA Executive Council,

Timothy R. Moore, PhD, LP, BCBA-D
MNABA President
tmoore@mnaba.org

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, July 05, 2012 9:13 PM
To: *DHS_Reform2020Comments
Subject: Remove age cap for autism services

Dear Mr. Godfrey:

Autism is a neurological disorder, not just an educational label. My son [REDACTED] has a medical diagnosis of autism; as such he deserves medically necessary care. However, since he is 7 the MA reforms proposed by DHS would prevent him from receiving the daily therapy that helps him progress.

Each child with autism is unique and there is no magic age when a child will be ready to transition to a school setting. My husband and I are both public school teachers. While we work and live in exceptional school districts, we know first-hand that no school can match the intensive therapy [REDACTED] currently gets. Public schools are constantly asked to do more with less funding. As such, schools may lack a program developed especially for children with autism. Para-professionals—the aides who spend the most time with our children—often lack the training and resources to provide more than “babysitting” for high needs kids.

At [REDACTED]—an applied behavioral analysis center—[REDACTED] works one on one with a highly trained therapist. For 8 hours each day, he receives programs tailored just his needs. They work on speech, play skills, and behavior. [REDACTED] continues to make progress, but is in no way ready to a “typical” school.

[REDACTED] is not potty trained, speaks only in single words, and has a feeding tube. He lacks social skills, has low understanding of spoken language and regularly engages in self-stimulating behavior which makes it nearly impossible for him to stay focused on a task. It is his functional level, not his age, which should determine the level of services covered by medical assistance.

One behalf of [REDACTED]—and all his school aged peers receiving ABA therapy—I urge you to remove the age cap for autism treatment.

Sincerely,
[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Tuesday, July 03, 2012 2:46 PM
To: *DHS_Reform2020Comments
Subject: Autism Reform

Hi,

I am a parent to a sweet and loving 3 ½ son with autism. He is currently receiving IEFT therapy and has benefited greatly from it. I hope that he will one day be able to go to school full time and excel in his mainstream classes, but that may not be the case. All I know is that I can see the changes in my son that he is making from receiving this therapy and I want to give him the opportunity to be the best person he can be. I believe this therapy is what is going to help him the most and do not want to see that option taken away once he turns 7. I would be more than happy to stop the therapy if we no longer thought it was necessary. No parent wants to have their kid in therapy. They want their kids to be out playing, but that is not a reality for us or many parents of children with autism. Autism is hard enough to deal with knowing that you are getting the best services you can get for your children. Having to worry about how you will pay for those services is more than I can take. Please help us help our children. Thank you.

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Monday, July 02, 2012 10:31 AM
To: *DHS_Reform2020Comments
Subject: PLEASE READ!
Attachments: DSCN1043.JPG

Hello David Godfrey, Medical Director

I would like to comment on the MA Autism Proposal as this affects our 8 year old son [REDACTED] with Autism.

Our son [REDACTED] was diagnosed at age 3 years old we did aggressive early intervention of ABA therapy, OT, PT, Speech and Special Diet and supplements. We have tried many things and most successful for him. We promised him we would do everything in our power to heal him as long as it didn't hurt him. [REDACTED] has gone from being severely autistic on the spectrum (not looking, not talking to only echolalia speech for two year) to now a high functioning boy with ASD. He can now look at us, talk to us and communicate most times which is a huge improvement. As parents, we both work but one of us has had to work part-time in order to get all the necessary treatments done for [REDACTED]. We are on medical assistance to help us meet the needs of our son. Without it he would go right back to being barely functional as we did have to stop therapies for awhile when he was not covered by MA and he regressed severely. The school system will not provide all the things necessary for [REDACTED] to remain high functioning as we have been fighting that battle the last (3) years since the medical diagnosis and educational diagnosis are different definitions they feel they don't have to cover things like social skills groups, speech, math help, etc unless they are at least 2-3 years behind grade level. This is not acceptable. A couple key points to make:

- ALL children enrolled in Medical Assistance are entitled to coverage for medically necessary treatment prescribed by their treating clinician.
- Coverage for health care should be based on medical necessity not age and early intervention is important but keeping them functioning is just as important.
- If a treatment is evidence-based – such as intensive early intervention behavior therapy or ABA applied behavior analysis, then it should be included in the “Autism benefit set” with no age restriction.
- If a treatment is a generally accepted practice, like “social skills therapy” then it should be included in the “Autism benefit set” again with no age restriction.
- Treatments, supports and services should be based NEED, NOT AGE.
- Treatments, supports and services should be based on need, not LABELS
- Children who have autism need choices for different treatments, as well as choices for different providers
- Don't limit school-age children to receiving treatment from ONLY schools – they will end up getting NO help.
- Yes! Please do look at outcome measures – in fact, please look at them NOW — before you make long lasting policy decisions about what types of treatments to cover!
- DHS should provide formal opportunities for members of the autism community to provide input before finalizing policy changes! Specifically, DHS should obtain input from the health care professional who treat individuals who have autism! DHS should also hear from individuals on the spectrum and their friends and family.

Our son has benefitted greatly from continued ABA therapy and Stanley Jones Speech and OT and social skills group that the schools will not provide. Please consider our son and other families in the long run if these children do not get the services they need it will cost our society MORE in care as they go from being self sufficient to needing Personal Care facilities when they fail to perform basic skills due to lack of services and funding and this WILL HAPPEN under your new proposed guidelines.

Thank you for listening and helping our children heal and live the best life we can give them ~ They deserve that!

Sincerely ,



To Whom It May Concern,

I am writing you to educate you on the improvement our family has seen in our four year old son [REDACTED] thanks to the ABA therapy he receives through [REDACTED]. My name is [REDACTED] and I am the mother of [REDACTED] who has been diagnosed with autism. For a parent to hear the words, "Your son has autism" is a very difficult thing. As a parent, we have a belief that our child will be able to achieve anything they want, and to hear your child has autism crushes all the dreams you have for your child. Thanks to ABA therapy, we now see a future for our son full of **HOPE!**

We started receiving ABA therapy, after searching for a program that had openings for 4 months, in December of 2010 when [REDACTED] was 3 ½ years old and have seen a huge change in our son in this time. We wanted to work with a program that is in-home in comparison to center-based because we wanted to be extremely involved in the hands-on care of our son. Thanks to the ABA therapy, my son is learning! He is able to communicate his wants and needs through the use of gestures and is less frustrated and irritable than previously! He points to body parts upon request, is able to match identical pictures, points to things to show us what he wants, taps our shoulder to get our attention, and UNDERSTANDS more and more language all of the time. He is also able to follow simple instructions such as put your coat on, sit down, and put that here. He is also beginning to play with toys in an appropriate manner and has fewer repetitive behaviors! Our daughter just turned 3 and thanks to ABA, our two children are beginning to play together! The smile on my son's face when he first understands a new program that they are teaching him is quite contagious. He is so proud of himself when he finally "gets it" and encourages me to once again dream big dreams for my son. He is finally **LEARNING HOW TO LEARN** and is beginning to understand the world around him. Our family is a much happier family than we were before! Because of his increased understanding of language and directions, we are able to go on more family outings such as boating, waterparks and the children's museum. Without these essential services, I cannot imagine where we would be today. [REDACTED] does participate in an Early Childhood Special Education program through our local school district, but we have found that program to be extremely inadequate in helping [REDACTED] improve.

Fortunately his speech therapist and teacher from the school came to observe an ABA session one day and were AMAZED at how much he actually COULD do. His teacher commented on how she was going to reframe the way she worked with [REDACTED] after seeing how he was successfully performing during ABA therapy. [REDACTED] can be amazingly intelligent yet struggles with daily living. We finally see a future for our son that is filled with great hope that he will be successful in life and accomplish great things! I know that we are setting a strong foundation for our son that will allow him to be successful and happy in the future.

I urge you to continue to support ABA therapy. This is a crucial service for our children and one that brings great rewards with it. To invest in programs that help our future generation be healthy, happy, independent from their parents, and most importantly successful in life is money well spent!

You are welcome to visit our home for a hands-on look at the differences ABA therapy brings at any time, please give me a call at [REDACTED] with any additional questions or to schedule a visit. Thank you for your time.

[REDACTED]

[REDACTED] [REDACTED] [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Monday, June 25, 2012 1:33 PM
To: *DHS_Reform2020Comments
Subject: autism and MA reform 2020 parent comments

Dear Legislators,

I have two boys on the spectrum, they are ages 6 and 11 years.

My youngest, [REDACTED], has been receiving ABA intervention for the last 18 months. He continues to make great progress under the care of his ABA providers. He also receives speech, OT, audiology and vision care on a regular basis. He has been served in the school system since his birth.

My 11 year old son, [REDACTED], is receiving ABA intervention this summer to address some social and pragmatic language skills that were not being sufficiently addressed within school hours and through weekly clinically based speech services.

Both are covered by an employer insurance plan and by MA through TEFRA. In addition, their developmental problems qualified them for additional services through a consumer support grant. We have used these funds for additional services and supplies including music therapy, respite, teaching materials, and computerized educational interventions, to name a few.

My concern about this new model of delivering MA is that it seems to be a plan to do the opposite of what you are suggesting your goals are. I believe that this plan will reduce access to medical services and that it will create a new bureaucracy that will slow down the process and increase waste of time and money. I see it as a potential barrier to having their needs met.

I don't think medical services should be accessed through an IEP. I have problems with age being a factor in determining the level of support to be offered and I have a problem with having no choice over who is delivering medical services to my child.

My experience with school systems in general is that as a stand-alone treatment for autism it has not proven to be especially effective or efficient for our kids, nor are they in any way prepared to handle this proposed additional responsibility.

There are many problems with assuming school personnel can somehow manage the medical needs of autism children. The school system was designed to teach able bodied children a high level of academic and cognitive functioning. It has been deemed necessary to deliver at least 6 hours of instruction daily to accomplish this. The needs of disabled children have been patch-worked into this system. Individualized special services delivered in schools are designed to support the academic needs of the child. This is what school systems are prepared to handle. (For my boys the school OT works on handwriting and the Speech Pathologist works on vocabulary). A therapist working in a clinic has the task of aiding a child to be able to function in any environment and throughout their entire lives (for my boys this is dressing and eating with the OT and simple conversation skills with the Speech Pathologist). They have been asked to coordinate their services with school, but as a parent I see the need to have the service providers divide and conquer. The schools and clinics serve different functions and this is not an overlap in services. Our children will exit the school system at no later than 21 years of age. They will be expected to communicate and care for themselves for 60 years

more. Merging these services into a school building may seem efficient, but are you ready to provide the needed physical space and extend their school day to provide medical services?

- a. It has been my experience that case managers at school have a full schedule. Often when IEP negotiations fail and the staff needs to address these concerns, the student services drop out for all the children served by the IEP staff while meetings take place. It seems an unnecessary additional burden to the system to ask for them to add medical services to the discussions.

Also, IEP's right now can take *months* to revise and several meetings to meet with the current legal requirements of satisfying all the parties involved. The IEP process is designed to safeguard parents' rights to advocate for the needs of the children, but the process can cause lengthy delays in school supplied services, even if you follow the law to the letter. Under the current model of service, medical services can begin, stop or change without group consensus. If the IEP process is to include medical services, the child could go without medically necessary services for months.

- c. IEP staff are not medical staff and though many professions overlap the medical industry, medical services are not well supplied during a school day. Schools after all need to teach academic skills during the limited number of hours that children are at school. You suggest that this new model will ensure an expansion of ABA therapy, but I think it's misguided to think that an IEP team would add it to a student's service plan. School staff in general are not terribly supportive of rote memorization nor of rewards for learning which is considered mandatory for most ABA models. Most school staff personnel have very limited training in behavioral approaches and are not well versed in integrating the techniques. The strategies are not what they learned through their professional development and are often in conflict with what they "know." It would be in conflict with many education trained staff to admit that a behavioral approach is a better model for any but the most impaired. School districts would not dispense ABA therapy in a reliable manner. They are not prepared to handle this change in how we serve our children.

If the purpose is for increased use of medically sound interventions, like ABA I suggest that, rather than creating barriers to ABA by inserting an uninformed gatekeeper, you could consider expanding ABA services by providing facilities or other cost saving or incentive programs to entice providers to serving in outlying communities. Also, getting the word out to parents is critical. Pediatricians and school staff should be identifying and suggesting to parents that they seek ABA services for their patients and students who need them. ABA services can be very helpful in getting a child started and learning ready. I have witnessed many many school staff struggling with preschoolers who cannot sit in a chair or attend to the teacher. A worthy goal for the entire community serving children with autism would be to prevent children on the spectrum from reaching age 5 without a means of communication. ABA would be a good beginner's intervention for many. In addition, parents need more training in specific strategies to increase their child's functioning. I've been to school based parent training which provided a lot of vague generalities, expounding the latest theory in child development, and had a parent ask at the end of the session "who is going to tell me how I can help my child?" Our teachers are not prepared to adapt what they have learned for a parent/child interaction and how to train adults. All of the parent training sessions have mostly focused on accepting your child and learning how important it is to play with your child. Nice, but not as useful as teaching your child what "block" or "doll" means or how to say "I have to go potty". It takes a village to achieve lasting results; quality school interventions, informed and involved parents, and carefully chosen medical services. Both educational and medical service models are important pieces to getting our kids from dysfunctional child to functional adult. I suggest that parent

training be a community project. A rotation of medical personnel from various service providers could provide much needed content.

F

I have a problem with allocating services based upon age. My youngest was an early preemie and though he received various medical services for all of his early life, he didn't receive professional ABA therapy until he was diagnosed with autism at age 4 and a half. To arbitrarily cut off medically delivered services to [REDACTED] at age 7 would create unnecessary delays to his last few months of needed treatment. It could be detrimental to his continued development. In addition, to deny or limit access to ABA therapy for my 11 year old would be tragic. School interventions have not been successful in increasing his social skills to the point that most children accept him as a friend, and yet nobody suggests that the school services that are not evidence based be discontinued. Accountability is in the details, [REDACTED] clearly benefits from periodic episodes of behavioral based therapy. My older son is friends with a boy who, though he received special education services since he was 3 years old, had no language until he started ABA services at age 8 years. He had been on waiting lists for 5 years. His parents decided to drive him 90 minutes daily to a clinical based ABA provider, and after 2 years of ABA he became fully verbal and a fairly good conversationalist! I have seen many children in the waiting room of an ABA provider who are in the same situation he was 2 years ago. Under the new model of service delivery these school aged children would likely never be able to communicate their needs.

Removing provider choice from the family is a bad approach to controlling costs. During my 8 years of learning about and treating autism I learned that who you choose to treat your child can have a profound impact on their learning. We, as parents have all shared stories about medical or school personnel who have been ineffective and entirely off-base in their approaches for our kids. To reduce the negative impact of a poor choice in providers, it would be helpful for parents of newly diagnosed parents to have training in how to determine if a provider is a good fit for the family, how to monitor progress, and how to end a bad relationship in a timely manner.

I understand some have concerns about duplicate testing for children on the spectrum since they are tested to access school services and to access medical services. I have my children seen at the [REDACTED] specialty clinic once every 2 years for a solid testing of IQ, language and other skills. It is important to have access to an opinion from people not involved in the treatment and from people who have a good grasp on what services are offered in the community. The [REDACTED] staff fills the bill on this. They make evidence based recommendations, and as a parent I choose what we can afford and what our priorities are. This medical testing and recommendation list is also shared with the school IEP team so they can learn more about how best to serve my boys at school. The school system has to read it and that is all. So which testing is duplicated? In our case almost none. The only instance that the same test was administered more than one time in a year is when BCBS required it for continuation of ABA services every 6 months.

Please rethink this MA delivery proposal for children with autism. I think that if the current systems did a better job of training parents to select the right services for their child, to spot deficiencies in treatment providers, as well as deliver important skills training to their own children, we would have better results. Training parents to become better case managers would cost less than having a case manager take over the decision making process and save money today and every day into the future, not by reducing needed services, by reducing service needs of school aged children and eventually with the adults born with autism spectrum disorder.

Sincerely,

[REDACTED]

Schels, Johanna T (DHS)

From: [REDACTED]
Sent: Thursday, June 21, 2012 10:48 PM
To: *DHS_Reform2020Comments
Cc: [REDACTED]
Subject: DHS Proposed "Autism Benefit Set"

It has been brought to our attention that the Department of Public Health Services is proposing that therapeutic services for the treatment of behaviors associated with Autism be terminated at age 7. The proposal indicates that those services would then become the responsibility of the public school systems. We as parents of a 13 year old non-verbal child with Autism have concerns with the proposed changes. We thought that you should consider our story as you assess this proposal.

Our son [REDACTED] started to lose his ability to communicate verbally when he was 2. Before reaching his 3rd birthday he was completely non-verbal and he was diagnosed with Autism. We enrolled him in early childhood programs through our school district and a program for children with Autism at the [REDACTED]. Through these programs he made progress in the areas of early academics, occupational therapy, and behavior control. At age 7, the [REDACTED] no longer had a program for him and we enrolled him full time in the special needs program of our local school district. Our local school district has done a reasonably good job with [REDACTED] in the areas academics and occupational therapies. Where the local schools have failed in our eyes is in the areas of communication and behavior management. They are not adequately funded or trained to address the daily difficulties that these students face. It has long been our contention that [REDACTED] most important needs are communication and behavioral therapies yet he only receives two direct ½ hour sessions with a professional communications therapist weekly. Behavior therapy is nonexistent in the school special needs program.

[REDACTED] behaviors have ranged from violently hitting himself in the head to biting himself to soiling his pants in protest to avoid undesirable activities. When [REDACTED] has had behavior issues at school the typical solution is to call us or send us a note and ask how they should deal with the issues. Unfortunately we are no more experts in the world of behavior therapy than the team at the local school. This lack of expertise in these areas has lead to considerable frustration for all parties and especially for [REDACTED].

We managed to get by for a number of years doing the best we could to deal with [REDACTED] problems as they arose. Around [REDACTED] 12th birthday there was a sudden and dramatic change in him for the worse. [REDACTED] had reached puberty. His inappropriate and self injurious behaviors had escalated to levels that were not manageable in the home or at school. We began to wonder if we would be able to continue to care for him. After a couple of extremely frustrating months we pulled [REDACTED] out of school after ½ of each day was completed and began 1:1 sessions for 25 hours per week in our home with therapists from [REDACTED]. The resulting turnaround has been astounding. He is doing things now that he has never done before. His behaviors at home, at school, and in the community have shown dramatic improvement.

The proposal to put the onus for providing these necessary therapies on the schools will be a complete disaster for many students and their families. We can tell you that if behavior therapy is treated and funded in a similar manner as speech therapy in the schools, the two ½ hour sessions weekly will not be remotely adequate for children like [REDACTED]. Not every child on the Autism spectrum or in the special needs programs requires a comparable level of therapy to [REDACTED]. His case is extreme. It is not reasonable to hire full time professionals in each and every school special needs program to

work with these kids for the number of hours that is required. The fact of the matter is that the schools will not and cannot provide adequate services for children like [REDACTED]. Just because there is a desire to save money does not mean that these children of extreme special need should not get appropriate and meaningful treatment simply because they have passed by their 7th birthday.

Thank you for your consideration. Please feel free to contact us if you have any questions.

Regards,

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Dooley, Lea M (DHS)

From: Charles Oakes <Charlie@wciservices.org>
Sent: Thursday, June 21, 2012 9:54 AM
To: *DHS_Reform2020Comments
Cc: MN DACA
Subject: Comments from Charles N. Oakes

The Reform2020 proposal for Waivered Services employment reform is too vague to inform and it makes no mention of current vocational programs that are operated as either Day Training and Habilitation programs or Community Rehabilitation programs. Both of those models are licensed nonprofit corporations that have provided the vast majority of successful work, job placement, and community integration in Minnesota for the last 40-50 years, yet they are not even mentioned in the employment reform recommendation. It is as if the Department of Human Services independently waves a magic wand to create employment for people with chronic disabilities. To completely ignore the partnership with the organizations that actually perform the work, the nonprofit providers that actually produce the positive outcomes is both insulting and, unfortunately, also traditional rude behavior by MN DHS.

Sincerely,

Charles N. Oakes, CEO

WCI JobLink

1300 22nd Street SW

PO Box 813

Willmar, MN 56201-0813

Phone 320-235-5310 Ext 203

www.westcentralindustries.com

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Dooley, Lea M (DHS)

From: Pfannenstein, Margee (DEED)
Sent: Wednesday, June 20, 2012 12:30 PM
To: *DHS_Reform2020Comments
Subject: Referral to Services for the Blind - before reinforcing complete dependence on support services that are costly and create candidates for assisted living or nursing home care.

In the past year, as a Senior Service Career Rehabilitation Counselor with Services for the Blind, several referrals of persons who are middle-aged (40-55) have been received by DHS. These referrals were received long after the blindness had occurred . Support services were being provided over years that assumed that because these folks were blind, they were helpless and needed to depend on others for everything. This attitude is much more disabling than the blindness because it , not only interferes with independent living, it prevents any potential of suitable training and employment. Progressive dependence on others eventually results in a nursing home and/or assisted living candidate - even before this person becomes a senior citizen. Customized care that only provides services that are required is less apt. to have institutionalization as an outcome. An early referral to Services for the Blind is highly recommended to prevent this scenario. DHS staff should be aware that persons with vision loss/blindness can generally function without support services if they are given access to the proper tools and training. Please consider consulting SSB to assess the situation and educate those that would reinforce dependence inappropriately at a high cost to low vision/ blind individuals, as well as , a high cost to the taxpayers. M. W. Pfannenstein, CRC, SSB –Senior Services Unit

July 11, 20012

To: DHS and the “Autism Listening” Community
From: Anne Harrington

On behalf of children with autism and their families I am extremely grateful to have the opportunity to share in the “community dialogue” regarding autism treatment and needs of our community. After years of working to bring access to a **range** of evidence-based treatment options for families of young children with autism in Minnesota it was so gratifying to hear the open-minded and forward thinking perspective of DHS including consideration for providing coverage of treatment approaches that may be well-founded, science-based, and time-tested treatment approaches, but lack the rigor of controlled-trial evidence and are still in the “evidence development” stages.

Thank you for the opportunity to bring to your attention the evolving treatment practice for children with ASD’s and the evidence supporting a variety of approaches including developmental approaches for the treatment of autistic spectrum disorders and other special needs conditions. There is a growing body of evidence supporting treatment approaches that go beyond the long-standing behavioral/skill acquisition approach (ABA) to treatment. Developmental approaches incorporate research based on well-founded developmental theory such as Piaget and Bowlby. Examples of some of the developmental approaches—including but not limited to DIR (Greenspan), SCERTS (Prizant), Responsive Teaching (Mahoney), PACT (Aldred), Denver (Rogers) and Hanen models—focus on building the foundations of development for successful social relationships, communication, and thinking and problem-solving while also addressing the regulatory/behavioral challenges of children with ASD. They capitalize on the natural motivation of primary relationships between children and parents as well as children and primary professionals. In doing so, they harness the child’s interests, emotions, and natural motivators. Because of their complexity and focus on overall developmental progress rather than discreet skill building, these developmental approaches are more difficult to operationalize and measure than the more straightforward, skill-based behavioral (e.g. ABA) methods. This helps explain the challenges in data collection and relative paucity of research evidence to date when comparing behavioral vs developmental treatment models. Over the last decade, however, the practice of developmental intervention has created fertile ground for research initiatives that are now emerging and showing equally positive and promising outcomes for children with this type of intervention as well.

The National Research Council in its’ book, “Educating Children with Autism” (2001) determined that although there is evidence that many interventions lead to improvements and that some children shift in specific diagnosis along the autism spectrum during the preschool years in particular, **there does not appear to be a simple relationship between any particular intervention technique, child characteristics and outcomes for children with ASD’s**. Rather characteristics of the most appropriate intervention for a given child must be tied to that child and family’s needs. They stated that effective services should vary considerably across individual children, depending on a child’s age, cognitive and language levels, behavioral needs, and family priorities. Their findings show a strong consensus that the following features are critical in early intervention services:

- Entry into early intervention programs as soon as an autism spectrum disorder or other developmental challenge is considered and identified;
- Active engagement in intensive, engaging, functional, developmentally appropriate, instructional programming for a minimum of at least 25 hours per week and varied according to the child’s chronological age and developmental level;
- Repeated planned teaching opportunities generally organized around relatively brief periods of time for the youngest children (15-20 minute intervals) including sufficient amounts of adult attention in one-to-one and very small group instruction to meet individualized goals;
- Low student/teacher ratios (no more than two young children with ASD’s per adult in a pre-school classroom)
- Mechanisms for ongoing program evaluation and assessments of children’s progress with results translated into adjustments in programming. Lack of documentable progress over a 3 month period should be taken to indicate a need to: increase intensity by lowering

student/teacher ratios, increase programming time, reformulate strategies, curricula or individual child goals or objectives, change of staffing or provide additional training and consultation to staff.

- Inclusion of a family component including parent training
- Appropriate educational objectives should be accomplished within 1 year and expected to affect a child's participation in education, the community, and family life

(Summary by Anne Harrington from the book; Educating Children With Autism)

There are many advantages of intensive **developmental** interventions. Developmental approaches, which focus on building healthy foundations for relating, communicating and thinking, use parents as their child's first and best play partner and have the immediately available natural environment of the home as an intervention site. Developmental models like the PACT study in England are also being studied from a rigorous economic perspective since intensive intervention when provided by professionals instead of parents can be very expensive costing between \$50-75,000/year. The P.L.A.Y. Project study, based on the DIR framework of Greenspan and Weider, is a parent education model that trains parents to become more effective at engaging their child and that can be easily and quickly disseminated. Such efficient, cost effective, and family centered developmental models are desperately needed nationally. With a grant co-written with the Autism Society of MN and as Coordinator of the Minneapolis Public Schools ECSE Autism Program I was able to implement a pilot P.L.A.Y. Project in the MPS ECSE Birth to Five Autism program during school year 2007-2008. We served 40 families including our Spanish-speaking and Somali families through this parent education model and it was well received and showed promise as a positive component of intervention services in our urban school district. When the grant year ended and the project was discontinued in MPS I chose to leave my position there in hopes of expanding access to these resources through other means.

As you may be aware, the 2007 Clinical Report on Management of Children with Autism, published by the American Academy of Pediatrics Journal (Myers et al, 2007)¹, as a guidance for the clinician in rendering pediatric care, is being used politically by others to focus insurance coverage only on Applied Behavioral Analysis (ABA). It was clearly not the intent of the article to promote one type of therapy over another. Nonetheless, the Myers et al article did not sufficiently critique the limitations of ABA giving the false albeit unintended impression that ABA was the best model to treat children with autism. Clearly, the political use of the AAP clinical report is not the fault of the AAP, which in essence agrees with the National Academy of Sciences' landmark report recommending a broader "evidence-based" and comprehensive paradigm, which includes developmental, educational, and ABA approaches. (Lord, Catherine; McGee, James, 2001)².

Given the current state of the art of research and the diverse nature of autism spectrum disorders, it becomes vital to the future of children with developmental challenges for our communities to continue to espouse a broad-based range of models that have evidence supporting them. This diverse community needs an array of proven treatment approaches that are not only individualized but are developmentally appropriate and can be cost-effective as well and where parents in partnership with trained clinicians decide the best approach for each child. One size does not and cannot fit all. It is also painfully evident that addressing the needs of children with autism will "take a village" working together rather than as separate entities. Therefore, it is essential that agencies like the Departments of Human Services, Health, and Education, the broader medical community, and other agencies work together with parents as partners to forge an integrated, collaborative, multiagency approach with the common goal of promoting the development and successful participation of children with the complex developmental disability of autism spectrum disorders in their homes, schools and communities.

I appreciate the opportunity you have provided this community to "share and listen", to better meet the diverse needs of children and families effected by autism. As a parent, a Special Educator, a Parent Educator and a Mental Health Practitioner, I believe I bring a unique perspective to this effort and draw from years of training and experience in the field. I would be pleased to meet with you directly or to be

considered for a role in your Reform 2020 Waiver Proposal development group. The lives of children and families living with autism depend on our understanding and responsiveness to their needs.

Sincerely,

Anne Harrington

Autism Resource Specialist, Mental Health Practitioner, Parent Educator, ECSE Teacher, Certified DIR/Floortime® Practitioner, Licensed P.L.A.Y. Project® Provider, Founder: Celebrate The Spectrum, Executive Director: Center for Engaging Autism (non-profit)
Contact Information: 612-298-8037, harringtonab@yahoo.com

¹ Myers S. M., Johnson C.P., and the Council on Children With Disabilities (2007) Management of Children With Autism Spectrum Disorders. *Pediatrics*; 120; 1162-1182.

² Lord, Catherine; McGee, James (Editors). Committee on Educational Interventions for Children with Autism. *Educating Children with Autism*. Division of Behavioral and Social Sciences and Education, National Research Council. Washington, DC: National Academy Press (2001).

Dear David Godfrey-

I am writing to express my concern regarding eliminating autism coverage for children over the age of 7. It is unrealistic to assume that all children can succeed in our traditional school system

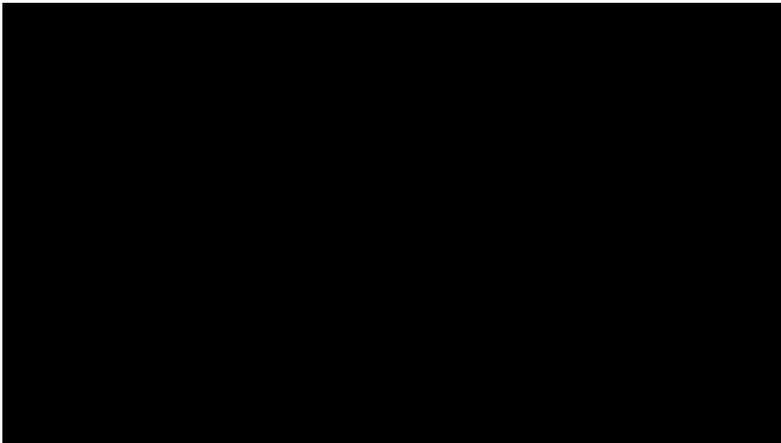
According to the U.S. Department of Education, the number of children age 3 to 21 in federally supported programs for autism increased from 22,000 in the 1993-1994 school year to 223,000 in 2005-2006. At the same time, public schools have a shortage of more than 12,000 special education teachers, and the number is expected to grow. With so many students and so few teachers, the public school system often is unable to meet the needs of many children with autism spectrum disorders (ASD) like Asperger syndrome and autistic disorder.

Autism poses a challenge for schools because the disorder affects each person in different ways and to different degrees. For example, many children with autism don't speak or interact at all while children with milder forms like Asperger's syndrome may be very talkative. Special needs classrooms may focus on academics rather than social skills when in reality, autistic children need the most help developing socially. Autistic support classrooms, on the other hand, tend to be segregated from the rest of the school and may be so focused on building social skills they forget a child's academic abilities.

Even if services in school are adequate, most children with autism or Asperger's require extra services to learn to apply what they learn in school to other settings. They learn one skill at a time (e.g., organizing their backpack) and need constant repetition and one-on-one instruction to retain the information and apply it to other situations. Often, children with autism spectrum disorders need supplemental support from speech, occupational, and behavioral therapists.

Schools are not the best option for children with autism. MA should continue to cover medically necessary autism treatment.

Sincerely,



[REDACTED] [REDACTED] [REDACTED]

Dew Mr. Godfrey:

Autism is a medical diagnosis, not an educational one. Teaching credentials don't qualify a person to diagnose autism or other medical conditions. In many cases, teachers also lack the specialist training to help children with autism reach their full potential. For this reason, it is vital that children have access to effective autism treatment—such as ABA—for as long as necessary.

Behavioral interventions are intensive, structured programs where a trained therapist works with a child to systematically teach behavior and communication skills. Most programs are based on behavior modification principles; some programs teach parents to work with their autistic child; and other programs target play and communicative skills.

Dual programs include the following:

- Individualized attention paid to each child
- Broad-based curriculum that supports social interaction, play, and communication
- Systematic teaching that emphasizes outcomes (what the child should know and do)
- Family participation being encouraged by the facilitators
- A focus on functional skills (learning that has a purpose in the world)

Due to budget constraints, many schools simply cannot provide this level of services. Without drastic changes to the school funding model, private ABA paid for by MA must continue to be an option for children beyond the age of 7.

Sincerely,

[REDACTED]

Dear Mr. Godfrey-

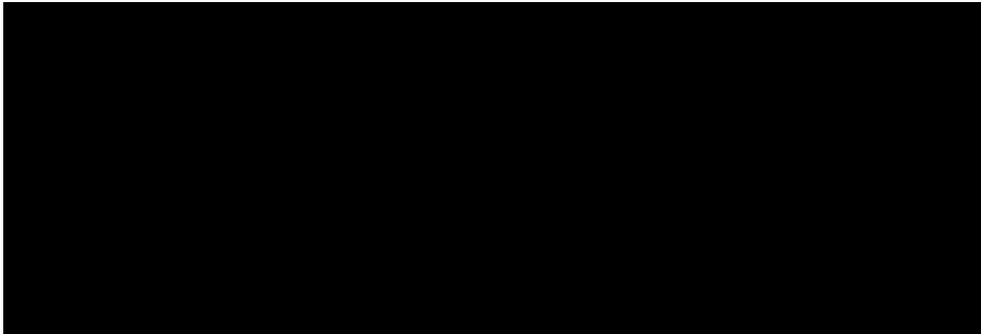
The proposed 2020 reforms stress the importance of early intervention for autism. A recent study from May 2010 found that more than half of school aged children were age 5 or older when first diagnosed with autism. Since MA will end private ABA coverage for children by age 7, this means that these children will have at most 2 years of intensive quality intervention.

Outside experts say there are still many gaps in the diagnosis and treatment of autism spectrum disorder among school-aged kids in the U.S. In the study, 12% of kids with autism spectrum disorder didn't receive any of the suggested services. Less than half received the kind of behavioral therapies that are believed to be most helpful.

<http://www.washingtonpost.com/archive/local/2012/05/23/local-2012-05-23/most-children-with-autism-diagnosed-at-5-or-older/>

In my opinion, Minnesota is a leader in autism treatment for children of all ages. We owe it to these children, their families, and our entire community to continue to provide the care that will help these children live full lives.

Sincerely,



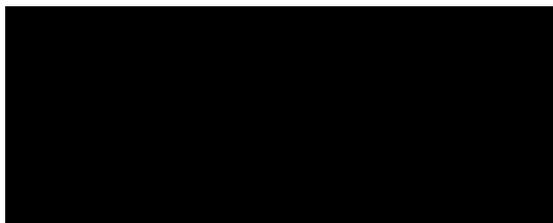
Dear David Godfrey:

Despite the cliché, I think that working with autistic children may in fact be "the toughest job you'll ever love." ■ love working with children on all ends of the autism spectrum. ABA therapy is effective with children at all ages and levels of severity-whether they are non-verbal, gifted, have behavior problems, or struggle with social skills, ABA therapists create an individualized program for each child.

For many of the children at the ABA center where I work, medical assistance is all that allows them to receive this effective treatment. Proposed reform from DHS would eliminate coverage for these children above age 7 who need and deserve it.

Please revise the Reform 2020 proposal so it no longer ends ABA services for seven year olds and above.

Sincerely,

A large black rectangular redaction box covering the signature area.

Dear David Godfrey:

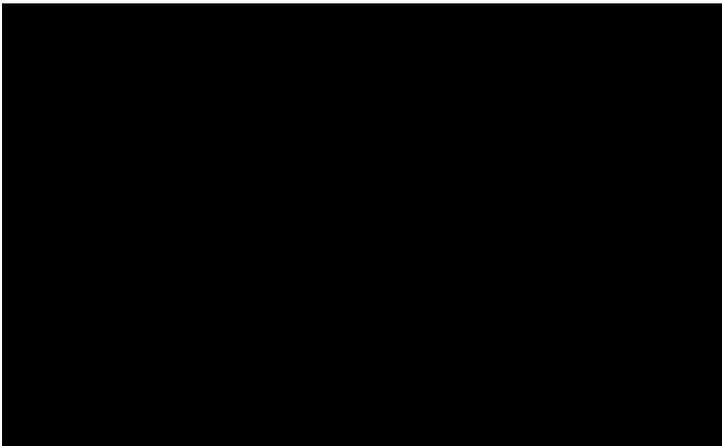
Each day I work with an amazing group of children with autism. They amaze me with their hard work as they struggle with the skills that so many of us take for granted.

Many children with autism benefit from ABA therapy. In all the children I work with, progress is ongoing. While there is much focus on early intervention, many of these children will continue to need this intensive therapy well beyond the "early intervention" stage. I have worked with children who have lost ABA therapy due to insurance reductions. After participating in other therapies or schoolbased services, many experienced a loss in skills. Receiving medical assistance allowed these children to return to the ABA therapy that had proven effective with them.

The proposed reforms will force many of these "school age" children into a system which is not prepared for them. Ending autism coverage at age 7 simply shifts the problem to another location.

Thank you for your continued support in our fight against autism.

Sincerely,



Dear Mr. Godfrey;

Autism is a medical diagnosis, not an educational one. Teaching credentials don't qualify a person to diagnose autism or other medical conditions. In many cases, teachers also lack the specialized training to help children with autism reach their full potential. For this reason, it is vital that children have access to effective autism interventions—such as ABA—for as long as necessary.

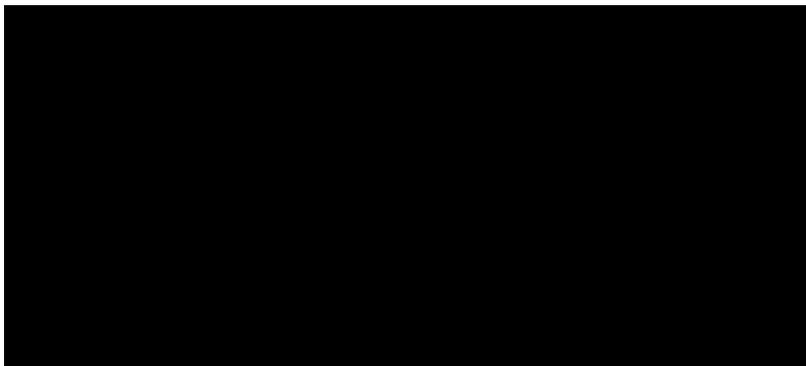
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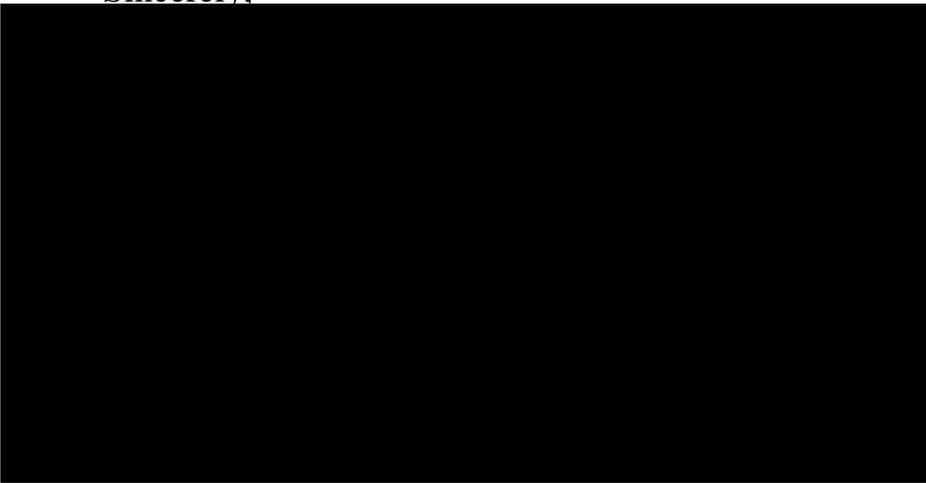
Dear Mr. Godfrey:

ABA therapy is recommended and supported by the Surgeon General, the American Academy of Pediatrics and the National Research Council, to name a few. Also, numerous studies and reports have shown its long-term cost benefits. In addition, ABA therapy coverage is already mandated by some US states, and extended by a number of companies in the private industry.

Despite the studies showing the effectiveness of ABA, the recent MA proposal cuts this important service for children above age 7. This "one size fits all" approach doesn't work with the autism spectrum. Each child has a range of skills and weaknesses, as well as varying speeds of progress.

Children with autism deserve this high quality therapy that will help them reach their full potential! Determine level of service for school aged children on an individual basis, not solely on age.

Sincerely,



Dear Mr. Godfrey-

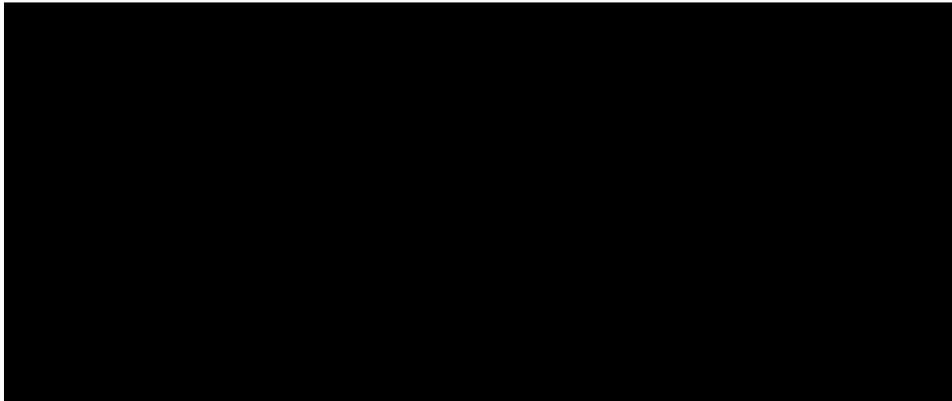
In 88 children are now diagnosed with autism.
I am proud to provide quality intensive therapy for them

I, and the many families I work with, are concerned about whether medical assistance will continue to cover the intensive ABA therapy that is helping so many children. Every day I see first-hand the difference that one on one therapy makes for these children. They have reached milestones many never thought were possible. Whether it is the child saying his first word, making a friend or transitioning successfully to a public kindergarten, we celebrate each success

This progress happens regardless of age. I work with many children above age 7 who strive with the structure and individual support ABA therapy provides.

Please remove the age cap from the Reform 2020 proposal. Thank you in advance for your much-needed assistance in this important matter.

Sincerely,



Dear Mr. Godfrey-

I am proud to work as a therapist for autistic children. In my eyes, every one of these children is a success story and proof that medical assistance coverage for ABA needs to continue. This progress happens in different levels and at different rates. There is nothing magic about the age (if 7 that would guarantee a child will no longer be in need of ABA therapy and ready for school.

Research also supports the effectiveness of PSA

"ABA is considered by many researchers and clinicians to be the most effective *evidence-based therapeutic approach* demonstrated thus far for children with *autism*.¹ The U.S. Surgeon General states that thirty years of research on the ABA approach have shown very positive outcomes when ABA is used as an *early intervention* tool for *autism*. This research includes verallandrmark studies showing that about 50% of Children with *autism* who were treated with the ABA approach before the age of four had significant increases in *IQ*, *verbal* ability, and/or social functioning. Even those who did not show these dramatic improvements had significantly better improvement than matched children in the *control* groups. In addition, some children who received ABA therapy were eventually able to attend classes with their peers.[•]
(<http://autism.healingthresholds.com/therapy/applied-behavior-analysis-aba>)

As DHS considers reforms for autism treatment, please make sure that they take into account the research, as well as information from families, and skilled therapists who know that ABA therapy makes a life-long difference.

Sincerely,



Dear Mr. Godfrey:

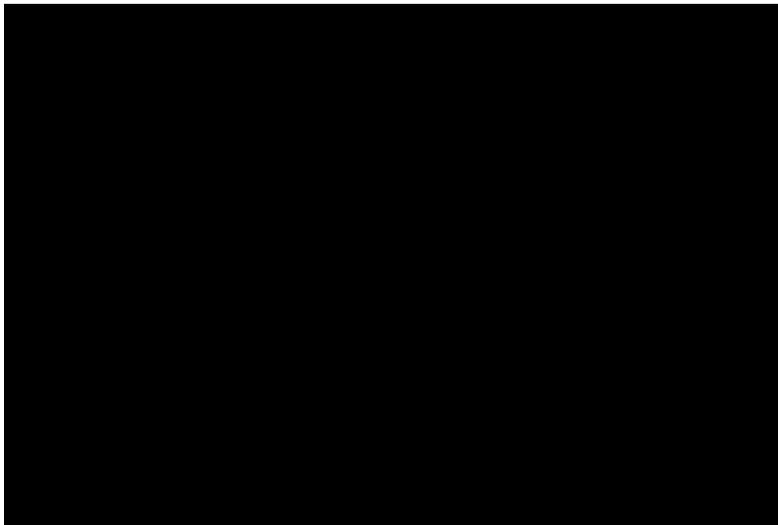
According to DHS Reform 2020 proposal, MA will not cover autism treatment for children above age 7. I am opposed to this change and strongly feel that our public school system cannot meet these children's needs.

The National Research Council has noted that the ideal services for autistic children and those with Asperger's don't always match the reality of what most publicly funded education programs offer. Many schools argue they are complying with the law and providing appropriate services for children with ASD. But parents have a different definition of what adequate services means for their child. Across the country, parents have sued school districts that set up behavioral therapy programs for autistic students because the parents found developmental therapies to be more effective. When schools set up special autism classrooms, parents argue their children should be mainstreamed into a typical classroom rather than segregated.

Most school districts cannot provide adequate specialized services because the state and federal budget simply will not cover the high costs. According to Michael Ganz, author of *Understanding Autism: From Basic Neuroscience to Treatment*, it can cost about \$3.2 million to take care of an autistic person over his or her lifetime. Caring for all people with autism and Asperger's over their lifetimes costs an estimated \$35 billion per year. Thus, district administrators are torn between parental demands, legal mandates, and limited financial resources in finding ways to educate students with autism.

Autism is already a national crisis. Eliminating private ABA treatment will only create children-and adults-who need more care.

Sincerely,



Deaf David Godfrey-

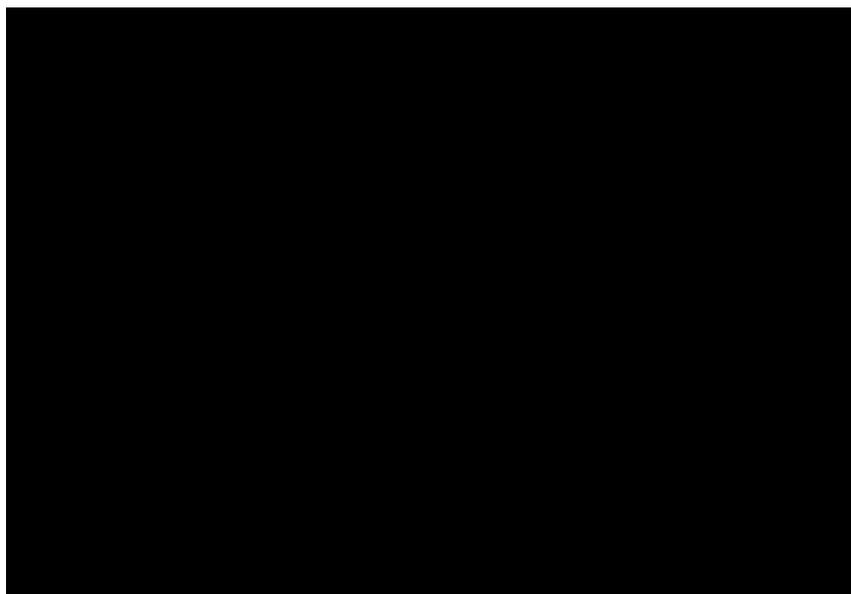
I am writing to express my concern regarding eliminating autism coverage for children over the age of 7. It is unrealistic to assume that all children can succeed in our traditional school system.

According to the U.S. Department of Education, the number of children age 3 to 21 in federally supported programs for autism increased from 22,000 in the 1993-1994 school year to 223,000 in 2005-2006. At the same time, public schools have a shortage of more than 12,000 special education teachers, and the number is expected to grow. With so many students and so few teachers, the public school system often is unable to meet the needs of many children with autism spectrum disorders (ASD) like Asperger syndrome and autistic disorder.

Autism poses a challenge for schools because the disorder affects each person in different ways and to different degrees. For example, many children with autism don't speak or interact at all, while children with milder forms like Asperger's syndrome may be very talkative. Special needs classrooms may focus on academics rather than social skills when in reality, autistic children need the most help developing socially. Autistic support classrooms, on the other hand, tend to be segregated from the rest of the school and may be so focused on building social skills they forget a child's academic abilities.

Even if services in school are adequate, most children with autism or Asperger's require extra services to learn to apply what they learn in school to other settings. They learn one skill at a time (e.g., organizing their backpack) and need constant repetition and one-on-one instruction to retain the information and apply it to other situations. Often, children with autism spectrum disorders need supplemental support from speech, occupational, and behavioral therapists.

Schools are not the best option for children with autism. MA should continue to cover medically necessary autism treatment.



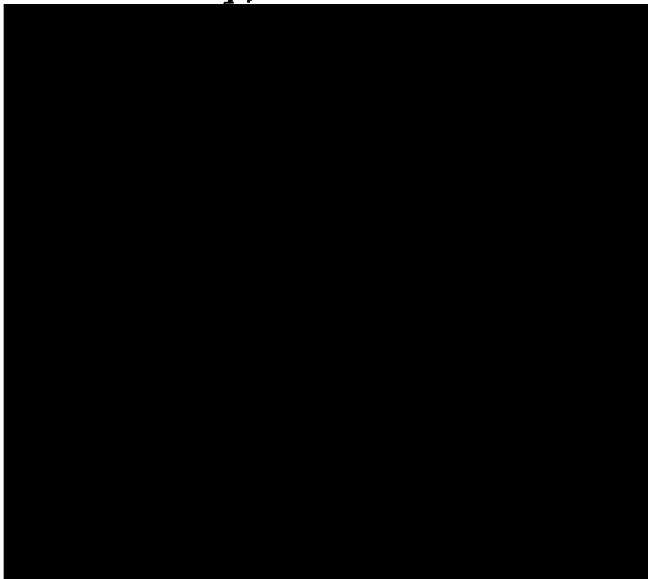
Dear David Godfrey:

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For many of the children at the ABA center where I work, medical assistance is all that allows them to receive this effective treatment. Proposed reform from DHS would eliminate coverage for these children above age 7 who need and deserve it.

Please revise the Reform 2020 proposal so it no longer ends ABA services for seven year olds and above.

Sincerely,



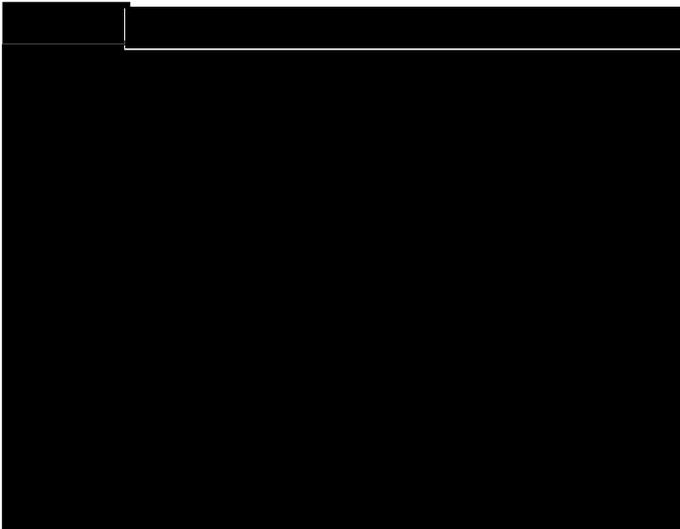
Dear Mr. Godfrey-

Public schools are required to educate children with autism. The truth is, as you'll hear from every school administrator you'll ever meet, "The law requires that we provide your child with a Chevy, not a Cadillac." In practice, this means that your child with autism is most likely to get an adequate education based on someone else's vision of what adequate looks like.

In *some* cases, what looks at first like an adequate educational program really isn't. A child with huge sensory and behavioral issues is never going to do well in a mainstream setting. A child with Asperger's is not going to thrive in a classroom filled with profoundly challenged kids. In those fairly extreme cases, it's often possible to make a case for change on your own or through an advocate or mediator. Frequently, districts will see the problem and make changes based on your child's individual needs.

But what happens when the program is barely adequate but not very good? After all, every child with autism is different, and every parent with an autistic child has a different vision of what their child needs. That means that it's extremely difficult to set up a single, solid autism program that suits the entire autism population.

In Minnesota, children with autism have access to a range of quality autism treatment options. Why is MA insisting that they settle for "barely adequate?" I urge you to remove the age 7 cap on autism treatment.





Dear Mr. Godfrey:

Autism is the fastest growing developmental disability in the United States. The Centers for Disease Control and Prevention now estimates that 1 in 88 children will have autism affecting an estimated 1.7 million Americans. The estimated cost to a family to support a child with autism over their life time is believed to be minimally 3.5 million dollars.

At this time many insurance providers do not cover the cost of interventions, therapies, or services identified as medical necessities for a child who has autism. Medical Assistance recently began cover the *ABA* therapy at Holland Center, where I work. Proposed reform by DHS has us concerned that this coverage may end.

Your leadership is needed now more than ever and I hope I can count on you to tell DHS that kids enrolled in MA must continue to receive coverage for medically necessary autism treatment.

Sincerely,



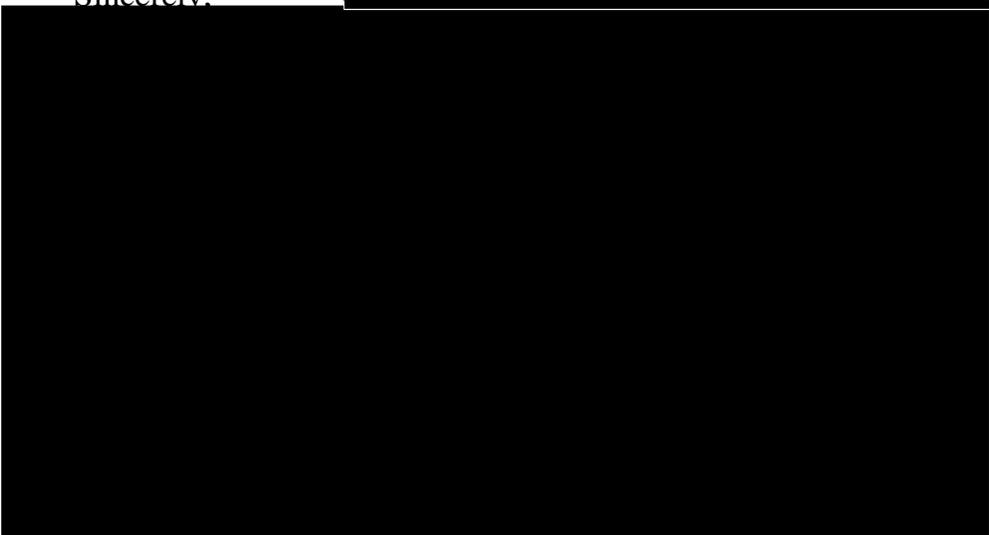
Dear Mr. Godfrey:

I am a therapist working in an ABA center for children with autism. According to Autism Speaks, "a number of studies have demonstrated that ABA techniques can produce improvements in communication, social relationships, play, self care, school and employment. These studies involved age groups ranging from preschoolers to adults. Results for all age groups showed that ABA increased participation in family and community activities."

Many children are only able to get this effective, intensive therapy through medical assistance. These families have expressed concern that reforms proposed by DHS would eliminate coverage once a child reaches the age of 7. While my hope is that all the children I work with can be successful in school, I know that children progress at different levels. I've proudly watched kids succeed in kindergarten, but have also witnessed others return to ABA services after difficulties in the public schools. Some children even lost skills while in the school system as they needed the repetition and help in communication that we're trained to provide.

Please listen to the families and therapists who know that the needs of some "older" children with autism cannot be met by the schools.

Sincerely,



Dear David Godfrey-

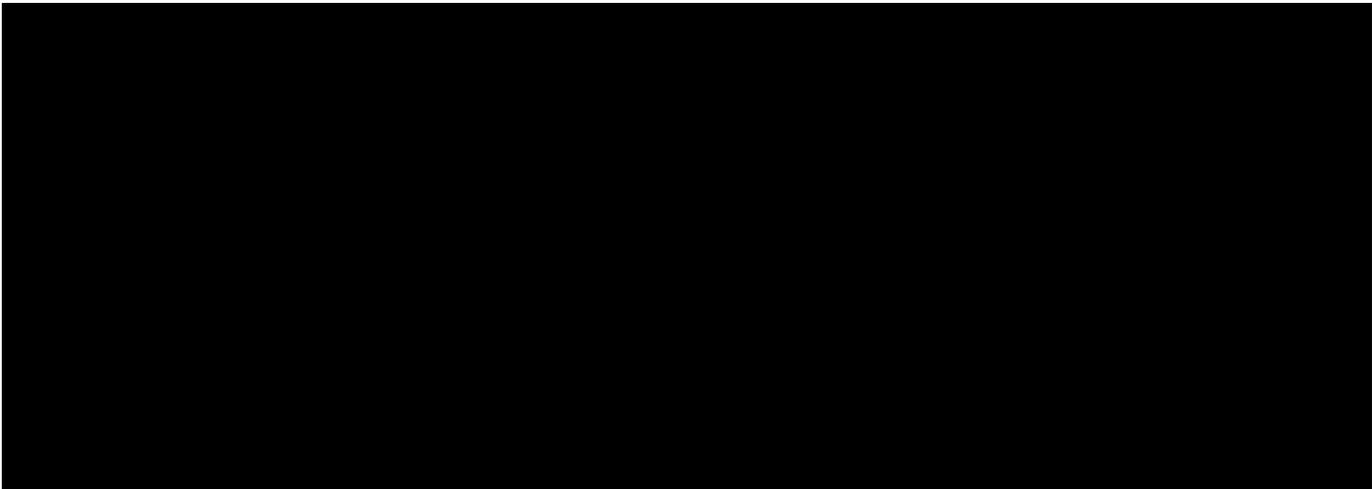
Your support is needed to ensure that Medical Assistance continues to cover ABA therapy for all children with autism. I oppose the proposal from DHS that will require all children age 7 and above to attend school, rather than receive private ABA services.

The facts about autism are alarming and require additional resources, not reduced coverage.

- Autism is the fastest-growing serious developmental disability in the u.s.
- Autism costs the nation over \$137 billion per year, a figure expected to significantly increase in the next decade
- More children will be diagnosed with autism this year than with AIDS, diabetes & cancer combined.
- Autism receives approximately 5% of the government research funding of many less prevalent childhood diseases
- Thousands of children have shown significant improvement resulting from early diagnosis and use of effective interventions

<http://www.tacanow.org/family-resources/latest-autism-statistics-2/>

Continued coverage of ABA therapy is needed. On behalf of all children with autism, please remove the autism age cap from your reform proposal.



Dear Mr. Godfrey-

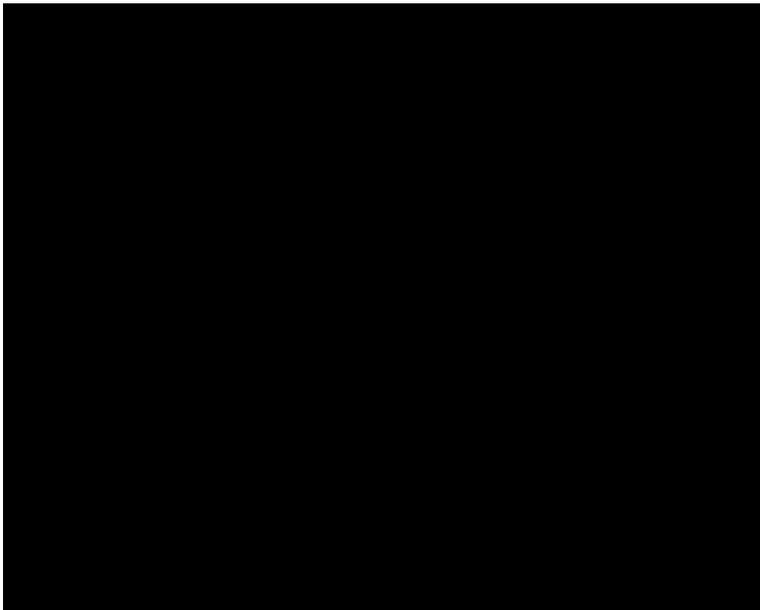
The proposed 2020 reforms stress the importance of early intervention for autism. A recent study from May 2010 found that more than half of school aged children were age 5 or older when first diagnosed with autism. Since MA will end private ABA coverage for children by age 7, this means that these children will have at most 2 years of intensive quality intervention.

Outside experts say there are still many gaps in the diagnosis and treatment of autism spectrum disorder among school-aged kids in the U.S. In the study, 12% of kids with autism spectrum disorder didn't receive any of the suggested services. Less than half received the kind of behavioral therapies that are believed to be most helpful.

<http://www.webmd.com/brain/autism/news/20120523/most-children-with-autism-diagnosed-at-5-or-older>

In my opinion, Minnesota is a leader in autism treatment for children of all ages. We owe it to these children, their families, and our entire community to continue to provide the care that will help these children live full lives.

Sincerely,

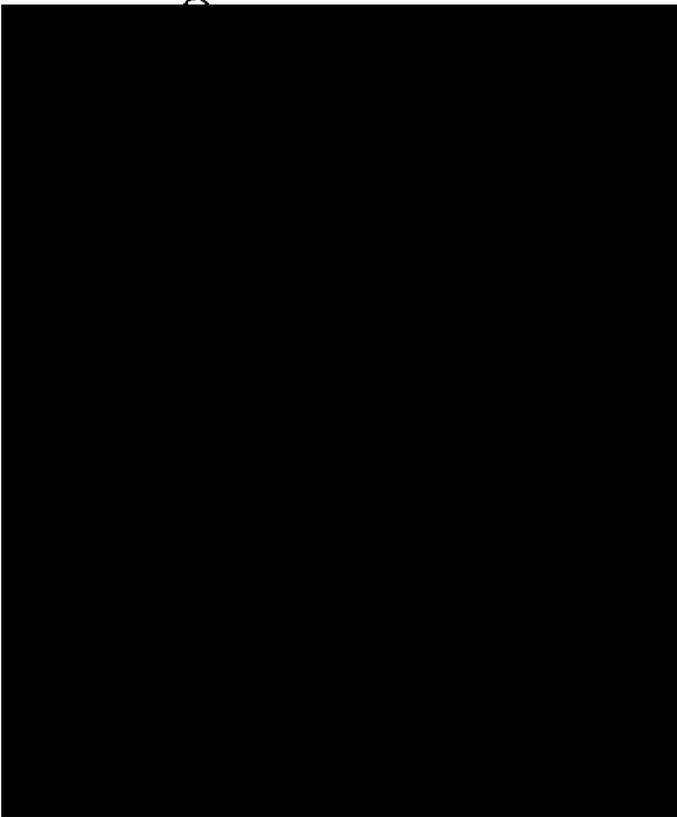


Dear Mr. Godfrey-

I am writing to express my concern regarding the age cap for autism treatment. ABA services are vital to children with autism! Age alone cannot predict when an autistic child will be ready for school.

Children who receive IEBT have a 48% chance of achieving "best outcomes." This means that 48% of children who receive IEBT will attain a typical IQ, will no longer need supports or services in regular mainstream education, and no longer meet the diagnostic criteria for autism. Another 40% will improve functional skills and reduce challenging behaviors — such as aggressive behaviors and self-injurious behaviors. For the children who respond well to IEBT, an interruption or reduction in treatment can alter their prognosis. It could mean the difference between enabling a family to keep their child at home or not being able to care for their own child at home. It could mean the difference between a child achieving independence ("best outcomes") and needing specialized supports and services her entire life.

Quality, medically necessary autism treatment cannot be based on a number. Please have MA continue to cover ABA therapy for children of all ages.



Dear David Godfrey-

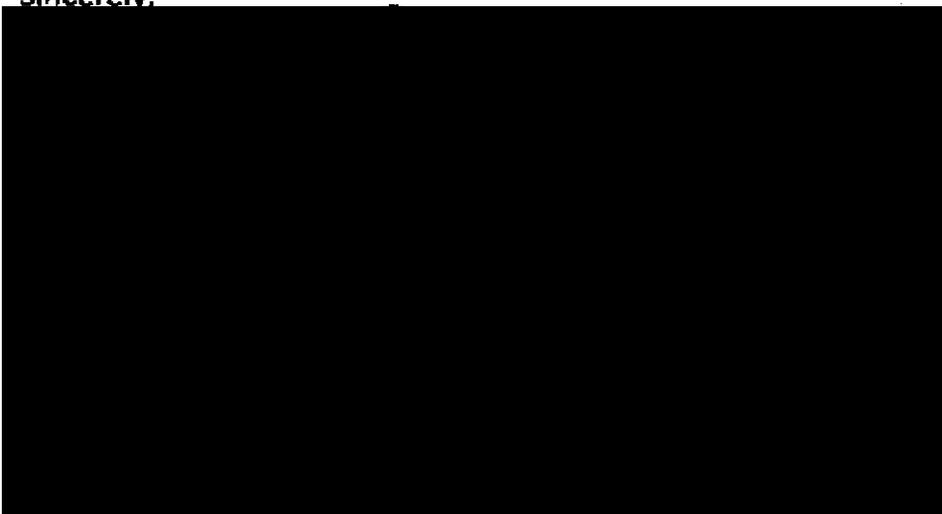
1 in 88 children are now diagnosed with autism. This statistic is based on prevalence rates in 8 year old children; these children will be denied autism therapy under the Reform2020 proposal.

We, and many families, are concerned about how long medical assistance will continue to cover the Intensive ABA therapy that is helping our child and so many others. While all families would love their child with autism to be ready for school at age 7, that deadline is arbitrary and often unrealistic.

Please ensure that kids enrolled in MA continue to receive autism therapy until their functional level, not their age, deems it unnecessary.

We thank you in advance for your much-needed assistance in this important and time-sensitive matter.

Sincerely,



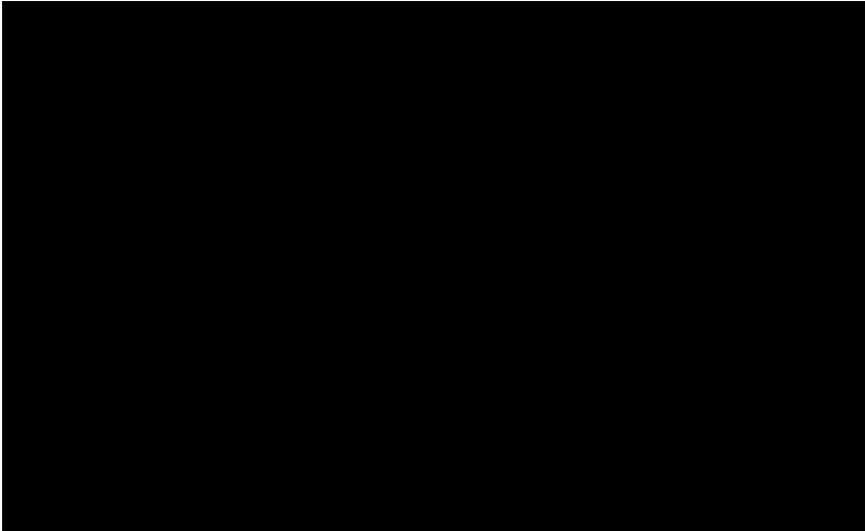


Dear David Godfrey-

I am writing in response to the recent reform proposed by DHS- As a parent of a child special needs, I am concerned about the age cap for autism treatment.

As you are aware the cases of autism continue to climb. A recent Harvard study estimated the cost of raising a child with autism to be \$3.2 million in comparison to the \$290,000 it reportedly costs to raise a neurotypical child. During a time of great economic concern., your action to offer families with options to reduce these costs is needed. Research has proven the dramatic difference such therapies and interventions have on children with autism and other special needs.

Please change the proposed reforms. Continue to cover autism treatment, such as ABA, for as long as a child needs it.



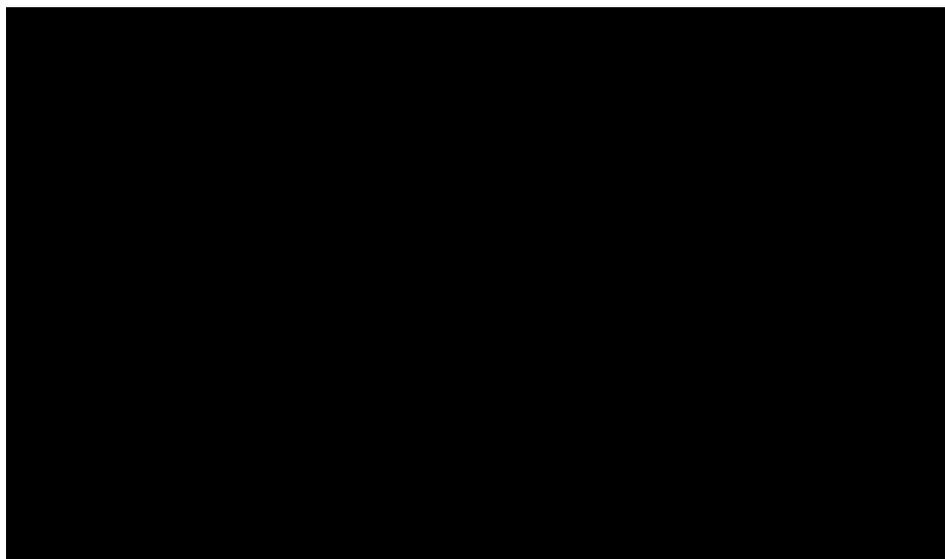
Dear David Godfrey:

According to Autism Speaks, "a number of studies have demonstrated that ABA techniques can produce improvements in communication, social relationships, play, self care, school and employment. These studies involved age groups ranging from preschoolers to adults. Results for all age groups showed that ABA increased participation in family and community activities."

We are fortunate that Medical Assistance has covered quality, intensive ABA for our child with autism. The proposed reforms would eliminate this since our child is over the age of 7.

We have witnessed first-hand the continued impact of effective therapy. We ask that MA continue to cover this medically necessary treatment that schools simply cannot provide.

Sincerely,



Dear David Godfrey-

We need your support to ensure that Medical Assistance continues to cover ABA therapy for children with autism. The proposal from DHS includes an age limit that could eliminate therapy from many school-aged children who still need intensive treatment. Autism is not going away and effective intensive treatment must be funded.

Did you know?

- More children will be diagnosed with autism this year than with AIDS, diabetes & cancer combined
- Autism is the fastest-growing serious developmental disability in the U.S.
- Autism costs the nation over \$137 billion per year, a figure expected to significantly increase in the next decade
- Autism receives approximately 5% of the government research funding of many less prevalent childhood diseases
- Boys are four times more likely than girls to have autism
- While there is no medical detection or known cure for autism, thousands of children have shown significant improvement resulting from early diagnosis and use of effective interventions
- The increase in prevalence rate cannot be explained by better diagnosis alone. Some have suggested that autism is just being better diagnosed today versus years ago and that many cases of mental retardation are now being coded as autism. This would also suggest that the experts diagnosing autism before did not know what they were doing. This is NOT TRUE. Autism is the only disorder dramatically on the rise while mental retardation, Down syndrome and cystic fibrosis remain relatively the same
- While the cause of autism remains unclear, current studies show genetics and environment both play a role in the autism prevalence increase.

<http://www.tacanow.org/family-resources/latest-autism-statistics-2/>

The above statistics show the need for effective, intensive autism treatment. This need does not end at age 7. We ask that coverage of autism treatment be based on a child's needs, not their age.

Sincerely,

[Redacted Signature]

Dear David Godfrey-

Children do not outgrow autism, yet the Reform 2020 proposal would end coverage for autism treatment at age 7.

Reform 2020 assumes that all children will be ready for a school based program by 7. Many children with autism may be able to transition to a school for kindergarten. I have seen students thrive in such situations based on the skills that they developed in ABA therapy. While we would love this to be true for all kids, many will need additional years of intensive therapy. The amount of ABA therapy cannot be determined on age, but rather by looking at the needs for each individual child.

Reform 2020 needs to be reformed! Intensive intervention is needed for autism without age limits.

Sincerely,



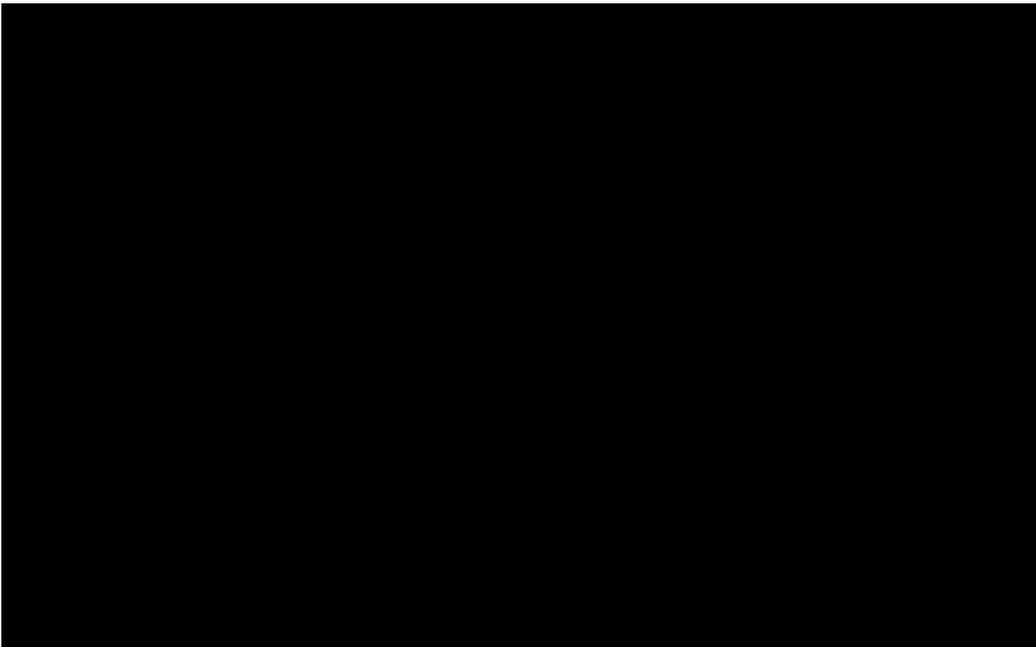
Dear Mr. Godrev:

Each child with autism is unique. They make progress at different rates and with different types of therapy. Because of this, it is impossible to set the criteria for all children with autism. This, however, is exactly what the OHS proposes. It states that by age 7, a child with autism must receive services through the school system, not MA. Two readiness issues are raised by this. Is the child ready for school? Is the school ready for these children?

To answer these questions, OHS must understand the true difference in the quality of services at a private ABA center compared to a public school.

- All ABA therapists must have at least a 4-year degree in psychology, education or other related field. In a school setting, the majority of a child's day is spent with a paraprofessional who likely has only a high school diploma and no prior ASD experience.
- ABA therapists work one-on-one with children with autism; they are indeed specialists. Special needs children in schools have a wide range of disabilities and are often served by the same staff. This requires teachers and aides to have knowledge that may be a mile wide, but only an inch deep.
- ABA services are provided in home or in centers designed to meet the special needs of children with autism. These children have special diets, sensory needs, and behavior issues. If a child with autism cannot handle the high-stimulating activity of a typical school he is often isolated in a single classroom leading to reduced options for therapy.

Even in the best districts, schools are not the best setting for all children with autism. Services for school-aged children must be decided based on needs, not age.



Dear Mr. Godfrey:

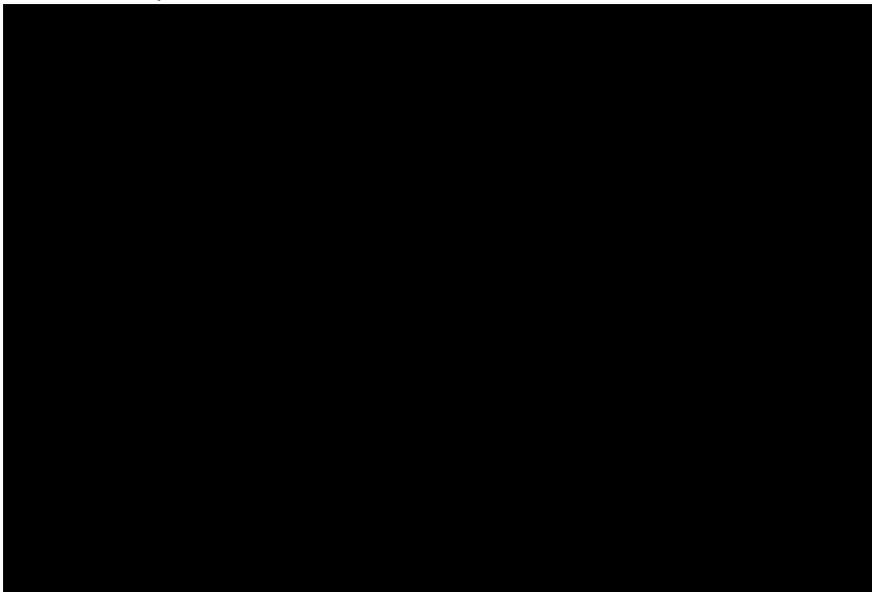
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- ABA services are provided in homes or in centers designed to meet the special needs of children with autism. These children have special *sensory* needs, and behavior issues. If a child with autism cannot handle the overwhelming activity of a typical school, he is often isolated in a separate classroom leading to reduced options for therapy.

Even in the best districts, schools are not the best setting for all children with autism. Services for school aged children must be decided based on needs, not age.

Sincerely,



[REDACTED] [REDACTED] [REDACTED]

Dear David Godfrey

I am writing in response to the recent reform proposed by DHS. As a parent of a child with special needs, am concerned about the age cap for autism treatment.

As you are aware the cases of autism continue to climb. A recent Harvard study estimated the cost of raising a child with autism to be \$3.2 million in comparison to the \$290,000 it reportedly costs to raise a neurotypical child. During a time of great economic concern, your action to offer families with options to reduce these costs is needed. Research has proven the dramatic difference such therapies and interventions have on children with autism and other special needs.

Please change the proposed reforms. Continue to cover autism treatment, such as ABA, for as long as a child needs it.

[REDACTED]

[REDACTED]

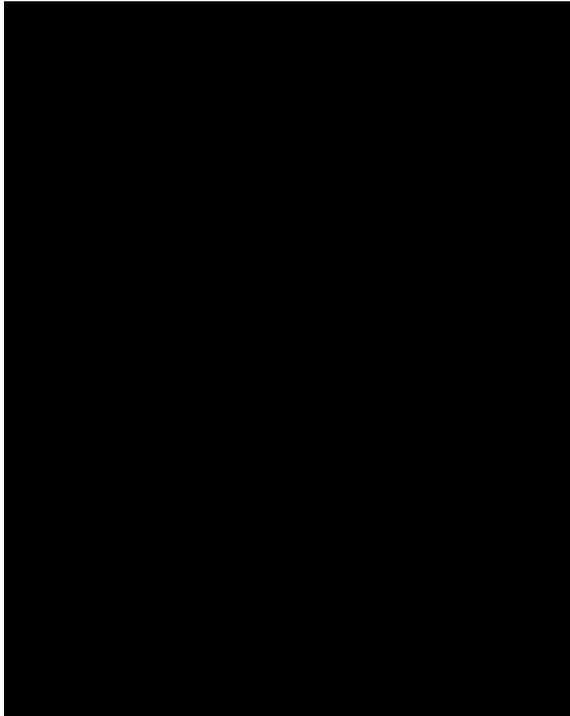
Dear David Godfrey-

1 in 88 children are now diagnosed with autism. This statistic is based on prevalence rates in 8 year old children; these children will be denied autism therapy under the Reform2020 proposal.

We, and many families, are concerned about how long medical assistance will continue to cover the intensive ABA therapy that is helping our child and so many others. While all families would love their child with autism to be ready for school at age 7, that deadline is arbitrary and often unrealistic.

Please ensure that kids enrolled in MA continue to receive autism therapy until their functional level, not their age, deems it unnecessary.

We thank you in advance for your much-needed assistance in this important and time-sensitive matter.



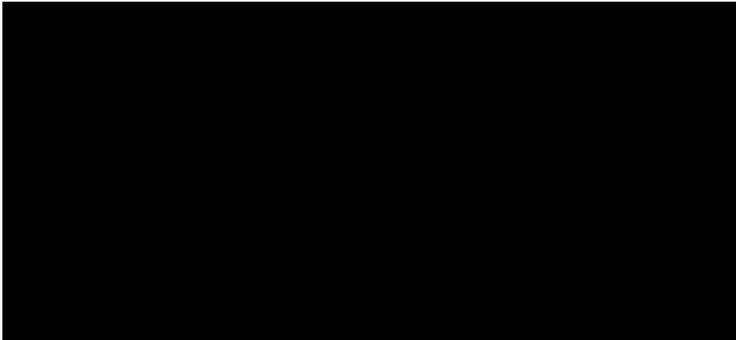
Dear David Godfey -

We are writing to express our concern over a proposed DRS reform that will impact our child's access to quality autism therapy beyond the age of 7.

Our child receives applied behavioral analysis (ABA) which is often referred to as intensive early behavior intervention treatment (IEIBT). This daily one on one therapy has led to increased communication and social interaction. Without it, the quality of life of our entire family would be impacted!

Children who receive IEIBT have a 48% chance of achieving "best outcomes." This means that 48% of children who receive IEIBT will attain a typical IQ, will no longer need supports or services in regular mainstream education, and no longer meet the diagnostic criteria for autism. Another 40% will improve functional skills and reduce challenging behaviors — such as aggressive behaviors and self-injurious behaviors. For the children who respond well to IEIBT, an interruption or reduction in treatment can alter their prognosis. It could mean the difference between enabling a family to keep their child at home or not being able to care for their own child at home. It could mean the difference between a child achieving independence ("best outcomes") and needing specialized supports and services her entire life.

ABA therapy is beneficial at all ages. We ask that MA continue to cover this medically necessary treatment beyond the age of 7.



Dear Mr. Godfrey-

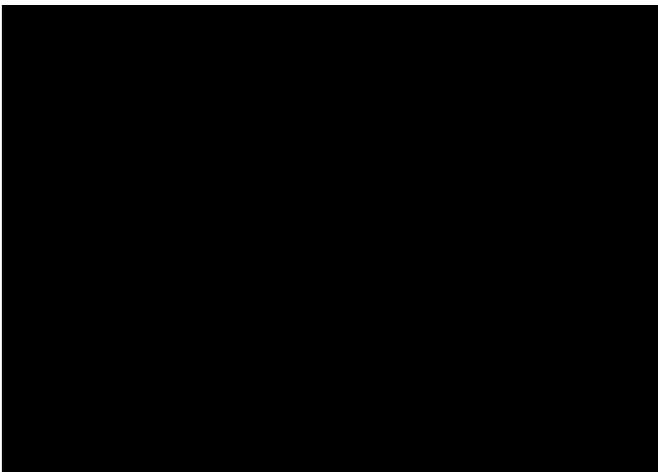
In May, new figures were released highlighting a huge increase in the annual costs of autism which have soared to \$137 billion a year. This represents a three-fold increase within the last decade.

If you ask "who pays for autism?" my answer would be everyone. We know many families living with autism are carrying much of these costs. They put a second mortgage on their home, sell their home to move into an apartment or with relatives, take out multiple credit cards, borrow from family members, and often one parent ends up taking a second job to help make ends meet. Some families have opted to double-up households with two families living together sharing expenses so they can put most of their housing funds into their children's needs.

It is important to note that an estimated 80% of those living with autism are ages 22 years or younger. We don't have enough data to calculate the lifetime costs of autism. Based on what we know today, it is estimated that these costs are \$3-5 million per affected individual. Sadly, with articles highlighting the tripling of costs, we don't see this trend slowing down anytime soon.

With the recent downturn in the economy, special needs families are being hit hard; support services are drying up. Assistance for families is dwindling while the pool for those needing help is soaring. Here is an excerpt from a recent article featured in the Disability Scoop online news site highlighting the soaring costs of autism: *"We are paying for the crisis if inaction and the crisis if inappropriate action," said David McDell of the University of Pennsylvania, who is behind the reform.*

Families rely on Medical Assistance to pay for autism treatment such as ABA. These intensive, quality treatments must continue beyond the age of 7; please remove this arbitrary age limit from the Reform 2020 proposal.



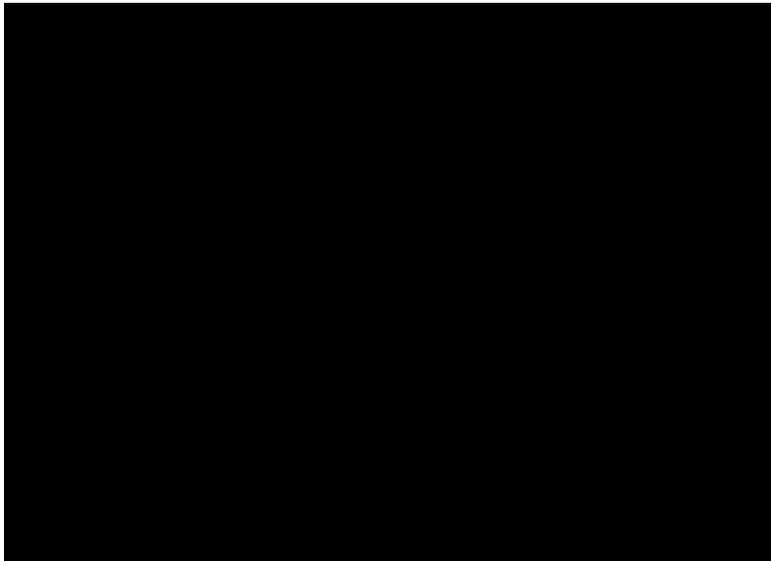
Dear David Godfrey:

As you may know, autism is the fastest growing developmental disability in the United States. The Centers for Disease Control and Prevention now estimates that in 88 children will have autism-affecting an estimated 1.7 million Americans. The estimated cost to a family to support a child with autism over their life time is believed to be minimally 3.5 million dollars.

At this time many insurance providers do not cover the cost of interventions, therapies, or services identified as medical necessities for a child who has autism. Our family has incurred many out of pocket expenses for our child even though we have a private health insurance policy.

We are fortunate that Medical Assistance recently began covering the ABA therapy that our child receives at Holland Center. Proposed reform by DHS would eliminate this coverage for children age 7 and older.

On behalf of my family, please continue to cover medically necessary autism treatment for children of all ages.



Dear David Godfrey:

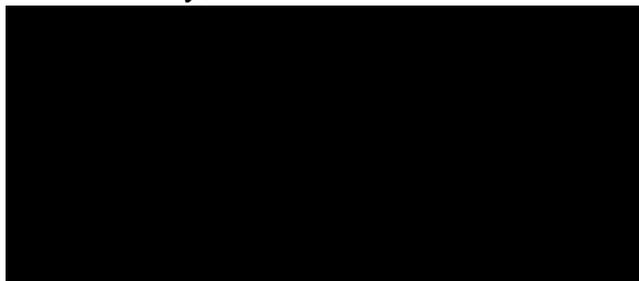
Children who have autism benefit from different types of treatment and services. Our child has benefitted from ABA therapy. We continue to see progress and know that he will need this intensive therapy well beyond the "early intervention stage".

Under the "Reform 2020" proposal, the school district-not MA-would be responsible for his care. Schools cannot meet the needs of children with autism. They are underfunded and lack the training and experience that ABA providers can offer.

Children who have autism should not have reduced coverage for medically necessary treatment, regardless of their age.

Thank you for your continued support in our fight against autism.

Sincerely,

A large black rectangular redaction box covering the signature area.

Dear David Godfrey-

We need your support to ensure that Medical Assistance continues to cover ABA therapy for children with autism. The proposal from DHS includes an age limit that could eliminate therapy from many school-aged children who still need intensive treatment. Autism *is* not going away and effective intensive treatment MUST be funded.

Did you know?

- More children will be diagnosed with autism this year than with AIDS, diabetes & cancer combined
- Autism is the fastest-growing serious developmental disability in the U.S.
- Autism costs the nation over \$137 billion per year, a figure expected to significantly increase in the next decade
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- While there is no medical detection or known cure for autism, thousands of children have shown significant improvement resulting from early diagnosis and use of effective intervention
- The increase in prevalence rate cannot be explained by better diagnosis alone. Some have suggested that autism is just being better diagnosed today versus years ago and that many cases of mental retardation are now being coded as autism. This would also assume that the experts diagnosing autism before did not know what they were doing. This is NOT TRUE. Autism is the only disorder dramatically on the rise while mental retardation, Down syndrome and cystic fibrosis remain relatively the same
- While the cause of autism remains unclear, current studies show genetics and environment both play a role in the autism prevalence increase.

<http://www.tacanow.org/family-resources/latest-autism-statistics-2/>

The above statistics show the need for effective, intensive autism treatment. This need does not end at age 7. We ask that coverage of autism treatment be based on a child's needs, not their age.

Sincerely,

A large black rectangular redaction box covers the signature and name of the sender. The redaction is complete, obscuring all text in this area.

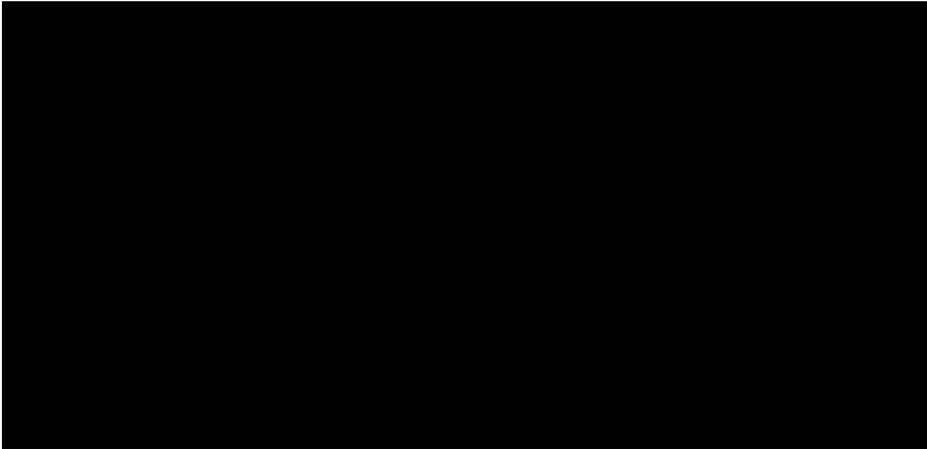
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According to Autism Speaks, a number of studies have demonstrated that ABA techniques can produce improvements in communication, social relationships, play, self care, school and employment. These studies involved age groups ranging from preschoolers to adults. Results for all age groups showed that ABA increased participation in family and community activities."

We are fortunate that Medical Assistance has covered quality, intensive ABA for our child with autism. The proposed reforms would eliminate this since our child is over the age of 7.

We have witnessed first-hand the continued impact of effective therapy. We ask that MA continue to cover this medically necessary treatment that schools simply cannot provide.

Sincerely,



Dear David Godfrey -

Children do not outgrow autism, yet the Reform 2020 proposal would end coverage for autism treatment at age 7.

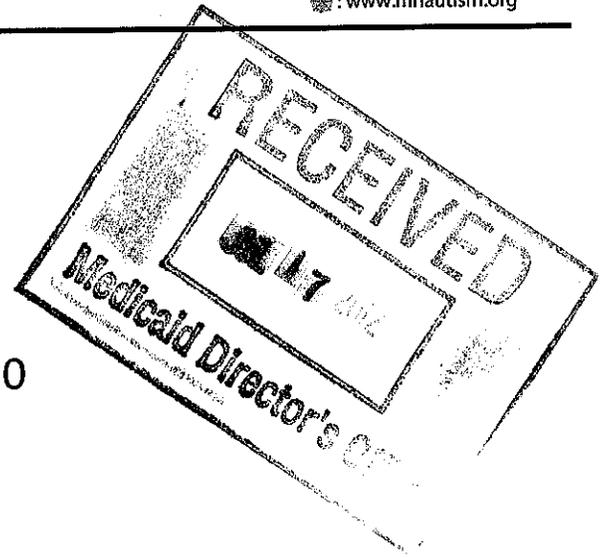
Reform 2020 assumes that all children will be ready for a school based program by 7. Many children with autism may be able to transition to a school for kindergarten. I have seen students thrive in such situations based on the skills that they developed in ABA therapy. While we would love this to be true for all kids, many will need additional years of intensive therapy. The amount of ABA therapy cannot be determined on age, but rather by looking at the needs for each individual child.

Reform-2020 needs to be reformed! Intensive intervention is needed for autism without age limits.



July 13, 2012

REFORM 2020



Waiver 1915(i) comments:

Although The Minnesota Autism Center (MAC) recognizes the need to expand funding options for children with Autism Spectrum Disorders (ASD), concerns exist over the implementation of the 1915(i) and limitations of service beyond age 7. The issues facing each child with autism are as diverse as the children themselves, requiring individualized programming. The rate of success depends on individual factors surrounding each child and their family components. Although rates of acquisition can be estimated, they in no way can be guaranteed and each child's need and issues change as they age. What is clearly established, however, is that intensive ABA programs allow children to reach goals of greater independence and quality of life far in comparison to their peers with autism who do not access ABA-based treatment programs.

The covered services under 1915(i), including improving a child's communication skills, increasing social interaction and reducing maladaptive behaviors, are those that all ABA programs provided at MAC address. The concern is to provide only "time-limited early intervention services that taper off as children reach school age". Currently, MAC programs reach children ages 2 – 21. All data supporting progress is graphed and analyzed and clearly demonstrates that need and success are achieved throughout the teenage years.

To conclude that after age 7 it is expected that a child be enrolled in school and receiving services in a school environment, does not contemplate the child that continues to need intensity to address their needs associated with their ASD diagnosis; an intensity that public schools are ill-prepared to provide.

Over the past five years, efforts have been underway to secure dedicated funding for autism treatment in all fifty states. Across the nation, states have rallied to enact legislation to cover treatment costs. To date, 31 states have enacted legislation to mandate coverage for autism treatment.¹ Of these 31 states who have enacted insurance coverage laws, NOT ONE limits services or coverage at the age of 7, in fact, most laws cover services well into the teenage years. Minnesota's own component for Individual and Family skills coverage, Children's Therapeutic Service and Supports (CTSS), provides coverage for medically necessary services into adulthood.

As with any other medical or mental health disorder, the determining factor for services is the threshold of medical necessity of service. Tying the hands of our states' medical and mental health professionals with an arbitrary, one-size-fits-all age determination appears to be in conflict with the broader intent of

¹ See www.autismvotes.org/site

Reform 2020. Shifting services from a specialist to generalist would never be considered appropriate treatment for a child if the disorder were cancer, diabetes, depression, etc. Autism is broadly recognized as a medical and mental health disorder and as such should allow treatments options consistent with any other childhood disorder.

Additionally, to expect the personnel of our over-crowded and under-funded schools to be able to meet the growing needs of the burgeoning autism population is not a realistic expectation. Taking a child with autism making progress under the supervision and care of an autism specialist and replacing the care with an autism generalist in the public schools is not creating a pathway to success for the school or the child. As with any other medical or mental health issue, primary care and direction of a child with autism should remain under the direction of a recognized specialist for the condition treated. We ask that Reform 2020 more clearly acknowledge the need and right to specialized autism care into adulthood.

MAC has always valued its relationship with The Department of Human Services (DHS) and the support MAC receives for its programs and the children it services. Families in Minnesota have been fortunate to have the support of the Legislature and DHS in covering services for ASD. As the prevalence of autism increases, so will the demand for quality and data-driven services. MAC is committed to the continuing expansion of programming and providing therapeutic support for children, adolescents and families. It is our hope that together we can continue to make positive strides in the fight against autism.

About the Minnesota Autism Center:

The Minnesota Autism Center is a Minnesota 501(c)(3) non-profit which has been providing therapeutic services for children, adolescents and families affected by autism for over 16 years. Programs through MAC provide therapeutic supports and are based upon the principles of Applied Behavioral Analysis (ABA). The Mission of MAC is to promote and provide home, school and center-based behavioral and academic service for children and adolescents affected by Autism Spectrum Disorders. MAC promotes the general education and welfare of persons challenged by Autism Spectrum Disorders and supports the development of healthy families.

Currently, MAC services over 250 families, in 31 Minnesota Counties. Services provided by MAC include assessment and diagnosis at MAC's assessment facility located in Minnetonka, Minnesota. Assessments are conducted by one of MAC's highly trained and experienced Mental Health Professionals. Working with the family, MAC's Clinicians assess, diagnosis, and provide advice for treatment based on each child's individual diagnostic profile and the medical necessity of services.

MAC provides a variety of service options for families in a variety of locations that fit best with the needs of each individual family. MAC Centers are located in Minnetonka, Woodbury, and Rochester. The MAC School, which provides services to adolescents in grades 4th through 12th, is located in Eagan, Minnesota. MAC also provides in-home support ranging from full service intensive intervention to consultation, in 31 Minnesota Counties.

In addition to traditional ABA therapeutic supports, MAC provides comprehensive services including speech and occupational therapy. This unique service model allows MAC's clinical team to work together

and create an integrated treatment plan, thus creating a fully rounded therapeutic program for each child. In line with the MAC Mission to address the needs of the entire family unit, MAC provides Parent Support Groups, Sibling Support Groups and Individual Therapy for Parents and family members. All groups are facilitated by one of MAC's trained clinicians.

Additionally, MAC works hand- in-hand with each child's social worker, pediatrician and school district personnel, to develop a comprehensive approach to therapy services. The goal of all MAC programs is to achieve the highest outcome possible for each individual child based upon their individual characteristics.

Currently, MAC employs over 330 Mental Health Practitioners and Professionals across the State of Minnesota. Many of these clinicians are BCBA or BCaBA certified and hold advanced degrees in behavioral studies.

As the prevalence of autism continues to rise², MAC has made strides to assure that programming is as clinically progressive and effective as possible. MAC has recently partnered with the nation's largest autism service provider, the Center for Autism and Related Disorders (CARD), and has acquired CARD's state-of-the-art online curriculum tool, "Skills". *Skills* provides an assessment and corresponding curriculum that addresses every skill a child learns in typical development from infancy to adolescence across every area of human development. *Skills* offers the first and only ABA-based comprehensive social skills, social cognitive and executive functions curricula available. It is also one of the only on-line programs available that provides the ability to write behavioral intervention plans for challenging behaviors. Nearly 4000 lessons including IEP goals, tracing forms and charts and graphs are encompassed in the program.

The *Skills* curriculum tool will allow MAC to provide the most effective therapy program available today. MAC clinicians will undergo an extensive training on the tool and begin implementing the curriculum in August.

The composition of the families and children MAC services is diverse. Over 33% of families serviced by MAC are minorities, with the Somali community representing 9% of all MAC families. The average age of a MAC child is 8.6 years. The average hours of services per child per/ per week are 27.5. As a 501(c)(3) organization, MAC is committed to serving all sectors of our states' autism population regardless of race, ethnicity, or social/economic status in not only the metro Twin Cities, but throughout Greater Minnesota.

² See www.cdc.gov/autism

Dooley, Lea M (DHS)

From: Kari Weddle <mail@change.org>
Sent: Monday, July 09, 2012 1:39 PM
To: *DHS_Reform2020Comments
Subject: Don't Cut Autism Coverage!

Greetings,

I just signed the following petition addressed to: Minnesota Department of Human Services.

Autism is treatable! All children who have autism should have affordable access to effective, medically necessary care for autism. DHS should act to ensure that both public health care programs and private insurance cover treatment for autism.

I am joining the Autism Advocacy & Law Center, LLC in petitioning the Minnesota Department of Human Services to ask them to revise their proposal to create an "Autism Benefit Set" under Medical Assistance. Medical Assistance coverage for children who have autism should be based on medical necessity and should include, at a minimum, coverage for evidence-based, clinically effective treatment.

Also, DHS should provide formal opportunities for members of the autism community to provide input before finalizing policy changes! Specifically, DHS should obtain input from the health care professional who treat individuals who have autism! DHS should also hear from individuals on the spectrum and their friends and family.

Don't Cut Autism Coverage!

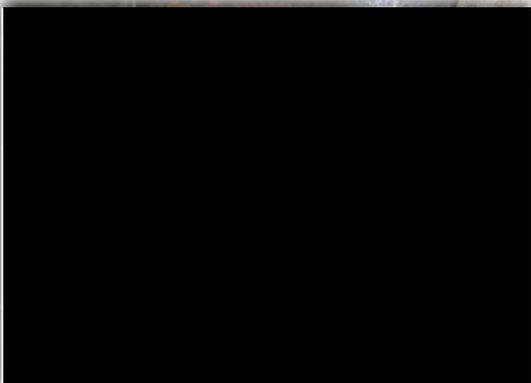
Sincerely,

Kari Weddle
Minneapolis, Minnesota

Note: this email was sent as part of a petition started on Change.org, viewable at <http://www.change.org/petitions/minnesota-department-of-human-services-don-t-cut-autism-coverage>. To respond, [click here](#)

Diagnosis

At first, everyone around us kept saying that [REDACTED] is delayed and will talk eventually. We wanted to believe that, but certain symptoms made us really suspicious that something has gone wrong. Little eye contact, sensitivity to noise and crowds, very limited preferred foods, and very few vocabularies gave us more assurance that [REDACTED] is being lost. At age 3, we began to see regression in the few words he had, no interaction with others, and lack of interest in pretty much any activities a typical age child would do. [REDACTED] took on a private speech therapy and was also enrolled in a public school district on a part time basis. [REDACTED] did not show any progress, in fact there was more regression. Through our perseverance to do what is best for our son, the ABA program was recommended to us. Our son needed intense treatment and different methods and techniques as they were vital in his case. [REDACTED] needs are enormous, in fact, he is on a very structured schedule on a daily basis. Part of the ABA program is not only intense but very structured and personalized.



[REDACTED] sparkling eyes at age 3

Message for Lawmakers

Hope and, more importantly, results are often found in Applied Behavior Analysis (ABA) and Intensive Early Intervention Behavior Therapy (IEIBT). A study by Chasson, Harris, and Neely in the State of Texas approximate that 47% of children treated recover "typical" function and 40% make significant improvement. Various studies indicate lifetime costs of autistic children can reach \$3 million if left untreated. These costs can be more than halved if ABA/IEIBT is applied to the child's care.

Please support the Autism Healthcare Protection Act H.F. 1071 (Rep. Norton) S.F. 1020 (Se. Higgins) or other such legislation that provides coverage for medically necessary autism treatment.

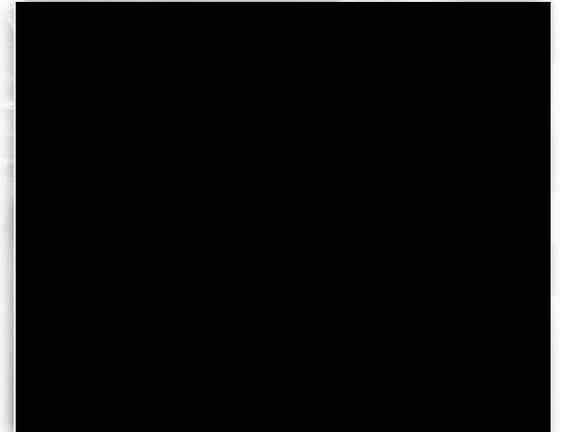
Follow link to find your legislatures:

<http://www.gis.leg.mn/OpenLayers/districts>

Parents

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Our Autism Story



[REDACTED] loves the water



July 2010

[REDACTED] was born on [REDACTED] [REDACTED] made his first steps at age 13 months. He counted 1 thru 10 and said few words. At 24 months, we started seeing less eye contact, solitude, tip toe walk, plugging ears, flapping hands, and sensory input. He was not interested in playing too much, in fact he preferred being alone. We realized something is serious as [REDACTED] began to slip away from us. From that day, [REDACTED] had begun an unpredictable journey.

What is Autism? What is Autism Spectrum Disorder?

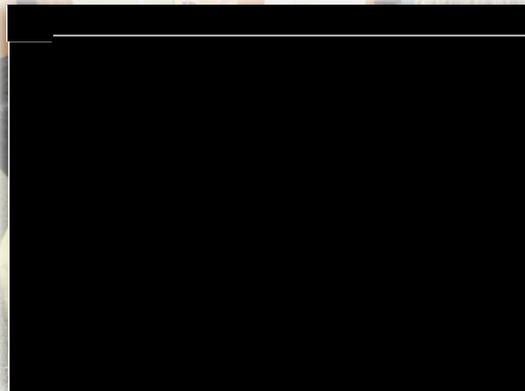
Autism spectrum disorder (ASD) and Autism are both general terms for a group of complex disorders of brain development. These disorders are characterized, in varying degrees, by difficulties in social interaction, verbal and non-verbal communication and repetitive behaviors. They include autistic disorders, Rett syndrome, childhood disintegrative disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS) and Asperger Syndrome. ASD can be associated with intellectual disability, difficulties in motor coordination and attention and physical health issues such as sleep and gastrointestinal disturbances. Some persons with ASD excel in visual skills, music, math, swimming, and art. According to autism science foundation, 1 in 88 Diagnosed with ASD, CDC reports (1 in 54 are Boys). March 29, 2012



■ jumping while flapping hands

What is A.B.A

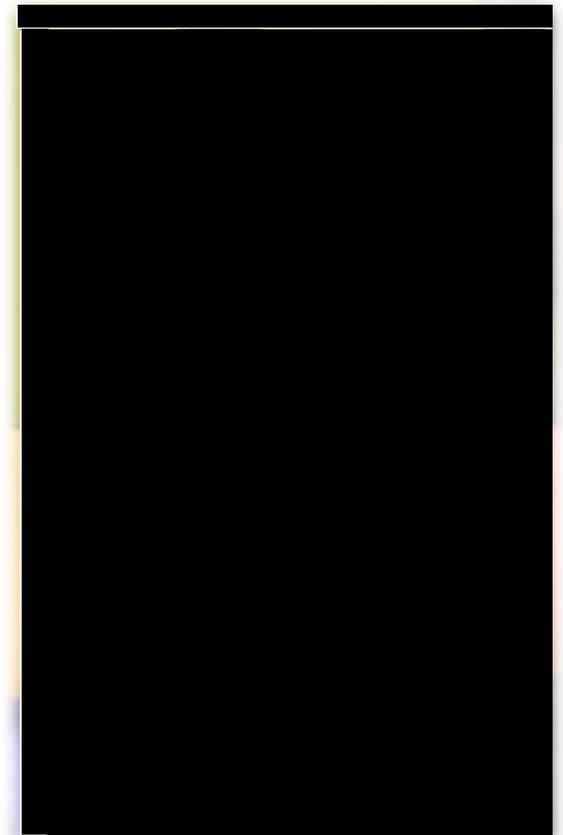
Applied behavioral analysis is a scientific approach to understanding behavior and how it is affected by the environment. "Behavior" refers to all kinds of actions and skills (not just misbehavior) and "environment" includes all sorts of physical and social events that might change or be changed by one's behavior. The science of behavior analysis focuses on principles about how behavior works, or how learning takes place. For example, one principle of behavior analysis is positive reinforcement. When a behavior is followed by something that is valued (a "reward"), that behavior is likely to be repeated. Through decades of research, the field of behavior analysis has developed many techniques for increasing useful behaviors and reducing those that may be harmful or that interfere with learning. Applied behavior analysis (ABA) is the use of those techniques and principles to address socially important problems, and to bring about meaningful behavior change.



■ requesting during ABA session

Who can benefit from ABA?

ABA methods have been used successfully with many kinds of learners of all ages, with and without disabilities, in many different settings. Those methods or techniques are used in both structured situations (such as formal instruction in classrooms) and in more "natural" everyday situations (such as during play or mealtime at home), and in 1-to-1 as well as group instruction. They are used to develop basic skills like looking, listening and imitating, as well as complex skills like reading, conversing, and taking the perspective of others.



■ closely paying attention
"love those eyes"



AUTISM ADVOCACY & LAW CENTER

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www.aut1smlawcenter.com

Executive Director

Amy Dawson

DATE: JULY 17, 2012

Carolyn Westra

To: David Godfrey, Medicaid Director
Minnesota Department of Human Service

Katie Olson

PO Box M6 998

St. Paul, Minnesota 55164

Re: Comments on Reform 2020 and the Proposed Autism Benefits Set.

Dear Mr. Godfrey,

On behalf of the 1150 people who signed the petition urging the Minnesota Department of Human Services to revise its MA Reform 2020 proposal, the Autism Advocacy & Law Center, LLC submits these written comments. A copy of the petition and the names of 1150 signatories is attached, along with 157 additional written comments collected by the Autism Advocacy & Law Center.

The Autism Advocacy & Law Center, along with more than 1,150 Minnesotans and numerous parents who testified at public hearings, has urged DHS to revise its MA 2020 Reform proposal.

The MA Reform 2020 proposal as written would route children diagnosed with autism into a 1915(i) Autism Benefit Set to provide access to treatment, services and supports. Early intervention would be available only to children under the age of 7. Once children turn 7, children would have to access therapeutic treatment through their public school district. Medical Assistance is intended to provide coverage for treatment based on medical necessity, however, and access to treatment needs to be expanded in Minnesota -- not restricted. Recent court decisions have made it clear that this means that coverage must include treatment prescribed by a child's treating clinician.

Thank you for meeting with me personally last Friday. Thank you also for your assurances that the revised DHS proposal will not result in any reductions in MA coverage for children who have autism and that there will be no age cap on treatment.

As you know, the Autism Advocacy & Law Center, LLC is particularly concerned about the imposition of any arbitrary limitations on MA coverage, and also about any changes that would limit the choice of providers for children who have autism. **I am very relieved by the Depart-**

ment's commitment to revising its proposal to remove the age cap of 7 for early intervention and to make it clear that school-aged children will not be limited to schools as their only choice for treatment of their autism symptoms. Thank you for agreeing to make these revisions.

As the Department moves forward with revising its proposal to develop a 1915(i) Autism Benefit Set, it is my hope that the focus will be on ensuring that children have improved access to timely and effective medically necessary care. I am particularly pleased to learn that the proposed 1915(i) Autism Benefit Set will improve access to treatment for children enrolled in MA-PMAP. I encourage DHS to address this problem now, however, rather than await reform efforts that may not take effect until 2014 at the earliest. Children enrolled in MA-PMAP are legally entitled to the same benefit set as those enrolled in MA-FFS.

DHS should act to ensure that MA reform contributes toward improved outcomes for children who have autism by guaranteeing that all children, at any age, have access to medically-necessary care that is evidence-based and clinically effective. Both public health plans and private health insurance should cover treatment and therapy to the extent prescribed by the child's physician as medically necessary -- with no limits on intensity of treatment or arbitrary age caps.

Specifically, the Autism Advocacy & Law Center requests that the revised 1915(i) proposal for an Autism Benefit Set be consistent with the following principles:

1. Any limits to coverage should be based on functional need and medical necessity -- not on arbitrary distinctions such as an age cap or a diagnostic label;
2. The proposal should clearly state that there will be no reduction of coverage for treatments, services or supports for children who have autism;
3. Coverage should clearly include treatment recommended as medically necessary by a child's treating clinician;
4. Children who have autism need more choices for various treatments from different providers -- no child should be limited to school-based services or be forced to wait 12 months for early intervention;
5. The Department should focus on outcome measures to ensure that treatments are clinically effective -- this will ensure that children are receiving high quality services and that tax dollars are being well spent;
6. If a treatment is evidence-based -- such as intensive early intervention behavior therapy or applied behavior analysis -- then it should be specifically included for coverage in the "Autism Benefit Set;"
7. Generally accepted practices, like "day treatment" and "social skills therapy," should also be included in the "Autism Benefit Set;"
8. Experts who typically diagnose, treat, and manage care for children who have autism should be consulted and included in developing the "Autism Benefit Set;"
9. Members of the autism community should be included in the process of policy change -- especially individuals who have autism and their families.

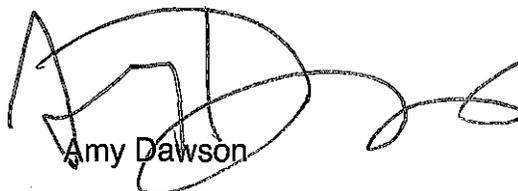
As the Department moves forward with revising its proposal for a 1915(i) Autism Benefit Set, the most important step is to receive meaningful public input. The development of the 1915(i) Autism Benefit Set proposal was conducted without any public input and without any transparency whatsoever. On a going forward basis, DHS should develop autism related policy with input from the experts from the Mayo Clinic and the Autism Spectrum Disorders Clinic at the University of

Minnesota, as well as from providers of the various types of treatment and services currently covered under MA. Since the proposal has a clear emphasis on early intervention, the Department should specifically engage providers of early intervention and ask them for outcome data and standards of care. This information will help ensure that policy changes are well-informed and that children receive high-quality care.

DHS has a responsibility to tax payers to be a good steward of resources. As such, the Department should act not only to ensure that treatments covered by MA are clinically effective, but also to ensure that children have meaningful private insurance coverage. As part of its reform effort, DHS should act to ensure that all state-regulated health insurance plans cover, at a minimum, evidence-based medically necessary care and treatment for individuals who have autism. If private health insurance covered evidence-based early intervention alone it would save the state at least \$1.6 million dollars annually.

During the past several weeks since the MA Reform 2020 proposal was released for public comment, DHS has shown a willingness to listen to the Autism Community and to revise its positions based on public input. Thank you for your responsiveness. The Autism Advocacy & Law Center looks forward to reviewing the revised proposal and to working with the Department to improve access to health care coverage for individuals who have autism.

Very Truly Yours,
AUTISM ADVOCACY & LAW CENTER, L.L.C.



Amy Dawson

To: The Governor of MN and Minnesota Department of Human Services

Subject: **Don't Cut Autism Coverage!**

Letter: Greetings,

I just signed the following petition addressed to: Minnesota Department of Human Services.

Autism is treatable! All children who have autism should have affordable access to effective, medically necessary care for autism. DHS should act to ensure that both public health care programs and private insurance cover treatment for autism.

I am joining the Autism Advocacy & Law Center, LLC in petitioning the Minnesota Department of Human Services to ask them to revise their proposal to create an "Autism Benefit Set" under Medical Assistance. Medical Assistance coverage for children who have autism should be based on medical necessity and should include, at a minimum, coverage for evidence-based, clinically effective treatment.

Also, DHS should provide formal opportunities for members of the autism community to provide input before finalizing policy changes! Specifically, DHS should obtain input from the health care professional who treat individuals who have autism! DHS should also hear from individuals on the spectrum and their friends and family.

Don't Cut Autism Coverage!

Sincerely,

Why People Are Signing The Petition: Don't Cut Autism Coverage!

- [REDACTED]

4days ago

1 person likes this reason

Our son, age 11, made SIGNIFICANT PROGRESS using ABA for the last 4 years. He may now possibly be able to get a job and be a functioning member of society in the future. We now homeschool him because services in the public school system are so rotten. He was making ZERO progress using public schools previously. Intense, one on one therapy works. Listen to the parents!!!

- [REDACTED]

6 days ago

Mom of a child with Autism. Early invention has changed my child's life, for the better! He was non verbal, at age 9 he responds to closed ended questions, he never was able to say the words, "I love you", as a toddler, now he does! There should be no age cap on his treatments/learning. There is non on yours.

- [REDACTED]

5 days ago

We recently moved from Minnesota, where my son received ABA services from the [REDACTED]. He made tremendous gains and has been attending school with no supports at all! Autism is absolutely treatable and curable!

- [REDACTED]

7 days ago

My granddaughter has autism and she has shown great improvements in her speech due to early intervention and therapy. This needs to continue to be available to all children with autism.

- [REDACTED]

6 days ago

I have more than one child that has received treatment after the age of 7. We have seen tremendous growth in our children. The school district was not qualified to treat our children and we even saw them getting worse while receiving special education. Children with autism deserve access to effective medical treatment. This will only save money for everyone in the long run.

- [REDACTED]
6 days ago

I have seen the outcomes firsthand. Children make unbelievable progress with this therapy. To stop funding would without a doubt be more expensive for the state in the long run.

- [REDACTED]
2 days ago

Our 4 year old grandson was diagnosed as having autism two years ago and with the help of therapy has made great progress. Please continue to help him get this service.

- [REDACTED]
about 20 hours ago

I have a boy with autism who have greatly benefited from ABA therapy in [REDACTED] and who because of that will be able to lead a fulfilled life, will have a job as a next computer designer or will be a next Mozart :o) and will pay taxes to the government instead of draining resources to fund his living in a group home. Do not cut the funding, by doing so it will cost the government more money in the long run.

- [REDACTED]
6 days ago

Mom of a child with Autism.

Kids need therapy coverage at ALL ages there should never be a stop to giving people with autism what medical coverage they need. Everyone has the right to be successful for those with autism that means access to medical treatments at all ages!

- [REDACTED]
2 days ago

I think there is a lot that could be done to help autistic people live more useful and fulfilling lives.

- [REDACTED]
about 13 hours ago

I have a 16 year old son with autism

- [REDACTED]
about 5 hours ago
Grandson age 9 lives in MN.

- [REDACTED]
about 7 hours ago

It is unfathomable to think that a child's potential ,to learn ends at age 7. In what other realm would this be considered acceptable? Teaching our children with autism with effective therapies today helps them to reach their full potential and increase their quality of life. If that isn't reason enough, it also decreases the cost of caring for an adult with autism for their entire lives, which will be a colossal financial strain on the next generation, as 1 in 88 children with autism becomes 1 in 88 adults with autism.

- [REDACTED]
7 days ago

My daughter has autism!

- [REDACTED]
4days ago

I know the public schools cannot give all the help needed for children with autism. **It** is a condition which needs intensive therapeutic treatment.

- [REDACTED]
about 23 hours ago

If it were not for the Early Childhood Programs, my daughter, who has autism, would not of progressed as far as she has. **It** was amazing what was accomplishe for her in these programs. To eliminate this programs would border on being inhumane.

- [REDACTED]
1 day ago

Nothing should be left out. I hope who wants to cut this has someone in life to deal with autism so they understand

- [REDACTED]
6 days ago

My son has shown dramatic improvement becuae of his home therapy program. He is doing things now he has never done before. Schools are not adequately funded or trained to address the daily difficulties that these students face. The proposal to put the onus for providing necessary therapies on the schools will be a complete disaster for many students and their families. Just because there is a desire to save money does not mean that these children of special need should not get appropriate and meaningful treatment

simply because they have passed by their 7th birthday.

- [REDACTED]
6 days ago

I work with children with autism providing IEIBT and I've seen firsthand the lives that are changed because of this therapy. Not allowing children to access this medically necessary therapy is shameful and antipathetic.

- [REDACTED]
1 day ago

I am a teacher that works with lots of various amazing children.

- [REDACTED]
1 day ago

People with autism can make great improvement with the proper therapy. I've seen it in my daughter and believe every child with autism should have the opportunity to reach their fullest potential.

- [REDACTED]
7 days ago

My autistic grandson is 7 1/2 and is still benefiting greatly from ABA services that he began at age 3 1/2. His treatment is covered by private insurance which would not pay if he weren't making progress. Educational intervention by school districts is necessary but is not the same. Studies have shown that the cost of treatment is FAR LESS than the cost of lifetime public services for an untreated autistic child. I know that cost is a big concern at this time but treatment must continue as long as the child is benefiting from it. If not, the cost will be far more down the road! ·

- [REDACTED]
4 days ago

I work with kids in Minnesota who have Autism. Kids with Autism need all the help they can get in those early years!

- [REDACTED]
6 days ago

My friend's son has autism, I want him to get all the available medical assistance.

- [REDACTED]
2 days ago

This condition stuns families emotionally and financially. Even with an income well above average it is impossible to pay for the necessary treatment which needs to be done as early as possible in a child's life for it to do good.

- [REDACTED]
2 days ago

These children need this funding.

- [REDACTED]
about 11 hours ago

Friend's child is autistic

- [REDACTED]
1 day ago

I have a great-nephew who is 7 and still needs such services to help him function. I don't believe the public schools will be enough to help him gain the skills he needs to grow into a person who can get along in society.

- [REDACTED]
about 22 hours ago
Intervention is the key. Children with Autism deserve it!

- [REDACTED]
6 days ago
My son has Autism and receives ABA

- [REDACTED]
7 days ago

We have personal experience with our son's intensive, evidence-based treatment for autism that only started at age 7. The treatment he received was highly effective and was provided with skill and intensity not available through any school district; school districts are no more qualified to directly "treat" autism than they are to treat cancer, for example. These kids desperately need treatment from those qualified to provide it using scientifically validated methods. Please help!

- [REDACTED]
1 day ago

As a mother with a son with Autism. I understand the importance.

- [REDACTED]

6 days ago

My seven year old still benefits from therapies, especially ABA therapy, and deserves to have coverage for the therapies that his providers have recommended as medically necessary for his continued development and quality of life.

- [REDACTED]

1 day ago

My son has autism. While living in Minnesota, he had intense behavioral therapy. IT WORKS. I can't imagine where we would be now without it, and no family or child should be denied the opportunity. Ignoring the long-term ramifications of not providing prescribed therapy for these children is foolish.

- [REDACTED]

2 days ago

A family that I love dearly depends upon this coverage in order to give their son the best life he can possibly have. Losing this coverage would crush them.

- [REDACTED]

My two son's have Autism,

- [REDACTED]

1 day ago

My son is autistic and has had many medical issues. I do not have insurance that covers **him** and we have badly needed medical assistance.

- [REDACTED]

I have seen the benefits of autism treatment time and time again. I know it works and I know how important it is for these families to have affordable access to effective, medically necessary care for autism!!

- [REDACTED]

about 1 hour ago

My husband nephew has autism and he lives in MN

- [REDACTED]
6 days ago

Children with autism need early intervention services to give them the skills they need to function in their environments. The earlier they receive services the better it is for the child with autism. What is the states plans for children with autism if they will not fund early intervention services? Put them in school at the age 5? Let the school system teach the child how to communicate? Each child with autism is different, earlyintervention is specific to the child. School systems do not have the resources they need to teach all children with autsim. Early intervention programs do.

- [REDACTED]
about 24 hours ago

Because I have first-hand seen the positive results that these programs can have

- [REDACTED]
2 days ago

I am a constituent and a mother of an autistic son.

- [REDACTED]
3 days ago

Because Early intervention works

- [REDACTED]
about 11 hours ago

My son [REDACTED] age 4, diagnosis PDD-NOS, would be lost without autism coverage, and so would we. It's ridiculous to think that he would get all the treatment he needs from the school district. There aren't enough teachers or funding for that. He has greatly improved since being in an autism day program and we look forward to seeing more progress with him!!

- [REDACTED]
1 day ago

Because services should be based on medical necessity and functional need, not age. Also, schools are not equipped to provide either the expertise or the resources necessary for effective treatmetn.

- [REDACTED]
6 days ago

Our son has been diagnosed with Autism and ABA intervention helped him greatly in many areas such as communication, calming down, and self care to mention few. This service needs to be available for all who needs it as they are not able to ask for themselves so we parents do in behalf of them.

- [REDACTED]
4 days ago

I have a dear friend with an amazing child who happens to be autistic. The public school system just brushed **him** under the rug. Programs are needed with trained professionals so these children can flourish!

- [REDACTED]
about 8 hours ago

grandson has autism

- [REDACTED]
4 days ago

Who would ever say a child in need, can not have the necessary medical, therapy, or other necessities to grow healthy and productive is living in the dark ages. America as a country has always pulled together to help those in need, and the children with Autism are in desperate need to have the proper therapy/treatments in order to grow as healthy and strong physically and mentally as possible. The program should be increased if nothing else.

My adorable grandson has improved greatly in many areas with early intervention and therapy.

If anything, the question that should be asked is how can we help children with Autism more.

The reality of the situation must be faced once and for all- we are talking about children in need and who could say no with a clear conscious?

- [REDACTED]
[REDACTED]
[REDACTED]

- [REDACTED]

4 days ago

ALL children deserve the Best!!

- [REDACTED]

7 days ago

ask your self WWJD enough said

- [REDACTED]

2 days ago

My nephew has autism, and his parents are fighting really hard to make sure his development accelerates now, while he's young. It's a crucial time, and I'd hate to see any tools taken away from them after all the hard work and sacrifice they've put in.

- [REDACTED]

about 21 hours ago

One of our grandsons has an autism spectrum disorder. We have seen first hand the value of the programs for which funding is sought, and recognize the burden borne by families with these children.

- [REDACTED]

1 day ago

Without early intervention, my son would have been in serious trouble when he entered school. Plus, so many parents don't have an opportunity to know what might be going on with their child without the help of experts.

- [REDACTED]

1 day ago

Supporting my friends touched by autism - specifically [REDACTED]

- [REDACTED]

4 days ago

iam a mother of a child with autism. the ABA therapy has changed my kid to verbal. this should continue to be available to get the resources for my kid.

- [REDACTED]

1 day ago

I have 2 grandchildren that are living proof of how early intervention is an absolute need to progress and be productive citizens.

- [REDACTED]
about 11 hours ago

As an educator, I am aware of cuts in spending in our public schools. The classes are getting larger and aides' time is stretched. Also, the idea of kids not having the opportunity for diagnosis after the age of 7 is bad.

- [REDACTED]
5 days ago

Therapy and early intervention works! Support treatments like Applied Behavior Analysis and Applied Verbal Behavior Therapies.!

- [REDACTED]
about 8 hours ago

We have a son with autism

- [REDACTED]
5 days ago

for my 5 year old nephew.

- [REDACTED]
7 days ago

For my son, [REDACTED], for the autistic kiddos of my good friends & for all the amazing kids and families facing this challenge.
I've watched early education & therapy WORK first hand.
The financial investment in these kids, early...is essential
:)

- [REDACTED]
about 12 hours ago

My child was diagnosed with autism at age 5. If you cap autism services at age 7, my daughter will no longer be eligible for the ABA services which have helped her already so much!

- [REDACTED]
5 days ago
Our aS year old son with Autism still needs OT and speech that the school will not provide!

- [REDACTED]
6 days ago

My Autistic son has made the most significant progress in the last year and a half. He is 8. Please don't give up the fight.

- [REDACTED]
7 days ago

On behalf of my 9 year old son, who lives with Autism.

- [REDACTED]
3 days ago

This is a critical public health issue, and restricting access to services will have an extremely negative effect on many families with autistic children.

- [REDACTED]

My child with autism was born [REDACTED] years ago. There were few others then, now there are many children with this disorder. Treatment is important at all ages. Please do not cut back on this treatment.

- [REDACTED]
2 days ago

I know young people with autism who are thriving in late teen/early adulthood because they have had this access to treatment.

- [REDACTED]
6 days ago

We are part of a ERISA insurance plan which means that our insurance is part of the loophole that does not have to cover things even with a mandate. Should we have to go the public route for coverage for our son with autism, we will have nowhere else to get coverage if DHS stops covering autism treatments. 1 in 88 children are diagnosed every single day with an ASD. They are not second-class citizens and they deserve treatment and a fulfilling life!

- [REDACTED]

6 days ago

Because I've been a therapist and have seen families struggle to treat their child.

- [REDACTED]

1 day ago

Great Grandson is autistic

- [REDACTED]

7 days ago

My son needs coverage! I owe all of his amazing progress to early intervention strategies!

- [REDACTED]

about 4 hours ago

My nephew lives in Minnesota and is severely autistic and his parents need the coverage for his care.

- [REDACTED]

1 day ago

My 7 year old grandson has severe non verbal autism.

- [REDACTED]

7 days ago

Autism families are suffering in countless ways. They are silently trapped in our homes with children who are sick, nonverbal, needy 24/7 and sometimes violent. Autism is treatable, but the most effective medical treatments often are not covered by insurance. Please do not add to the suffering of these families -- please do not cut what little coverage they have.

- [REDACTED]

8 days ago

I have a 6 year old son with autism.

- [REDACTED]

about 10 hours ago

My daughter is an autistic young adult.

- [REDACTED]
2 days ago

We have Autism in our family, it's a growing epidemic, please don't cut the coverage!

- [REDACTED]
about 21 hours ago

I have an 18 year old son with severe autism who benefited greatly from early intervention ABA. In addition, I have a 3 year old niece who was also diagnosed. with Autism and who is currently receiving ABA service which are having a tremendously positive impact on her condition. I know firsthand that Early Intervention ABA works and feel strongly that all children diagnosed with autism must have access to this vital resource.

- [REDACTED]
5 days ago

Kids with Autism should be treated with the evidence-based methods regardless their age. I respect and appreciate every teacher's hard work. However, I don't think that the public school systems have the enough experts and experiences to provide the adequate therapy/treatment to this unique and challenging group of kids. My son went to the special ed when he was 3. This is the year that he did the worst, almost no improvement. He even got worse in lots of areas. In addition, I am feeling very disappointed and sad that our beloved state tries to cut the Autism service by adding the age limit while most of other states moving forward by passing their AUTISM mandates law. Can our state moving forward instead of moving backward?

- [REDACTED]
4 days ago

I discovered this therapy via U of M, & it gave my great nephew a real life. My older niece and dozens of my past students were not lucky enough to have this, and will therefore be disabled all their lives,needing much public funding for support and care.. The money spent for little [REDACTED] therapy will yield a self supporting, taxpaying citizen.

- [REDACTED]
5 days ago

My 4 year old son, [REDACTED], is benefiting tremendously from early intervention therapy, primarily ABA. To select an arbitrary date to cut off treatment regardless of a child's unique needs and expect the schools to treat these kids is not a workable solution.

- [REDACTED]
5 days ago

My Friend's son has autism and he is making good progress with the therapy. Do not stop the Coverage..

- [REDACTED]
3 days ago

I support access to medically necessary treatment such as Intensive Early Behavioral Intervention for children with autism spectrum disorders.

- [REDACTED]
5 days ago

Only effective, evidence-based treatment can help people with autism achieve their full potential. Please don't set the age cap at 7 as it is just unfair to others who are older.

- [REDACTED]
2 days ago

Because autism is treatable and curable!

- [REDACTED]
5 days ago

As a teacher, I see how difficult life and learning can be for those on the spectrum. We need to continue research into causes and treatment.

- [REDACTED]
7 days ago

I am signing because autism has already affected my family, friends and will affect every taxpayer when children with autism grow up to be adults with autism that mainstream society CANNOT handle! I have seen first hand autism intervention for my little cousin who has benefited greatly from it.

- [REDACTED]
about 5 hours ago

[REDACTED] asked me to

- [REDACTED]
1 day ago
I believe that this cause needs support

- [REDACTED]
6 days ago

Medical provider of children with ASD who looks at measurable outcomes at ANY age to determine the medical necessity of continuing an evidence-based intervention

- [REDACTED]
1 day ago

I have spent the last two years as an ABA behavior therapist and I have seen how enormously it changes lives. We had a 6 year old start at our facility and she had 1 sign-'movie'- and no vocals. It was assumed that she was severely mentally retarded because of her lack of communication. We probed out 75 pictures of common items with her and were shocked to discover that she was able to identify 59 of them! There was so much knowledge locked up in her little head and she had no way to let it out. In just six months she's learned about 25 signs and can finally communicate her interests, wants, and needs with her family. Recently, her speech pathologist got her to form her very first word: 'mom'. Speech, ABA, and occupational therapy are what made her amazing progress possible; don't take that away from these wonderful children.

- [REDACTED]
6 days ago

For all my friends that struggle daily!

- [REDACTED]
7 days ago

My goddaughter has autism and i've seen the remarkable progress that can be made with appropriate therapy. All children should have equal access.

- [REDACTED]
6 days ago

I know parents of children with autism. Raised with the benefit of services to ameliorate my own [REDACTED], I understand the critical need for medically-necessary therapy. We may not--we cannot--compromise support for medically-necessary therapy because of ideological stances that government has no place in our lives. Medically-necessary therapy is vital to fostering the highest level of respect for life. Quality of life is vital. Support for medically-necessary therapy may not be compromised.

- [REDACTED]
7 days ago

For my 3 autism angels. [REDACTED]

- [REDACTED]
5 days ago

one of my grandsons is autistic

- [REDACTED]
3 days ago

Autism can be a life long condition, choosing to stop coverage after a very young age is ludicrous!

- [REDACTED]
6 days ago

My son deserves quality autism treatment based on his needs--not his age!

- [REDACTED]
[REDACTED] has autism.

- o [REDACTED]
5 days ago

I have a son age 6 with autism who has responded very positively to early interventions including ABA. The schools are not equipped for this type of intensity, and we need to keep providing medically necessary treatments for kids of ALL ages to help give them a happy and independent future.

- [REDACTED]
1 day ago

I've taken care of children with Autism, there is hope and families need to have proper coverage in order to seek treatment in order to live a normal life.

- [REDACTED]
about 8 hours ago

My 5 yr old grandson has autism, he needs to be able to attend a special school that fits his needs.

- [REDACTED]
[REDACTED] days ago

I have 2 children with Autism, one is 21 years old. Autism doesn't go away at age 7. They all need ongoing support and services, particularly medical coverage.

- [REDACTED]
1 day ago

"All children who have autism should have affordable access to effective, medically necessary care for autism." My nephew is early 30's and deserves the best service and treatment as afforded to ALL others. Age should never be a factor -It is real and alive and this petition needs support.

- [REDACTED]
2 days ago

So many more children have been diagnosed with autism. It is time for us to recognize it as a treatable condition, and make qualified, recognized treatments available, regardless of income level or age of the child.

- [REDACTED]
2 days ago

Often times, autism is slow to be diagnosed. Putting age caps on treatments unfairly penalizes children and families whose diagnosis came later in the child's development.

- o [REDACTED]
5 days ago

I have seen many lives improved by Autism Therapy Services!

- [REDACTED]
about 1 hour ago

A family member has autism.

- [REDACTED]
2 days ago

My sister works for an ABA center and constantly tells me how much progress the kids are making! I'm also a Clinical Psychology PhD student and the important of mental health funding cannot be overstated.

- [REDACTED]
1 day ago

Early intervention is crucial in treating kids who have Autism. We need to ensure that these kids are guaranteed the treatment(s) and services they deserve.

- [REDACTED]
4 days ago

For over 50 years children with autism have been treated successfully. Over half of children treated can live productive, independent lives. We wouldn't think of eliminating cancer treatment for children that has a 50% recovery rate. Why would we eliminate this treatment and devastate our society by needing to care for 1 in 88 people. It is unthinkable.

- [REDACTED]
5 days ago

As an educator, I can see that a healthy child is a learning student. Ergo, ALL children, regardless of their medical challenges DESERVE optimal and effective medical care. Our children, ALL our children, are the future of our country. Support them!!

- [REDACTED]
6 days ago

I know it works

- [REDACTED]
about 7 hours ago

I am a teacher. Please continue to fund treatment for children with autism, without an age cap for early intervention. These children need and deserve to achieve the highest level of functionality. It benefits that child, their family, their teachers, and their classmates.

- [REDACTED]
6 days ago

I am signing because our amazing grandson has benefited from Autism therapy that wouldn't of been possible without Autism coverage. It changes lives of families touched by Autism.

- [REDACTED]
2 days ago

On behalf of friends in MN whose autistic son is benefiting from this program.

- [REDACTED]
4 days ago

Autism is too vast of a condition to abandon them or their parents

- [REDACTED]
4 days ago

my son was diagnosed with autism when he was 2 and is now mainstreamed with minimal symptoms of autism.

- [REDACTED]
about 16 hours ago

To help children with autism. I'm much rather my taxes went toward helping children rather than lazy adults who just don't want to work.

- [REDACTED]
2 days ago

I have a grandson who has autism.

- [REDACTED]
4 days ago

One of my closest friends has a son who was born with autism, and I have seen how difficult and expensive it is for families with autistic children to live their lives and help their child thrive. The parents are afraid of what will happen when he reaches 7, he deserves and will need more care than the public school district can provide. This is not an area where we should be saving money. There is a lot of waste within human services. As a person with a disability, may I point out the extreme markup of any product labeled "medical" as one place to save countless dollars.

- [REDACTED]
4 days ago

Every child matters.....

- [REDACTED]
1 day ago
For my son

- [REDACTED]

6 days ago

My grandson is three and newly diagnosed. he does not speak or communicate. My daughter is a wonderful advocate for him but they are on a very limited budget. he needs therapies to help his developmental disabilities.

- [REDACTED]

6 days ago

I have a son with autism. He has received both private and school based services and has progressed well because of both. He would have received greater benefits from earlier treatment, if it was readily available and covered. I also believe that he would have continued to progress if some of his treatment wasn't stopped when he reached a certain age. There may not be a cure but there really are treatments that are very helpful and make the person with autism more successful and productive.

- [REDACTED]

1 day ago

I have a family member who has Autism and my family works closely with the issue through a non-profit organization: [REDACTED].

- [REDACTED]

about 13 hours ago

For autism. We have a family member who is doing great because of ABA...you take this away and where does he go from here?

- [REDACTED]

1 day ago

My son is autistic. We desperately need this coverage. He is tremendously benefitting from intensive therapy.

- [REDACTED]

about 11 hours ago

My autistic grandson lives in Minnesota and needs treatment. What if someone in the governor's family had autism??

- [REDACTED]

2 days ago

My son is currently being treated through ABA and has made great strides. This therapy is changing his life and ours!

- [REDACTED]
about 13 hours ago
This negatively affects many families I personally know and how they care for their autistic children.
- [REDACTED]
2 days ago
Our 4 year old son has autism. Without this coverage our family, along with many others, won't be able to get the intensive therapy our children need to overcome their autism diagnosis.
- [REDACTED]
4days ago
My dear friends daughter has an autistic child and although God is with her and her husband making them wonderful, strong parents-we sure don't need to make it anymore difficult on them. GOod luck and thank you for your fight.
- [REDACTED]
5 days ago
Applied Behavior Analysis is a evidence-based treatment that allows individuals with Autism and other developmental disabilities to make improvements in socially significant behavior, including language, as well as reduction of problem behavior. I speak from the perspective of both a sibling of a young adult with autism and a Board Certified Behavior Analyst, and have seen the impact that a well-managed ABA program can have on the lives of individuals and their families dealing with Autism. Please continue to allow us to help these families by providing quality support.
- [REDACTED]
5 days ago
I am the parent of 2 sons with Aspergers. My oldest was killed at his workplace.
- [REDACTED]
1 day ago
Friends, students, and family deserve this!
- [REDACTED]
6 days ago
My son 8, has autism. We have utilized multiple therapies including ABA, it, pt, speech to help him become a contributing citizen and become the best hecan be. We have paid extremely large premiums to TEFRA in order provide him with the care he needs and will continue to need through adulthood. Taking services from [REDACTED] and other children like him will be detrimental. Please continue to support our kids.They deserve to learn, grow and succeed like all children do.

- [REDACTED]
4days ago

For my son! Autism doesn't end at age 7 and neither should treatments.
- [REDACTED]
1 day ago
I am the parent of a child with autism
- [REDACTED]
7 days ago
Support of Autistic children and my grandson.
- [REDACTED]
1 day ago
I support both awareness and understanding of all forms of mental illness. The issues are not easy ones, but the families who are profoundly affected by a relative with this problem need both hope and assistance.
- [REDACTED]
1 day ago
I have a child with autism who has benefitted greatly from ABA.
- [REDACTED]
2 days ago
I have 6 friends or family that have an autistic child.
- [REDACTED]
about 4 hours ago
I am adding my name because I believe each child should be treated as an individual and have the access they need to the medical system. Arbitrary decisions based on an age is not a fair policy to those who may fall outside the boundaries.
- [REDACTED]
6 days ago
I am signing for my twin boys who began ABA therapy at age 8 and have made amazing progress in the past 11 months.
The medical needs of individuals living with autism do not magically end at age 7 nor. when they enter school, so medically necessary care and its coordination should not end. at that time either.
Many are not even diagnosed until age 7.or later.
Most school districts have neither the budget, personnel, or training to provide the intensity of treatment that so many of these individuals need to become independent students and adults. Medically necessary care should not end at any particular age.

- [REDACTED]
6 days ago
For all the little rock stars out there that are affected by Autism...you are loved and you deserve this!
- [REDACTED]
3 days ago
My son has autism. He didn't speak at all until he was 3 years old, if it wasn't for these services he would be non verbal. We need this support, without it would be a detriment to society.
- [REDACTED]
5 days ago

I'm a provider of Early Intensive Behavioral Intervention (EIBI) services and firmly support the effectiveness of Applied Behavior Analysis (ABA) as an evidence-based treatment that children with autism should be able to access.
- [REDACTED]
6 days ago
My grandson continues to progress due to quality intensive ABA therapy. The need doesn't stop just because he is 7. We must continue to fund autism therapy.
- [REDACTED]
7 days ago
Signing because my son is benefiting TREMENDOUSLY from IEIBT --our private insurance pays a lot but not all so need to use the TEFRA for some of it. Could NEVER afford it on our own. He is 7 years old but is gaining hundreds of skills and improves daily. Limiting early intervention and putting age limits would be detrimental and shouldn't even be a consideration.
- [REDACTED]
7 days ago
For my amazing son
- [REDACTED]
about 22 hours ago ·
I know many autistic children and they need our help!

-



5 days ago

My nephew and many others I am aware of have benefited from therapies outside of school after age 7. Many kids with autism struggle greatly once puberty hits and the therapeutic support to families is ever so important then as well as when younger. They don't stop learning at 7. Also schools don't have professionals who are adequately trained to meet the needs of the kids and often won't outside of the school setting.

Name	Location	Date
Sheri Radoux	Minneapolis, Mn United States	2012-07-09
Katie Olson	Richfield, Mn United States	2012-07-09
Kari Weddle	Minneapolis, Mn, United States	2012-07-09
Shellie Matthes	White Bear Lake, Mn, United States	2012-07-09
Pia Prenevost	Coon Rapids, Mn, United States	2012-07-09
Megan Watta	Simpsonville, Ky, United States	2012-07-09
Joseph Cullen	Hugo, Mn, United States	2012-07-09
Heather Klein	Bismark, Nd, United States	2012-07-09
Susan Humphreys	Burnsville, Mn, United States	2012-07-09
Tisha Mette	Plymouth, Mn, United States	2012-07-09
Carolyn Shaw	Collegeville, Pa, United States	2012-07-09
Tahni Cullen	Hugo, Mn, United States	2012-07-09
Greg Nelson	Coon Rapids, Mn, United States	2012-07-09
Kelly Martin	Coon Rapids, Mn, United States	2012-07-09
Kari Hill	Chanhassen, Mn, United States	2012-07-09
Carolyn Westra	Minneapolis, Mn, United States	2012-07-09
Beverly Luther	Minneapolis, Mn, United States	2012-07-09
Kevin Pankratz	Blaine, Mn, United States	2012-07-09
Rhonda Hattig	South Sioux City, Ne, United States	2012-07-09
Rachel Lockman	Minneapolis, Mn, United States	2012-07-09
Jerry Elliott	Edina, Mn, United States	2012-07-09
Jennifer Thompson	Minneapolis, Mn, United States	2012-07-09
Hilarie Conboy	Minneapolis, Mn, United States	2012-07-09
Nancy Elliot	Edina, Mn, United States	2012-07-09
Brittany Schmidt	Renner, Sd, United States	2012-07-10
Andrew Elbert	Waconia, Mn, United States	2012-07-10
Mary Johnson	Andover, Mn, United States	2012-07-10
Katelyn Thompson	Coon Rapids, Mn, United States	2012-07-10
Nichole Preston	Cambridge, Mn, United States	2012-07-10
Shasta Johnson	Chanhassen, Mn, United States	2012-07-10
Michelle Dosch	Andover, Mn, United States	2012-07-10
J Pinette	Wilmington, NC, United States	2012-07-10
Melissa Dodge	Eagan, Mn, United States	2012-07-10
Wendy Leibel	Pine City, Mn, United States	2012-07-10
Jonathan Thompson	Coon Rapids, Mn, United States	2012-07-10
Angela Miller	Princeton, Mn, United States	2012-07-10
Danielle Eastman	Wayzata, Mn, United States	2012-07-10
Brenna Backstrand	Hopkins, Mn, United States	2012-07-10
Christopher Mcarthur	Rosemount, Mn, United States	2012-07-10
Michael Zentgraf	Cedar, Mn, United States	2012-07-10
Anne Roehl	Minneapolis, Mn, United States	2012-07-10
Lisa Weydert	Elko, Mn, United States	2012-07-10
Amy Ruzynski	Anoka, Mn, United States	2012-07-10
James Hadley	Maple Grove, Mn, United States	2012-07-10
Kammy Kramer	Eagan, Mn, United States	2012-07-10

Lashaya Meyers	Minneapolis, Mn, United States	2012-07-10
Karla Ertelt	Algona, Ia, United States	2012-07-10
Soury Duckson	Albany, Mn, United States	2012-07-10
Melissa Hicks	Anoka, Mn, United States	2012-07-10
Linda Kirby	Eagan, Mn, United States	2012-07-10
Dianne Fish	Algona, Ia, United States	2012-07-10
Nancy Hokkanen	Bloomington, Mn, United States	2012-07-10
Carol Laube	Burnsville, Mn, United States	2012-07-10
Maria Conley	Lino Lakes, Mn; United States	2012-07-10
Wayne. Rohde	Woodbury, Mn, United States	2012-07-10
Eric Jenness	Champlin, Mn, United States	2012-07-10
Laura Zurbuchen	Minneapolis, Mn, United States	2012-07-10
Mel Alloway	Muscatine, La, United States	2012-07-10
Jason Laube	Farmington, Mn, United States	2012-07-10
Timothy Lindquist	Minneapolis, Mn, United States	2012-07-10
Naften Sadoff	Eagan, Mn, United States	2012-07-10
Suzanne Slanga	Fridley, Mn, United States	2012-07-10
Scot Nelson	Champlin, Mn, United States	2012-07-10
Joshua Wiley	Andover, Mn, United States	2012-07-10
Jenna Hadley Johnsen	Albertville, Mn, United States	2012-07-10
Mark Balto	Bklyn, Ny, United States	2012-07-10
Kari Hadley	Anoka, Mn, United States	2012-07-10
Danielle Peterson	Anoka, Mn, United States	2012-07-10
John Richard Young-	HigginsNorrstown, Pa,	2012-07-10
Beth Grimm	Champlin, Mn, United States	2012-07-10
Jennifer Johnson	Blaine, Mn, United States	2012 07-10.
Karla Davis	Kimball, Mn, United States	2012 07-10
Steve Peterson	Anoka, Mn, United States	2012-07-10
Roberta Dosch	Sauk Rapids, Mn, United States	2012-07-10
Heather Hanson	Eden Prairie, Mn, United States	2012-07-10
Keri Lewis	Lakeville, Mn, United States	2012-07-10
Barry Edwards	Minneapolis, Mn, United States	2012-07-10
Alicia Moore	St Paul, Mn, United States	2012-07-10
Kari Mildebrandt	Champlin, Mn, United States	2012-07-10
Khalil Khelah	Eden Prairie, Mn, United States	2012-07-10
Jill Bickler	Minneapolis, Mn, United States	2012 07-10
Irv Balto	Chaseburg, Wi, United States	2012-07-10
Heather Bourget	Saint Michael, Mn, United States	2012-07-10
Courtney Whitcraft	Applevalley, Mn; United States	2012 07-10
Danielle Mongin	Coon Rapids, Mn, United States	2012-07-10
Heidi Baham	Eden Prairie, Mn, United States	2012-07-10
Melissa Kestner	St Paul, Mn, United States	2012-07-11
Jennifer Larson	Orono, Mn, United States	2012-07-11
Jeff Malay	Minnetonka, Mn, United States	2012-07-11
Megan Sambs	Minneapolis, Mn, United States	2012-07-11
Kevin Jund	Blaine, Mn, United States	2012-07-11

Lisha Zhang	Edina, Mn, United States	2012-07-11
Ning Liu	Maple Grove, Mn, United States	2012-07-11
Carlee Brom	Hugo, Mn, United States	2012-07-11
Candace Moe	Shoreview, Mn, United States	2012-07-11
Kristen Mailander	Albertville, Mn, United States	2012-07-11
Kate Stottlemeyer	Shoreview, Mn, United States	2012-07-11
Jeremy Roberts	Carver, Mn, United States	2012-07-11
Kelsey Egan	La Crosse, Wi, United States	2012-07-11
Jill Francour	Inver Grove Heights, Mn, United States	2012-07-11
Denielle Schrom	Shakopee, Mn, United States	2012-07-11
Sue Schiii-Grotte	Apple Valley, Mn, United States	2012-07-11
Michelle Buyarski	Stillwater, Mn, United States	2012-07-11
Stephanie Gaughran	Maple Grove, Mn, United States	2012-07-11
Betty Reiman	Maple Grove, Mn, United States	2012-07-11
Kathy Berg	Andover, Mn, United States	2012-07-11
Natalie Homa	Burnsville, Mn, United States	2012-07-11
Jennifer Wisher	Roseville, Mn, United States	2012-07-11
Jon Wiger	Belle Plaine, Mn, United States	2012-07-11
Chris Autenrieth	Prior Lake, Mn, United States	2012-07-11
William Breeden	Mayer;.Mn, United States	2012-07-11
Heather Ramstorf	Lino Lakes, Mn, United States	2012-07-11
Rachel Rogers	Jeffersonville, -In, United States	2012-07-11
Adrienne Turzynski	Minneapolis, Mn.,United States	2012-07-11
Betty Falardeaux	Oakdale, Mn, United States	2012-07-11
Amy Lipski	White Bear Lake, Mn, United States	2012-07-11
Elizabeth Luecke	Shoreview, Mn, United States	2012-07-11
George Matkovits	Eden Prairie, Mn, United States	2012-07-11
Eileen Long	Rochester, Mn, United States	2012-07-11
Amy Sippi	Saint Paul, Mn, United States	2012-07-11
Tim Kasemodel	Wayzata, Mn, United States	2012-07-11
Vanessa Slivken	Fridley, Mn, United States	2012-07-11
Jessica Mathiason	Roseville, Mn, United States	2012-07-11
Brenda Miller	Appleton,Wi, United States	2012-07-11
Jennifer Brom	Hugo, Mn, United States	2012-07-11
Virginia H. Okeeffe	Tumwater, Wa, United States	2012-07-11
Sonia Stephen	Apple Valley, Mn, United States	2012-07-11
Kathy St Martin	Sauk Rapids, Mn, United States	2012-07-11
Kathy Johnson	Apple Valley, Mn, United States	2012-07-11
Jenni Deien	Carbondale, Il, United States	2012-07-11
Beth Befprt...	Rochester, Mn, United States	2012-07-11
Jane Sommers	Maple Gtrove, Mn, United States	2012-07-11
Brent Brickman	Tonka Bay, Mn, United States	2012-07-11
Anne Knudtson	Minneapolis, Mn, United States	2012-07-12
Todd Stolaruk	W Bloomfield, MI, United States	2012-07-12
Teresa Bakse	Rochester, Wa, United States	2012-07-12
Kimberly Coulter	Cottage Grove, Mn, United States	2012-07-12

Connie Koehn	Hugo, Mn, United States	2012-07-12
Kay Froemming	Ramsey, Mn, United States	2012-07-12
Heidi Zetterwall.	Oakdale, Mn, United States	2012-07-12
Karen Dale	Plymouth, Mn, United States	2012-07-12
Audra Timm.	Richfield, Mn, United States	2012-07-12
Barbara Cain	Saint Paul, Mn, United States	2012-07-12
Erica Carlson	Rockford, Mn, United .States	2012-07-12
Nancy Aleshire	Columbia Heights, Mn, United States	2012-07-12
Jill Olofson	Woodbury, Mn, United States	2012-07-12
Cyndi Cunningham	Saint Paul, Mn, United States	2012-07-12
Mark Bailey	Andover, Mn, United States	2012-07-12
Franklin Hotzel	Oakdale, Mn, United States	2012-07-12
Emily Marier.	Hugo, Mn, United States	2012-07-12
Pam Sanford	Inver Grove Heights, Mn, United States	2012-07-12
Stacy Brakefield	New Germany, Mn, United States	2012-07-12
Jackie Schmida	La Crosse, Wi, United States	2012-07-12
Roula Baroud	Lebanon, United States	2012-07-12
Alexander Wilson	Otsego, Mn, United States	2012-07-12
Kathleen Moran	Cortland, Oh, United States	2012-07-12
Rose Bidwell	Saint Paul, Mn, United States	2012-07-12
Bill Ritter	Maumee, Oh, United States	2012-07-12
Anita Anderson	St Paul, Mn, United States	2012-07-12
Katelyn Schlader	Savage, Mn, United .States	2012-07-12
Sonja Langsjoen	Apple Valley, Mn, United States	2012-07-12
Anne Greenwood	Minneapolis, Mn, United States	2012-07-12
Sandy Raitt	Bloomington, Mn, United States	2012-07-12
Sireesha Giddaluru	Edina, Mn, United States	2012-07-12
Julie Morin	St. Louis Park, Mn, United States	2012-07-12
Tricia Coons	Bemidji, Mn, United States	2012-07-12
Swapna Nair	Shakopee, Mn, United States	2012-07-12
Thomas Hicks	St. Louis Park, Mn, United States	2012-07-12
Jean Rutledge	Tampa, Fl, United States	2012-07-12
Kathy Schutt	Minnetonka, Mn, United States	2012-07-12
Laura Rossum	Anoka, Mn, United States	2012-07-12
Marco Nunes	Los Angeles, Ca, United States	2012-07-12
Angi Faiks	St. Paul, Mn; United States	2012-07-12
Benjamin Schlader	Savage, Mn, United States	2012-07-12
Lisa Scanlan	St Paul, Mn, United States	2012-07-12
Nimisha Nazaruddin	Brooklyn Park, Mn; United States	2012-07-12
Nicole Herold	Roseville, Mn, United States	2012-07-13
Valerie Mueller	Saint Joseph, Mn, United States	2012-07-13
Nicole Degroot	Hugo, Mn, United States	2012-07-13
Aaron Goldsteen	Minneapolis, Mn, United States	2012-07-13
Anthony Spencer	Woodbury, Mn, United States	2012-07-13
Tiffany Footitt	Moorhead, Mn, United States	2012-07-13
Beth Mejia	Minneapolis, Mn, United States	2012-07-13

Grant King	Jeffersonville, In, United States	2012-07-13
Paula Bhagyam	Houlton, Wi, United States	2012-07-13
Paul Hertz	Minnetonka, Mn, United States	2012-07-13
Angela Bell	New Hope, Mn, United States	2012-07-13
Mitzi Mellott	Princeton, Mn, United States	2012-07-13
Virginia Patton	Rice, Mn, United States	2012-07-13
Lindsay Zerressen	Douglasville, Ga, United States	2012-07-13
Carmen Tanahian	Minneapolis, Mn, United States	2012-07-13
Arry Iagesse	Homer Glen, Il, United States	2012-07-13
David Silvester	St. Paul, Mn, United States	2012-07-13
Jessica Frehse	Minneapolis, Mn, United States	2012-07-13
Caroline Zogheib	Fridley, Mn, United States	2012-07-13
Annmarie Kadid	New Brighton, United States	2012-07-13
Brenda Bauman	Minneapolis, Mn; United States	2012-07-13
Michael Jasper	Grand Rapids, Mn; United States	2012-07-13
Annmarie Boorsma	Waconia, Mn, United States	2012-07-13
I Jerin Joseph.	St: Paul;Mn;United States	2012-07 13
Aswathy Krishnan	Shakopee, Mn, United States	2012-07 13
Aida Alkadi	Fridley, Mn, United States	2012 07-13
Annekorah	Eagan, Mn, United States	2012-07-13
Smitha Sanalkumar	Eagan, Mn, United States	2012-07-13
Linda Dierking	Algonquin, Il, United States	2012-07-13
Joanne Williamsen	Minneapolis, Mn, United States	2012-07-13
Laura Marsh	Minnetonka, Mn, United States	2012-07-13
Kirby Richter	Eden Prairie, Mn, United States	2012-07-13
Dennis Winter	Brainerd, Mn, United States	2012-07-13
Slava Tkachenko	Lakeville, Mn, United States	2012-07-13
Paul Nienaber	Anoka, Mn, United States	2012-07-13
Sarah Sutherland	Minneapolis, Mn, United States	2012-07-13
Elizabeth Kohn	St Paul, Mn, United States	2012-07-13
Erik Ianning	Duluth, Mn, United States	2012-07-13
Sylvia Hiatt	Champaign, Il, United States	2012-07-13
Frank Grazzini	Minneapolis, Mn, United States	2012-07-13
Shyatesa Rupert	St Paul, Mn, United States	2012-07-13
Elaine Hastings	Excelsior, Mn, United States	2012-07-13
Judy Shinabarger	Mesa, Az, United States	2012-07-13
Felipe Ferradas	Hudson, Wi, United States	2012-07-13
Deb Buchholz	Plymouth, Mn, United States	2012-07-13
Mariellecedeno	Cudahy, Ca, United States	2012-07-13
Jean Zetterwall	Lino Lakes, Mn, United States	2012-07-13
Betty C	Edina, Mn, United States	2012-07-13
Mary Cady	Burnsville, Mn, United States	2012-07-13
Molly Kuttikadan	Lakeville, Mn, United States	2012-07-14
Asha Mathew	Memphis, Tn; United States	2012-07-14
Nancy Sonntag	Big Lake, Mn, United.States	2012-07-14
Doc Sonntag	Big Lake; Mn, United States	2012-07-14

Patty Nordahl	Lutsen Mn; United States	2012-07-14
Lisa Sirotiak	Lakevilie, Mn, United States	2012-07-14
Ann O'toole	Minneapolis, Mn, Ljnitied States	2012-07-14
Dara Kiese	Clear Lake, Mn, United States	2012-07-14
Lisa Barsness	Albertville, Mn, United States	2012-07-14
Amanda Mason	Clayton, Nc, Unitedstates	2012-07-14
Janet Robinson	Bloomington, Mn, United States	2012-07-14
Megan Stortz	Becker, Mn, United States	2012-07-14
Melissa Peterson	Big Lake, Mn, United States	2012-07-14
Gloria Steurer	Andover, Mn, United States	2012-07-14
Stephen Ackerman	Cottage Grove, Mn, United States	2012-07-14
Kristy Hintz	El Paso, Tx, United States	2012-07-14
Reena Paul	Eagan, Mn, United States	2012-07-14
Anne Lawton	Minneapolis, Mn, United States	2012-07-14
Tate Mathiason	Roseville, Mn, United States	2012-07-14
Darwin Barnes	Kasson, Mn, United States	2012-07-14
Brenda Kruger	Ham Lake, Mn, United States	2012-07-14
Austen Carey	St Paul, Mn, United States	2012-07-14
Wendy Pedersen	Minneapolis, Mn, United States	2012-07-14
Mads Bjorn-Roli	Minneapolis, Mn; United States	2012-07-14
Jenny Donovan	Minneapolis, Mn, United States	2012-07-14
Rachel Adamek	Minneapolis, Mn, United States	2012-07-14
Elizabeth Pedersen	Fort Lauderdale, Fl, United States	2012-07-14
Brandon Gil	Minneapolis, Mn, United States	2012-07-14
Gillian Smith	Bayside, Wi, United States	2012-07-14
Matt Pruett	Minneapolis, Mn, United States	2012-07-14
Erin Lawton	Edina, Mn, United States	2012-07-14
Brian Pattersob	Minneapolis, Mn, United States	2012-07-14
Douglas Pedersen	Minneapolis, Mn, United States	2012-07-14
Debbie Ernie	Mankato, Mn, United States	2012-07-14
Carol Henderson	Minneapolis, Mn, United States	2012-07-14
Shawna Wagoner	Minneapolis, Mn; United States	2012-07-14
Peer Shajudeen	Houston, Tx, United States	2012-07-14
Joanne Henry	Edina, Mn, United .States	2012-07-14
Anika Wallschlaeger	Minneapolis, Mn, United States	2012-07-14
Jessy Schrandt	Minneapolis, Mn, United States	2012-07-14
Zackary Whitley	Minneapolis, Mn, United States	2012-07-14
Kristine Lawton	Edina, Mn, United States	2012-07-14
Kelly Chang	Centennial, Co, United States	2012-07-14
Christine Tsang	New Brighton, Mn, United States	2012-07-14
Ann Kelly	Saint Paul, Mn, United States	2012-07-14
Lloyd Brown	Edina, Mn, United States	2012-07-14
Alissa Gambrel	Columbia Heights, Mn, United States	2012-07-14
Paul Johnson	San Francisco, Ca, United States	2012-07-14
Sarah Kreuter	St. Michael, Mn, United States	2012-07-14
Brenda Lander	Austin, Tx, United States	2012-07-14

Mary Noble	Minnetonka, Mn, United States	2012-07-14
Beth Gray	Minneapolis, Mn, United States	2012-07-14
Diane Gambrel	St Paul, Mn, United States	2012-07-14
Bob Barrie.	Edina, Mn, United States	2012-07-14
Kyle Gambrel	Columbia Heights, Mn, United States	2012-07-14
Leigh Lawton	Edina, Mn, United States	2012-07-14
Doris Schneider	Edina, Mn, United States	2012-07-14
Rebecca Foss	St. Paul, Mn, United States	2012-07-14
Shayne Johnson	Coon Rapids, Mn, United States	2012-07-14
Melissa Peterson	Eagan, Mn, United States	2012-07-14
Lori Johnson	West Saint Paul, Mn, United States	2012-07-14
Katia Holmes	Hopkins; Mn, United States	2012-07-14
Sean Johnson	Andover, Mn, United States	2012-07-14
Melissa Haley	St Paul, Mn, United States	2012-07-14
Schareane Elzinga	Portland,Or, United States	2012-07-14
Darcy Kaushagen	San Diego, Ca, United States	2012-07-14
Sue Kubiak	Saint Paul, Mn, United States	2012-07-14
Gena Elverhoy	Minneapolis, Mn, United States	2012-07-14
Tim Elzinga	Portland, Or, United States	2012-07-14
Karen Reis	St Paul, Mn, United States	2012-07-14
Claudia Wilson	Excelsior, Mn, United States	2012-07-14
Laurie Johnson	St Paul, Mn, United States	2012-07-14
Christina Reynolds	Shakopee, Mn, United States	2012-07-14
Robert Pedersen	Fort Worth, Tx, United States	2012-07-14
Beth Satterlund	Prior Lake, Mn, United States	2012-07-14
Anna Noland	Minnetonka, Mn, United States	2012-07-14
Amber Reiter	Belle Plaine, Mn, United States	2012-07-14
Andrea Goode	Laguna Niguel Ca, United States	2012-07-14
Mary Beth Grieves	Charlotte, Nc, United States	2012-07-14
Carlene Blair	Int'l Falls, Mn, United States	2012-07-14
Janice Knutson	Apple Valley, Mn, United States	2012-07-14
Elaine Hannam	Saint Ansgar, Ia, United States	2012-07-14
Jennifer Patterson	Edina, Mn, United.States	2012-07-14
Trina Arntsen	Minneapolis, Mn, United States	2012-07-14
Cole Gaugler	San Diego, Ca, United States	2012-07-14
Thomas Foss	Saint Paul, Mn, United States	2012-07-14
Vernessa Karki	Bloomington, Mn, United States	2012-07-14
Allison Adrian	St. Louis Park, Mn, United States	2012-07-14
Carol Greenwood	Minneapolis, Mn, United States	2012-07-14
Caitlyn Knudson	Minneapolis, Mn, United States	2012-07-14
James Young	Minneapolis, Mn, United States	2012-07-14
Bruce Hanson	Robbinsdale, Mn, United States	2012-07-14
April Kilduff	Chicago, Il, .United States	2012-07-14
Michael Quale	Eau Claire, Wi, United States	2012-07-14
John Crandall	Apple Valley, Mn, United States	2012-07-14
Ann Atiliker.	Brooklyn Park, Mn, United States	2012-07-14

Jennifer Becker	Rockford, Mn, United States	2012-07-14
Man Huynh	Saint Paul, Mn, United States	2012-07-14
Jennifer Carlson	Waconia, Mn, United States	2012-07-14
Roberta J. Pedersen	Fort Worth, Tx, United States	2012-07-14
Doni Hamann	St Paul, Mn, United States	2012-07-14
Heather Knox	Cedar Rapids, La, United States	2012-07-14
Marissa Partridge	Saint Michael, Mn, United States	2012-07-14
Susan Sperstad	Little Falls, Mn, United States	2012-07-15
Marc Reiter	Sheldon, La, United States	2012-07-15
Claire Antonneau	Belle Plaine, Mn, United States	2012-07-15
Barrie Bamberg	Mobile, Al, United States	2012-07-15
Karen Morea	Oyster Bay, Ny, United States	2012-07-15
Diane Fritz	Maple Grove, Mn, United States	2012-07-15
Kathy Kattestad	Eau Claire, Wi, United States	2012-07-15
Ann Apgar	Viera, Fl, United States	2012-07-15
Brian Ritchie	Minneapolis, Mn, United States	2012-07-15
Heather Donahue	Rosemount, Mn, United States	2012-07-15
Meghann Murphy	Minneapolis, Mn, United States	2012-07-15
Kathleen Collins	Cape Elizabeth, Me, United States	2012-07-15
Beth Lindahl	International Falls, Mn, United States	2012-07-15
Anna Sheng	Edina, Mn, United States	2012-07-15
Liz Matassa	Minneapolis, Mn, United States	2012-07-15
Bonnie Neumann	Burnsville, Mn, United States	2012-07-15
Sara Meyer	Bloomington, Mn, United States	2012-07-15
Brian Foley	St Paul, Mn, United States	2012-07-15
Paul Kellner	Eden Prairie, Mn, United States	2012-07-15
Cory Hughes	Matthews, Nc, United States	2012-07-15
Shelly Bell	Minneapolis, Mn, United States	2012-07-15
Shelly Leitheiser	St Cloud, Mn, United States	2012-07-15
Shelly Leitheiser	Saint Cloud, Mn, United States	2012-07-15
Jennifer Fieldman	Osseo, Mn, United States	2012-07-15
Joshua Casey	Minneapolis, Mn, United States	2012-07-15
Cindi Tagg	Buffalo, Mn, United States	2012-07-15
Stacy Parker	Elk River, Mn, United States	2012-07-15
Margaret Mason	Minneapolis, Mn, United States	2012-07-15
Randy Lander	Austin, Tx, United States	2012-07-15
Ian Butcher	Monmouth, Or, United States	2012-07-15
Tess White	Eastsound, Wa, United States	2012-07-15
James Jenkins	Grand Junction, Co, United States	2012-07-15
Kelly Scott	St Paul, Mn, United States	2012-07-15
Teala Mangano	Round Rock, Tx, United States	2012-07-15
Valerie Semple	Sioux City, La, United States	2012-07-15
Valerie Villa	Sioux City, La, United States	2012-07-15
Bob Lipski	White Bear Lake, Mn, United States	2012-07-15
Helen Wilson	Excelsior, Mn, United States	2012-07-15
Joshua Loeffler	Austin, Tx, United States.	2012-07-15

Renee Lawrenz	Lakeville, Mn, United States	2012-07-15
Joi Singleton	Burnsville, Mn, United States	2012-07-15
Nikki Grosso	Red Wing, Mn, United States	2012-07-15
Muriel Holliday	Rochester, Mn, United States	2012-07-15
Joseph Pata	Matthews, Nc, United States	2012-07-15
Beth Olson	Minneapolis, Mn, United States	2012-07-15
Bethany Adele Veiman	Anoka, Mn, United States	2012-07-15
Rachel Worner	Farmington, Mn, United States	2012-07-15
Diane Fritz	Osseo, Mn, United States	2012-07-15
Kelsey Cater	Burnsville, Mn, United States	2012-07-15
Basil And Ann Papayoti	Montreal, Canada	2012-07-15
Ben Klaers	Eagan, Mn, United States	2012-07-15
Divya Nair	Burnsville, Mn, United States	2012-07-15
Laurie Pflipseri	St Cloud, Mn, United States	2012-07-15
Pam Randolph	Waconia, Mn, United States	2012-07-15
Carol Jorgenson	Eden Prairie, Mn, United States	2012-07-15
Brooke Schwanz	Richfield, Mn, United States	2012-07-15
Diane Jones	Rogers, Mn, United States	2012-07-15
Seema Menon	St Paul, Mn, United States	2012-07-15
Erik Thorsell	Minneapolis, Mn, United States	2012-07-15
Carrie Shanahan	Minneapolis, Mn, United States	2012-07-15
John Foley	Page, Az, United States	2012-07-15
Donna Kurlander	Charlotte, Nc, United States	2012-07-15
Joanna Dougherty	Narberth, Pa, United States	2012-07-15
Devin Kline	West Hartford, Ct, United States	2012-07-15
Shannah Stephens	Charlotte, Nc, United States	2012-07-15
Carly O'Neill	Mound, Mn, United States	2012-07-15
Anna Frahm	Cologne, Mn, United States	2012-07-15
Marc Stephens	Minneapolis, Mn, United States	2012-07-15
Holly Stevens	Westport, Ct, United States	2012-07-15
Sophie Kelly	Broomfield, Co, United States	2012-07-15
Carolyn Rossetti	Libertyville, Il, United States	2012-07-15
Nancy Newell	Minneapolis, Mn, United States	2012-07-15
Kelsey Julian	Libertyville, Il, United States	2012-07-15
Lzzy Banna	Libertyville, Il, United States	2012-07-15
Donna Davis	Broomfield, Co, United States	2012-07-15
Sierra Yoder	Libertyville, Il, United States	2012-07-15
Jennifer Pahng	Libertyville, Il, United States	2012-07-15
Esteban Arellano	Brighton, Co, United States	2012-07-15
Thomas Watson	Appleton, Mn, United States	2012-07-15
Marilyn Kelly	Bloomington, Mn, United States	2012-07-15
Amber Bowmer	Renton, Wa, United States	2012-07-15
Edmund Glasenapp	St Paul, Mn, United States	2012-07-15
Amy Massen-Shidla	St. Louis Park, Mn, United States	2012-07-15
Bart Pflipsen	St Cloud, Mn, United States	2012-07-15
Charles Armstrong	Seattle, Wa, United States	2012-07-15

Shedy Berrios	Jacksonville Nc, Nc, United States	2012-07-15
Kori Hennessy	Minneapolis, Mn, United States	2012-07-15
Stacy Vanderwerf	Mankato, Mn, United States	2012-07-15
Grant Dean	Libertyville, Il, United States	2012-07-15
Patricia Shea	St. Paul, Mn, United States	2012-07-15
Mary Jo Clasen	St Paul, Mn, United States	2012-07-15
Sheryl Thornberg	Eden Prairie, Mn, United States	2012-07-15
Lucas Dachenhausen	Portland, Or, United States	2012-07-15
Melissa Oliveri	Minneapolis, Mn, United States	2012-07-15
Ryan Mcdonald	Maple Grove, Mn, United States	2012-07-15
Sheeba Philip	Shakopee, Mn, United States	2012-07-15
Jessica Stolt	Champlin, Mn, United States	2012-07-15
Cynthia Boluek	State College, Pa, United States	2012-07-15
Carissa Knudson	Plymouth, Mn, United States	2012-07-15
Tracy Payne	Davenport, La, United States	2012-07-15
Richard Yudhishthu	Minneapolis, Mn, United States	2012-07-15
Aki Yoshino	Minneapolis, Mn, United States	2012-07-15
Michael Cohen	Brooklyn, Ny, United States	2012-07-15
Tina Stevens	Eagan, Mn, United States	2012-07-15
Danielle Bryson	Greenville, Sc, United States	2012-07-15
Barbara Van Gorder	Fort Worth, Tx, United States	2012-07-15
James & Barbara Mulrooney	Mendota Heights, Mn,	2012-07-15
Wanda Benda	Jackson, Mn, United States	2012-07-15
Tia Aljets	Rochester, Mn, United States	2012-07-15
Shannon Campbell	Bloomington, Mn, United States	2012-07-15
Elizabeth Markose	Brooklyn Park, Mn, United States	2012-07-15
Jason Stevens	Eagan, Mn; United States	2012-07-15
Susan Finley.	Clarksville, Tn, United States	2012-07-15
Jada Nutter	Minneapolis, Mn, United States	2012-07-15
Julie Oldenberg	Farmington, Mn, United States	2012-07-15
Rebecca Barnack	United States	2012-07-15
Shelly Michels	Roseville, Mn, United States	2012-07-15
Patricia Remm	Omaha, Ne, United States	2012-07-16
Jane Lim	Little Rock, Ar, United States	2012-07-16
Colette Maciver	Brainerd, Mn, United States	2012-07-16
Hugo Quinonez	Edina, Mn, United States	2012-07-16
Melissa Haroza	Minneapolis, Mn, United States	2012-07-16
Summer Barkema	St Louis Park, Mn, United States	2012-07-16
John Forestner	Fort Worth, Tx, United States	2012-07-16
Jasmine Sidhe	St Paul, Mn, United States	2012-07-16
Harmeet Singh	Singapore, Al, United States	2012-07-16
Suzanne Burkness	Elk River, Mn, United States	2012-07-16
Heidi Hayford	Cambridge, Mn, United States	2012-07-16
Anne Smith	Elk River, Mn, United States	2012-07-16
Debbie Alper	Newton, Ma, United States	2012-07-16
G. Bradley Alford	Fort Worth, Tx, United States	2012-07-16

Megan Durand	United States	2012-07-16
Sheryl Meints	Atwater, Mn, United States	2012-07-16
Dan Diebold	Lilydale, Mn, United States	2012-07-16
Sydney Mosko	Georgetown, Ky, United States	2012-07-16
Patti Rosenthal	Virginia Beach, Va, United States	2012-07-16
Sandy Romsdahl	Dalbo, Mn, United States	2012-07-16
Sara Kolby	Wyoming, Mn, United States	2012-07-16
Norah Mitchell	Minnetonka, Mn, United States	2012-07-16
JK Lim	Little Canada, Mn, United States	2012-07-16
Bill McGrath	Northfield, Mn, United States	2012-07-16
Adam Goehner	St. Anthony, Mn, United States	2012-07-16
Charisse Narragon	Raymond, Mn, United States	2012-07-16
Lindsey Eckert	New Brighton, Mn, United States	2012-07-16
Lisa Ellingsworth	Middletown, De, United States	2012-07-16
Betty Agrimson	Eden Prairie, Mn, United States	2012-07-16
Jeff Baidoo	Saint Paul, Mn, United States	2012-07-16
Krista Stankey	Minneapolis, Mn, United States	2012-07-16
Kelly Naughton	Andover, Mn, United States	2012-07-16
Tammy Brown	Rogers, Mn, United States	2012-07-16
Sandy Coiling	Jordan, Mn, United States	2012-07-16
Dawn Walters	Crystal, Mn, United States	2012-07-16
Johnny Diebold	Eagan, Mn, United States	2012-07-16
Harlan Johnson	Jordan, Mn, United States	2012-07-16
Esther Kaiser	St Paul, Mn, United States	2012-07-16
Thomas F. Mulrooney,	MD Mendota Heights, Mn, United States	2012-07-16
Jennifer Jackman	Big Lake, Mn, United States	2012-07-16
Angie Abfalter	Eden Prairie, Mn, United States	2012-07-16
Pamela Stoltenberg	Ramsey, Mn, United States	2012-07-16
Amber Greelis	Andover, Mn, United States	2012-07-16
Ashley Milton	Stpaul, Mn, United States	2012-07-16
Bev White	Edina, Mn, United States	2012-07-16
Leah Schilling	Eden Prairie, Mn, United States	2012-07-16
Jessica Hawley	New Market, Mn, United States	2012-07-16
Benjamin Jacobson	Minneapolis, Mn, United States	2012-07-16
Chris Becker	Hammond, Wi, United States	2012-07-16
Melissa Rabida	Andover, Mn, United States	2012-07-16
Ryan Lysne	Plymouth, Mn, United States	2012-07-16
Dana Mccallum	Fort Worth, Tx, United States	2012-07-16
Carrie Clausen	Elk River, Mn, United States	2012-07-16
Cara Painter	Plymouth, Mn, United States	2012-07-16
Erika Swanson	Eden Prairie, Mn, United States	2012-07-16
Nichole Malaty	La Mesa, Ca, United States	2012-07-16
Erin Horacek	St Paul, Mn, United States	2012-07-16
Teresa Divine	Shakopee, Mn, United States	2012-07-16
Halimatou Diallo	Minneapolis, Mn, United States	2012-07-16
Liz Wilson	Minneapolis, Mn, United States	2012-07-16

Oksana Eisinger	Lakeville, Mn, United States	2012-07-16
Denise Lutgen-Gallaty	Minneapolis, Mn, United States	2012-07-16
Chris Riley	Elk River, Mn, United States	2012-07-16
Amy Oswandel	New Albany, In, United States	2012-07-16
Jackie Franklin	Osseo, Mn, United States	2012-07-16
Barbara Rountree	Newport Beach, Ca, United States	2012-07-16
Janice Holth	Minneapolis, Mn, United States	2012-07-16
Laurie Post	Clearwater, Mn, United States	2012-07-16
Brenda Gasser	Andover, Mn, United States	2012-07-16
John Cierzan	Eden Prairie, Mn, United States	2012-07-16
Susan Noble	Medina, Mn, United States	2012-07-16
Tammi Heraly	Clearwater, Mn, United States	2012-07-16
Nick Standke	Prior Lake, Mn, United States	2012-07-16
Paul Banks	Norwalk, Ct, United States	2012-07-16
Carrie Telega	Big Lake, Mn, United States	2012-07-16
Nick Petersen	St Paul, Mn, United States	2012-07-16
Ann Donath	Lakeville, Mn, United States	2012-07-16
Debra Meyer	Mahtomedi, Mn, United States	2012-07-16
Pam Pierskalla	St. Joseph, Mn, United States	2012-07-16
Mike Rossetti	Bloomington, Il, United States	2012-07-16
Connie Fuchs	Rochester, Mn, United States	2012-07-16
Susan Stephens	Minneapolis, Mn, United States	2012-07-16
Davis Silver	Minneapolis, Mn, United States	2012-07-16
Timothy Parker	Crystal, Mn, United States	2012-07-16
Bridget Jewell	Eagan, Mn, United States	2012-07-16
Bob Thomas	Burnsville, Mn, United States	2012-07-16
Kathleen Mulrooney	Edina, Mn, United States	2012-07-16
Michelle Swenson	Champlin, Mn, United States	2012-07-16
Ann Martin	Blaine, Mn, United States	2012-07-16
Avi Silver	United States	2012-07-16
Beverly Saunders	Blaine, Mn, United States	2012-07-16
Tara Loeper	Minneapolis, Mn, United States	2012-07-16
Marc Sherer	Champlin, Mn, United States	2012-07-16
Beth Jackson	St Paul Park, Mn, United States	2012-07-16
Heather Hemquist	Blaine, Mn, United States	2012-07-16
Sarah Klocker	Ramsey, Mn, United States	2012-07-16
Scott Grebe	Minnetrissa, Mn, United States	2012-07-16
Patti Achterling	St Paul, Mn, United States	2012-07-16
Brandie Schwab	Sauk Rapids, Mn, United States	2012-07-16
David Samuels	Minneapolis, Mn, United States	2012-07-16
Kristin Morant	Otsego, Mn, United States	2012-07-16
Kandi Kopel	St Paul, Mn, United States	2012-07-16
Raya Newbold	Pine River, Mn, United States	2012-07-16
Kathy Thompson	Eagan, Mn, United States	2012-07-16
Susan Burk	Saginaw, MI, United States	2012-07-16
Amanda Larson	Minneapolis, Mn, United States	2012-07-16

Jennifer White	Minneapolis, Mn, United States	2012-07-16
Shayne Buzzell	Coon Rapids, Mn, United States	2012-07-16
Kerstin Hammarberg	Minneapolis, Mn, United States	2012-07-16
Janelle Pfeifer	Champlin, Mn, United States	2012-07-16
Nathalie Beaine	Minneapolis, Mn, United States	2012-07-16
Nicole Valencia	Apple Valley, Mn, United States	2012-07-16
David Leppik	St Louis Park, Mn, United States	2012-07-16
Peter Kogan	St Paul, Mn, United States	2012-07-16
Marnie Hensel	Wayzata, Mn, United States	2012-07-16
Jailice Walton	Carver, Mn, United States	2012-07-16
Laura Sweeney	Hopkins, Mn, United States	2012-07-16
Thomas Wirku	St Paul, Mn, United States	2012-07-16
Mary Dale	Corcoran, Mn, United States	2012-07-16
Steven Tsujisaka	Redwood City, Ca, United States	2012-07-16
D Goers	Ssp, Mn, United States	2012-07-16
Laurie Tanner	Granbury, Tx, United States	2012-07-16
Meghan Foley	Eagan, Mn, United States	2012-07-16
Michael Foley	Minneapolis, Mn, United States	2012-07-16
Tara Reinke	Minneapolis, Mn, United States	2012-07-16
Jill Whelpley	Chanhassen, Mn, United States	2012-07-16
Robyn Scott	Aiken, Sc, United States	2012-07-16
Jennifer Rona	Brainerd, Mn, United States	2012-07-16
Barbara J Johnson	Eau Claire, Wi, United States	2012.-07-16
Michelle Schultz	Austin, Mn, United States	2012-07-16
Devie Hagen	Osseo, Mn, United States	2012-07-16
Kristy Bredeson	Edina, Mn, United States.	2012-07-16
Debrah Fischer	Edina, Mn, United States	2012-07-16
Julie Barnack	Alexandria, Mn, United States	2012-07-16
Tracey Landberg	Elk River, Mn, United States	2012-07-16
David Eldred	Minneapolis, Mn, United States	2012-07-16
Marie Doran	Spicer, Mn, United States	2012-07-16
Koreen Firnstahl	Ham Lake, Mn, United States	2012-07-16
Jillian Awe	Brooklyn Park, Mn, United States	2012-07-16
Brenda Davis	Big Lake, Mn, United States	2012-07-16
Shanon Bakken	Glenwood City, Wi, United States	2012-07-16
James Noland	Greenville, Sc, United States	2012-07-16
Jack Bertrand	Burnsville, Mn, United States	2012-07-16
Beth Fondell	Bloomington, Mn, .United States	2012-07-16
Anthony Rossetti	Winona, Il, United States	2012-07-16
Shahira Shareef	Bellevue, Wa, United States	2012-07-16
Jacob Jerzewski	Madison, Wi, United States	2012-07-16
Chady Alahmar	Eden Prairie, Mn, United States	2012-07-16
Sue Skelton	Minneapolis, Mn, United. States	2012-07-16
Julie Schell	Kansas City, Mo, United States	2012-07-16
Sarah Milligan-Toffler	Mpls, Mn, United States	2012-07-16
Janet Rasmussen	Eagan, Mn, United States	2012-07-16

Candy Tola	Cottage Grove, Mn, United States	2012-07-16
Kelly Cahlander	Apple Valley, Mn, United States	2012-07-16
Alan Fitterer	Montgomery, Mn, United States	2012-07-16
Cate Mckinney	St Paul, Mn, United States	2012-07-16
Judith Melander	Medicine Lake, Mn, United States	2012-07-16
Robin Kellogg	Big Sky, Mt, United States	2012-07-16
Christine Kraimer	Lonsdale, Mn, United States	2012-07-16
David Morrow	Minneapolis, Mn, United States	2012-07-16
Sarah Johnson	Andover, Mn, United States	2012-07-16
Alison Lund	St Paul, Mn, United States	2012-07-17
Lauren Clark	St. Paul, Mn, United States	2012-07-17
Heather Ditschler	Zimmerman, Mn, United States	2012-07-17
Judi Rossetti	Libertyville, Il, United States	2012-07-17
Deb Pangerl	Rush City, Mn, United States	2012-07-17
Mike Courtney	Yulee, Fl, United States	2012-07-17
Ronald Eldred	St Paul, Mn, United States	2012-07-17
Kim Fuller	Everett, Wa, United States	2012-07-17
Angela Petersen	St Michael, Mn, United States	2012-07-17
Nick Guidera	Broomfield, Co, United States	2012-07-17
Erik Sumstad	Onamia, Mn, United States	2012-07-17
Abby Standke	Prior Lake, Mn, United States	2012-07-17
Barbara Streifel	St. Paul, Mn, United States	2012-07-17
Mireille Tanachian	Eden Prairie, Mn, United States	2012-07-17
Jeanette Jacobson	Raymond, Mn, United States	2012-07-17
Mary Holtze	London, United Kingdom	2012-07-17
Mike Newbold	Pine River, Mn, United States	2012-07-17
Thomas Kramer	St Paul, Mn, United States	2012-07-17
Joanne Sax	Minneapolis, Mn, United States	2012-07-17
Erin Riedemann	Crosby, Mn, United States	2012-07-17
Bayley Taple	Minneapolis, Mn, United States	2012-07-17
Katie Chapman	Eagan, Mn, United States	2012-07-17
Suntell Richardson	Hopkins, Mn, United States	2012-07-17
Daniel Mulrooney	Germantown, Tn, United States	2012-07-17
Mary Mcnaney	Saint Paul, Mn, United States	2012-07-17
Linda Standke	Bloomington, Mn, United States	2012-07-17
Jeff Standke	Bloomington, Mn, United States	2012-07-17
Ashley Winter	West Des Moines, La, United States	2012-07-17
Lindsey Dana	Cottage Grove, Mn, United States	2012-07-17
Gail Moll	Edina, Mn, United States	2012-07-17
Jodi Gubbrud	Saint Paul, Mn, United States	2012-07-17
Brian Folkman	Lakeville; Mn, United States	2012-07-17
Lay Hong Ma	Leawood, Ks, United States	2012-07-17
Chris Arlandson	St Paul, Mn, United States	2012-07-17
Catherine Scott	Plymouth, Mn, United States	2012-07-17
Tarring Lee	Setapak, Kuala Lumpur, Malaysia,	2012-07-17
Rachel Reekers	Mounds View, Mn, United States	2012-07-17

Chris Prawdzik	Minneapolis, Mn, United States	2012-07-17
Leslie Kreutter	Annandale, Mn, United States	2012-07-17
Janet Chapman	Marshall, Mn, United States	2012-07-17
Gabriel Arana	Minneapolis, Mn, United States	2012-07-17
Kris Fatze	Minneapolis; Mn, United States	2012-07-17
Joe Chapman	St Paul, Mn, United States	2012-07-17
Diane Hl Ippke	Pierz, Mn, United States	2012-07-17
Steven Veit	Minneapolis, Mn, United States	2012-07-17
Bobbi Schaan	St John, Nd, United States	2012-07-17
Jean Scanlon	Minneapolis, Mn, United States	2012-07-17
Joan Smith	Blaine, Mn, United States	2012-07-17
Elizabeth Scheel	St Cloud, Mn, United States	2012-07-17
Alaina Grose	Brooklyn Park, Mn, United States	2012-07-17
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Cheryl Jandrich	Eagan, Mn, United States	2012-07-17
Diana Blood	Burnsville, Mn, United States	2012-07-17
Jada Jacob	Hopkins, Mn, United States	2012-07-17
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Anne Williams	St. Paul, Mn, United States	2012-07-17
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Katie Duffney	Osseo, Mn, United States	2012-07-17
Chandra O'brien	Ramsey, Mn, United States	2012-07-17



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

Secretary Sebelius
February 13, 2012
Page 2

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,

A handwritten signature in cursive script, appearing to read "Lucinda Jesson". The signature is fluid and extends across the width of the page.

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

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.

²Not 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 waived 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 in 1995. 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-improverishment 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 monitoring¹⁰ 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 memory¹¹, using information, daily decision making, or behavioral needs that require at least occasional staff intervention¹²; 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 adaptations 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 not 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 assets¹³;
- The person's income and assets would be inadequate to fund a nursing facility stay for more than 135 days¹⁴;
- The monthly cost of AC services must be less than 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 assistance¹⁶

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
<p>Alternative Care (AC) program serving elderly who need NF LOC but are not yet financially eligible for Medicaid</p>	<p>NF LOC criteria applied consistently across facilities and communities</p> <p>AC Program provided to low-income elderly who need NF LOC but who are not yet financially eligible for Medicaid</p>	<p>Total LTC costs</p> <p>HCBS costs</p> <p>Health Care Costs (Medicare and Medicaid)</p> <p>Medicaid conversion rate</p> <p>Nursing facility utilization rate</p> <p>Hospitalization and ER visits</p> <p>Utilization and costs of AC</p>
<p>Essential Community Supports Program (ECS) serving elderly who meet NF LOC and are not yet financially eligible for Medicaid</p>	<p>NF LOC criteria applied consistently across facilities and communities</p> <p>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</p>	<p>Total LTC Costs</p> <p>HCBS costs</p> <p>Health Care Costs (Medicare and Medicaid)</p> <p>Medicaid conversion rate</p> <p>Nursing facility utilization rate</p> <p>Hospitalizations and ER visits</p>

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

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
<p>Alternative Care program Serving elderly who need NF LOC but are not yet financially eligible for Medicaid</p>	<p><u>Target Population:</u> MA Ineligible >= Age 65 in AC</p> <p><u>Comparison Group</u> MA Ineligible >=Age 65 who applied and were rejected (presumably for low need); includes ECS participants</p>	<p>Medicaid claims</p>	<p>2012-2016</p> <p>2006-2011</p>
<p>Essential Community Supports Program (ECS) serving elderly who meet NF LOC and are not yet financially eligible for Medicaid</p>	<p><u>Target Populations:</u></p> <ul style="list-style-type: none"> 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 <p>MA Ineligible < Age 65</p> <p>MA Ineligible >=Age 65</p> <p><u>Comparison Groups:</u></p> <ul style="list-style-type: none"> a) Nursing facility applicants who <u>would have failed</u> to meet NF LOC criteria prior to nursing facility 	<p>NF LTCC</p> <p>MDS</p> <p>Medicaid Claims</p>	<p>2012-2016</p> <p>2006-2011</p>

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

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 eliminated 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 <i>impaired cognition</i> : <ul style="list-style-type: none"> • Short term memory loss • Disorientation of person, place, time or location • Impaired decision-making ability OR <i>Frequent history of the following behavior symptoms</i> : <ul style="list-style-type: none"> • Wandering • Physical abuse of others • Resistive to care • Behavior problems requiring some supervision for safety of self or others • Severe communication problems 		<i>Self neglect</i> : 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 <i>Neglect, abuse, or exploitation</i> : 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 <i>admissions</i> , falls, or overall frailty.
Proposed Operational Criteria: Functional Limitation 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)	OR	Proposed Operational Criteria: Clinical Need A need for clinical monitoring at least once a day	OR	Proposed Operational Criteria: Cognition or Behavior Significant difficulty with memory, using information, daily decision making, or behavioral needs that require at least occasional intervention.	OR	Proposed Operational Criteria: Frailty or Vulnerability 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 Long Term Care Consultation Services Assessment Form

A. Assessment Activity Information

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 ____/____/____

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

- 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)

RI

R2

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) _____

Client Information continued

Section Ba. continued

RI

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare - Part B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 No Yes Don't know

LTC SD 4

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

Veterans Administration insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other health insurance (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 (SMART)
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:

Speak English?	Yes	No
Understand English?	<input type="checkbox"/>	<input type="checkbox"/>
Were interpreter services used to complete the assessment?	<input type="checkbox"/>	<input type="checkbox"/>

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:

<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Pacific Islander or Native Hawaiian	<input type="checkbox"/> White
<input type="checkbox"/> Other (Specify) _____	

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 | 05 Homeless |
| 02 Living with spouse/parents | 04 Living in congregate setting | |

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.

- | | |
|--------------------------|--|
| <input type="checkbox"/> | 01 To have custody of the person; establish place of abode |
| <input type="checkbox"/> | 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 |
| <input type="checkbox"/> | 03 To take reasonable care of clothing, furniture, vehicles, and other personal effects |
| <input type="checkbox"/> | 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 |
| <input type="checkbox"/> | 05 To approve or withhold approval of any contract, except for necessities, which the person wishes to enter into |
| <input type="checkbox"/> | 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?

Name: _____

Address _____

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

RI

R2

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

C.1 Referral source:

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

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

<input type="checkbox"/>	<input type="checkbox"/>

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)

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

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)

RI

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

D. IADLs

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

RI

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?

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?

RI

R2

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?

- | | |
|--|---|
| <input type="checkbox"/> Home | <input type="checkbox"/> Boarding care facility |
| <input type="checkbox"/> Smaller home or apartment | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Relative's home (Specify) _____ | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Board and lodge | <input type="checkbox"/> 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)?

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 _____

Infectious Diseases

- Tuberculosis
- Hepatitis
- HIV positive (AIDS)
- STD
- Other _____

Gynecological

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

Respiratory

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

Genitourinary

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

Musculoskeletal

- Osteoporosis
- Amputation
- Back pain
- Arthritis
(type) _____
- Fractures
- Other _____

Gastrointestinal

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

Neurological

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

Cancer

- Type _____

Other

- Allergies
(type) _____
- Drug Sensitivities
(type) _____

Hearing

- Decreased acuity
- Earaches
- Hearing aid
- Other _____

Endocrine

- Diabetes
- Thyroid problems
- Other _____

Anemia

- (type) _____

Other

Skin Rashes

- Stasis ulcers
- Dermatitis
- Shingles
- Decubitus ulcer
- Other _____

Visual

- Blurred vision
- Glaucoma
- Cataracts
- Corrective lens
- Other _____

Comments on Health/Community Support Plan Implications:

	Diagnosis	ICD-9 Code
Primary: _____		
Secondary: _____		
History of DD? <input type="checkbox"/> Y/N		
If yes, what is the diagnosis?: _____		
History of MI? <input type="checkbox"/> Y/N		
If yes, what is the diagnosis?: _____		
History of BI? <input type="checkbox"/> 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)

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

Comments on Medications/Community Support Plan/Supervision Implications

Special Equipment/Assistive Devices

RI

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		Yes	Needs
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Medical phone alert	<input type="checkbox"/>	<input type="checkbox"/>
Cane	<input type="checkbox"/>	<input type="checkbox"/>	Supplies e.g., Incontinence pads	<input type="checkbox"/>	<input type="checkbox"/>
Walker	<input type="checkbox"/>	<input type="checkbox"/>	Bedside commode	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair (manual, electric)	<input type="checkbox"/>	<input type="checkbox"/>	Bathing equipment	<input type="checkbox"/>	<input type="checkbox"/>
Brace (leg, back)	<input type="checkbox"/>	<input type="checkbox"/>	Transfer equipment	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Adaptive eating equipment	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Lift chair	<input type="checkbox"/>	<input type="checkbox"/>	(Specify) _____		
Hospital bed	<input type="checkbox"/>	<input type="checkbox"/>	None <input type="checkbox"/>		

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		Yes	Needs
Bedsore treatment	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory treatment	<input type="checkbox"/>	<input type="checkbox"/>
Bowel care	<input type="checkbox"/>	<input type="checkbox"/>	Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
Catheter care	<input type="checkbox"/>	<input type="checkbox"/>	Wound care	<input type="checkbox"/>	<input type="checkbox"/>
Colostomy care	<input type="checkbox"/>	<input type="checkbox"/>	Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis at home	<input type="checkbox"/>	<input type="checkbox"/>	Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis outpatient	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory therapy	<input type="checkbox"/>	<input type="checkbox"/>
IV therapies	<input type="checkbox"/>	<input type="checkbox"/>	Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>
Ostomy care	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes education	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	(Specify) _____		
			None <input type="checkbox"/>		

Overall Health Assessment/Plan for Skilled Nurse Visits

Alcohol/Tobacco/Substance Use

RI

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:
None

RI

R2

	Yes		Yes
Dental problems?	<input type="checkbox"/>	Can't eat certain foods?	<input type="checkbox"/>
Swallowing problems?	<input type="checkbox"/>	Any food allergies?	<input type="checkbox"/>
Nausea?	<input type="checkbox"/>	Any other problems with eating?	<input type="checkbox"/>
Taste problems?	<input type="checkbox"/>	(Describe) _____	

F.25 Are you on any of the following special diets:
None

	Yes		Yes
Low salt	<input type="checkbox"/>	Calorie supplement?	<input type="checkbox"/>
Low fat?	<input type="checkbox"/>	Other special diet?	<input type="checkbox"/>
Low sugar?	<input type="checkbox"/>	(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	<input type="checkbox"/>	Restaurants/fast food	<input type="checkbox"/>
At family member's residence	<input type="checkbox"/>	Meals at congregate meal sites	<input type="checkbox"/>

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).

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?

G. ADLs

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

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?

RI

R2

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.

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

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

<input type="checkbox"/> Intravenous Fluids	<input type="checkbox"/> Hyperalimentation/Hickman Catheter
<input type="checkbox"/> Intravenous Medications	<input type="checkbox"/> Oxygen & Respiratory Therapy
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Ostomies & Catheters
<input type="checkbox"/> Drainage Tubes	<input type="checkbox"/> Wound Care/Decubiti
<input type="checkbox"/> Symptom Control for Term. Ill	<input type="checkbox"/> Skin Care
<input type="checkbox"/> Isolation Precautions	<input type="checkbox"/> 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, F5.

 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

RI

R2

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?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been depressed, or very unhappy?	<input type="checkbox"/>	<input type="checkbox"/>	Seen or heard things that other people didn't see or hear?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been feeling like you have too much energy or can't stop being busy?	<input type="checkbox"/>	<input type="checkbox"/>	Become physically aggressive, or made any threats to harm anyone?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been anxious a lot or bothered by your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	Made any threat to harm or kill yourself?	<input type="checkbox"/>	<input type="checkbox"/>

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

Yes No. (If yes, complete below)

Name of provider

Comments

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

RI.

R2

	Yes		Yes
Frequently misplaced items such as your purse (wallet) or glasses?	<input type="checkbox"/>	Lost your way around the house, e.g., can't find the bedroom or bathroom?	<input type="checkbox"/>
Failed to recognize family members or friends?	<input type="checkbox"/>	Had other problems with your memory?	<input type="checkbox"/>
		(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)
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Have cognitive deficits that pose a threat to his/her ability to remain in (or return to) the community?	Show suicidal ideation?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	Demonstrate other behavior problems?
	<input type="checkbox"/> <input type="checkbox"/>
	(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:

RI

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

Abuse/Neglect Screen: (Ask person only)

RI

R2

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?

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

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

RI

R2

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

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

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

Other

29 Undecided	36 Elected Elderly CDCS	43 NF visit every 3 years
30 Person died.	37 Elected Elderly Non-CDCS Services from CDCS	44 BI-NB waiver access
32 Updated AC financial.	39 Refusal of health risk assessment	47 No longer need waiver access
35 MSHO, MSC+ and SNBC health risk assessment	41 CADI waiver access	98 Other
	42 BI-NF waiver access	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

<input type="checkbox"/> 01 County/Tribal agency	<input type="checkbox"/> 02 Health Plan	<input type="checkbox"/> 03 County Subcontracting for Health Plan	<input type="checkbox"/> 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):

- | | |
|---|--------------------------------------|
| 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 |
| 03 Health status | 08 Caregiver exhaustion |
| 04 Lack of housing | 09 Client choice |
| 05 Services not available | 10 Rehabilitation not complete |
| | 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

- | | | |
|--------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> | 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:

- | | | |
|--------------------------|-----------------------|-----------------------------|
| <input type="checkbox"/> | 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:

- | | | | |
|--------------------------|-------------------------------|--|-------------|
| <input type="checkbox"/> | 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

RI

R2

<input type="checkbox"/>	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

RI

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

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

RI

R2

L. Alternative Care Information

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

RI

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)	<input type="checkbox"/>	_____
Housekeeping (such as help with meal preparation, cleaning and laundry)	<input type="checkbox"/>	_____
Transportation	<input type="checkbox"/>	_____
Shopping and errands	<input type="checkbox"/>	_____
Supervision for safety	<input type="checkbox"/>	_____
Money management	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____
(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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Relationships with other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Relationships with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. (IF APPLICABLE:) Your work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Your emotional well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

RI

R2

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	<input type="checkbox"/>	Caregiver has difficulty making appropriate decisions	<input type="checkbox"/>
Family responsibilities restrict caregiving	<input type="checkbox"/>	Caregiver financially dependent upon person	<input type="checkbox"/>
Limited knowledge to manage care	<input type="checkbox"/>	Caregiver may have mental health/substance abuse	<input type="checkbox"/>
Caregiver is physically impaired	<input type="checkbox"/>	Other (SPECIFY) _____	<input type="checkbox"/>
Person's needs are heavy physical burden for caregiver	<input type="checkbox"/>	None	<input type="checkbox"/>
Caregiver's finances limit caregiving potential	<input type="checkbox"/>		

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

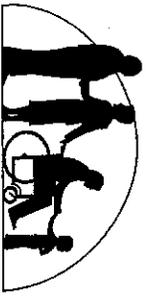
O.11 What caregiver services are you presently receiving? (e.g. respite, care planning, training, information, care coordination, coaching, etc.)
 None Other _____

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:



AC, BI, CADL, 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

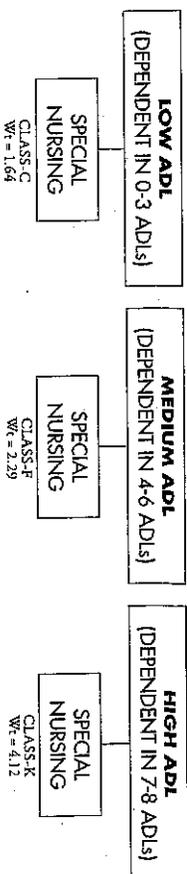
LOW ADL (DEPENDENT IN 0-3 ADLs)	MEDIUM ADL (DEPENDENT IN 4-6 ADLs)	HIGH ADL (DEPENDENT IN 7-8 ADLs)
---	--	--

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

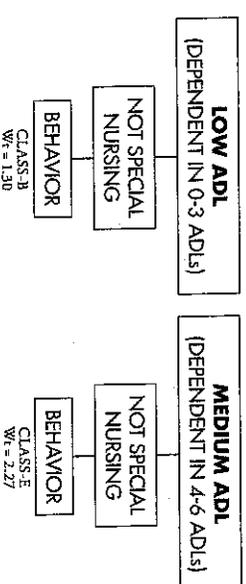
Special Nursing Case Mix Categories

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**.



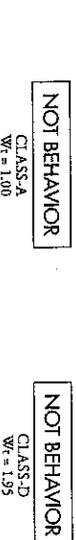
Step 4

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

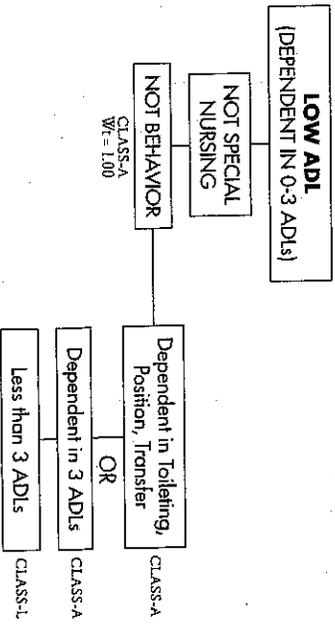
IF NOT Special Nursing and NOT Behavior:
 Low ADL = A, Medium ADL = D.



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.

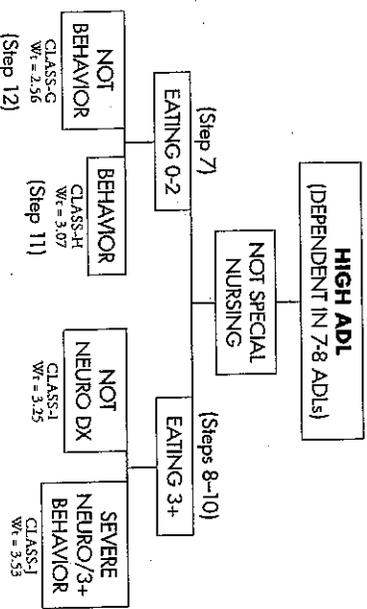


Step 7

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.

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

		Comments	Assessor's Score
LTC SD Block 33	Dressing		
Value	Independent	_____	00
<input type="checkbox"/>	• Intermittent supervision or reminders. May need physical assistance with fasteners, shoes or laying out clothes	_____	01
Dep.	• Constant supervision, but no physical assistance. (N/A 0-48 months)	_____	*02
<input type="checkbox"/>	• 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

		Comments	Assessor's Score
LTC SD Block 34	Grooming		
Value	Independent	_____	00
<input type="checkbox"/>	• Intermittent supervision or reminders	_____	01
Dep.	• Help of another to complete task, but child is physically able to participate. (N/A 0-48 months)	_____	*02
<input type="checkbox"/>	• Totally dependent on another for all grooming needs. Child is physically unable to participate. (N/A 0-24 months)	_____	*03

		Comments	Assessor's Score
LTC SD Block 35	Bathing		
Value	Independent	_____	00
<input type="checkbox"/>	• Intermittent supervision or reminders	_____	01
	• Needs help in and out of tub	_____	02
Dep.	• Constant supervision, but child does not need physical assistance. (N/A 0-60 months)	_____	*03
<input type="checkbox"/>	• 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

		Comments	Assessor's Score
LTC SD Block 36	Eating		
Value	Independent	_____	00
<input type="checkbox"/>	• Intermittent supervision or reminders	_____	01
Dep.	• Needs constant supervision and/or assistance in setting up meals, i.e. cutting meat, pouring fluids. (N/A 0-60 months)	_____	02
<input type="checkbox"/>	• 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.

RI	R2

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

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

Comments Assessor's Score

	00
	01
	*02
	*03
	*04

RI

R2

LTC SD
Block 39
Value

Dep.

Mobility (walking)

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

Comments Assessor's Score

	00
	01
	*02
	*03

LTC SD
Block 37
Value

Dep.

Positioning (bed mobility)

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

Comments Assessor's Score

	00
	01
	*02
	*03

LTC SD
Block 41
Value

Dep.

Toileting

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

Comments Assessor's Score

	00
	*01
	*02
	*03
	*04
	*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%
████	██	none
████	██	████
54.9%	Case Management, Paraprofessional	
2.1%	CDCS	
0.2%	CDCS Background Checks	
2.1%	CDCS Mandatory Case Management	
████	██	
3.2%	Companion Services	████
18.0%	Customized Living	
5.1%	Customized Living 24 Hour	
0.2%	Foster Care, Corporate	
0.6%	Foster Care, Family	
████	██	████ %
0.3%	Home Health Aide or CNA	
████	██	████
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 Extended 1:1	
0.5%	Supervision of PCA	
████	██	████
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

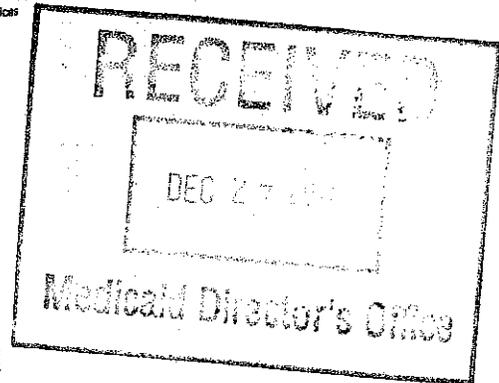
Appendix V - Public Comments

Date: December 22, 2011

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

From: Patti Cullen, CAE
President/CEO
Care Providers of Minnesota
(952) 854-2844
pcullen@careproviders.org

Gayle Kvenvold
President/CEO
Aging Services of Minnesota
(651) 645-4545
gkvenvold@agingservicesmn.org



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 disenrolled?

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.

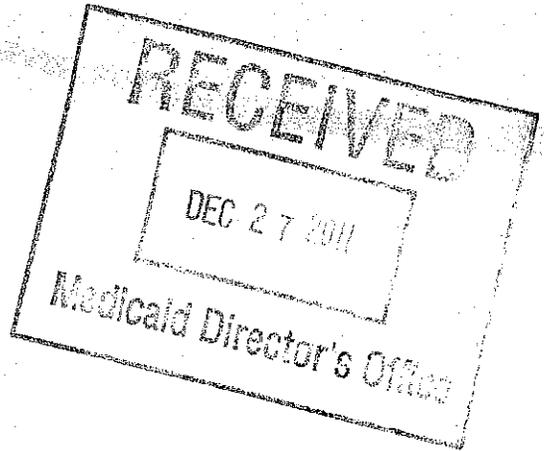
VIII. General Policy Considerations:

- 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.



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

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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.

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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@aarpp.org or 651-271-6586.

Thank you.

Sincerely,

A handwritten signature in black ink that reads "Michele H. Kimball". The signature is written in a cursive style with a large initial "M".

Michele Kimball
Senior State Director

Kooistra, Jan M (DHS)

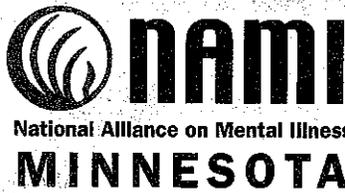
From: Steve Larson <stevel@arcmn.org>
Sent: Tuesday, December 27, 2011 10:28 AM
To: Kooistra, Jan M (DHS)
Subject: comments 1115 waiver
Attachments: AH Final Comments on 1115 waiver NF LOC 12-22-11 887726 (2).docx

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

Steve Larson
Public Policy Director
The Arc of Minnesota
800 Transfer Road
Saint Paul, MN 55114

Office - 651 523 0823 Ext. 115
Cell - 651 334 7970
stevel@arcmn.org

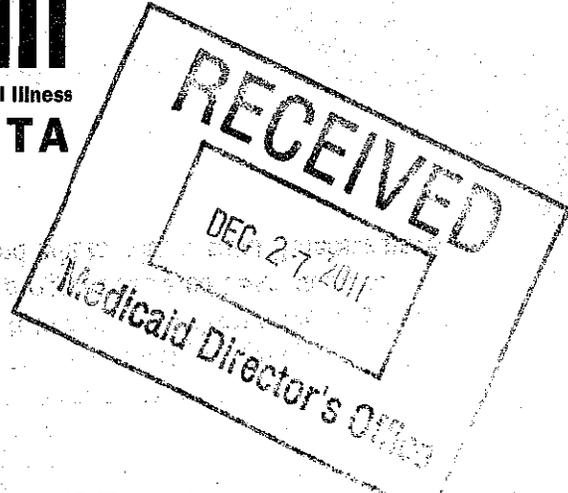
Join The Arc of Minnesota's Action Alert Network! Contact me for details!



J.K

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.



800 Transfer Road, Suite 31, St. Paul, MN 55114
651-645-2948 or 1-888-NAMI-HELPS www.namihelps.org

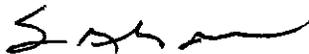
Cognitive or Behavior: We would assume that most people with a serious mental illness would become eligible for the CADI waiver under this section. The proposed criteria, however, offer even less clarity. How will the department interpret "significant" or "occasional?" There is no longer any mention 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 is 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
Senior Policy and Program Manager
The MN Consortium for Citizens with Disabilities
800 Transfer Road, Suite 7A
St. Paul, MN, 55114
Office: 651 523 0823, ext 112
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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.

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**LEGAL AID SOCIETY OF MINNEAPOLIS
SENIOR LAW PROJECT**
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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

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 HCBW wavier for individuals demonstrating one or more of the following: 1) A higher need of assistance in four or 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.

December 27, 2011

Page 3

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@mldmnlegal.org

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

Date: December 27, 2011

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December 27, 2011

Page 3

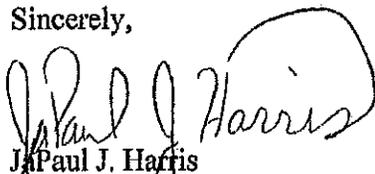
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Thank you for the opportunity to provide comments on the Long-Term Care Realignment Section 1115 Waiver Proposal. We urge that DHS publicly respond to the comments made during this comment period.

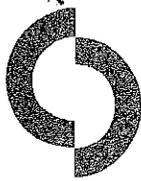
Sincerely,



J. Paul J. Harris

Supervising Attorney

Legal Aid Society of Minneapolis, Senior Law Project



chestnut cambronne
ATTORNEYS AT LAW

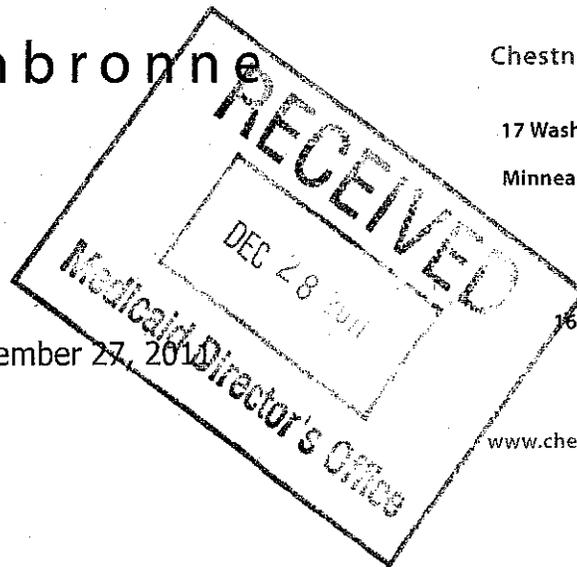
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December 27, 2010

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 Department's 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

Jan Kooistra
December 27, 2011
Page 2

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.

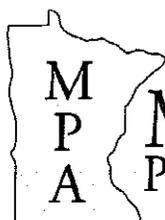
Sincerely,

CHESTNUT CAMBRONNE PA



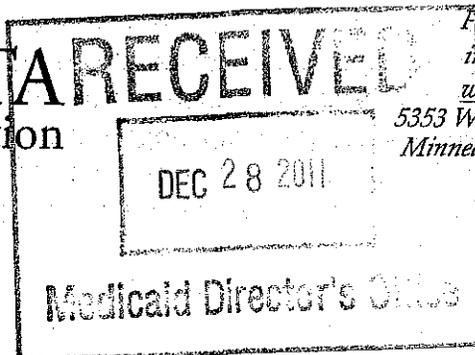
David A. Rephan

DAR:dp



MINNESOTA
Psychological Association

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



Tel: 952-564-3048
Fax: 952-252-8096
info@mnppsych.org
www.mnppsych.org
5353 Wayzata Boulevard
Minneapolis, Minnesota
55416

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

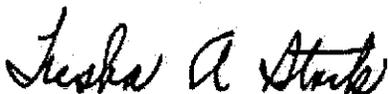
Best regards,



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
1360 Energy Park Drive
Suite 310
St. Paul, MN 55108-5252
651-646-4354
651-646-4539 FAX
julianzweber@qwestoffice.net

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JULIAN J. ZWEBER
ATTORNEY AT LAW

ENERGY PARK FINANCIAL CENTER
1360 ENERGY PARK DRIVE, SUITE 310
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.

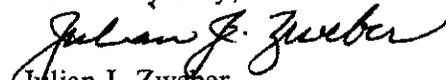
1. This proposal clearly violates both the letter and the spirit of the Maintenance of Efforts requirements set forth in the Affordable Care Act of 2010. CMS guidance clearly identifies increasing nursing facility level of care criteria as a violation of the ACA MOE.
2. Although wearing the language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

Jan Kooistra, Federal Relations
December 28, 2011
Page 3

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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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.

100 E. Highway 14 • Tyler, MN 56178

Local 1-507-247-5900 • Toll Free 1-866-457-3131 • Fax 1-507-247-5868

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
lp Pluto@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 **Margaret A. Holm**
by:

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



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

The Protection and Advocacy System for Minnesota

430 First Avenue North, Suite 300 Minneapolis, MN 55401-1780

Telephone: (612) 334-5785 Toll Free: (800) 292-4150 Client Intake: (612) 334-5970

Facsimile: (612) 334-5755 TDD: (612) 332-4668 www.mndlc.org

A United Way Agency

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.

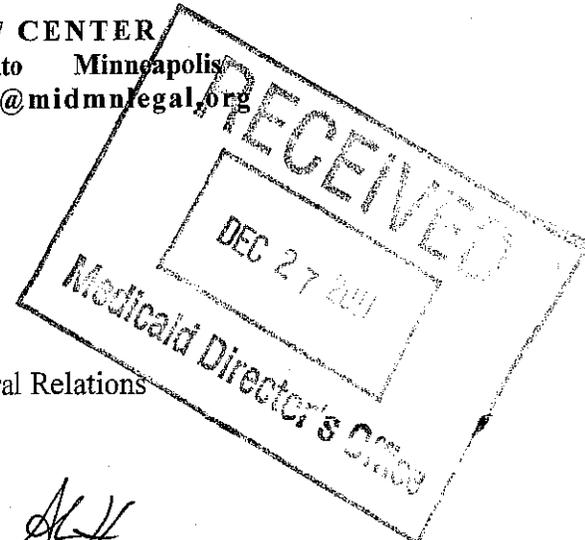
3. DHS should post all public comments it receives on its website and also should provide them to CMS as an appendix to its waiver application.

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.



JK

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



MEMO

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

From: Anne L. Henry, Minnesota Disability Law Center *ALH*
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

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A United Way Agency

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.

December 22, 2011

Page 5

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.

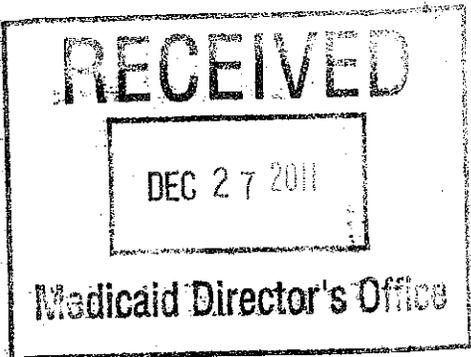
ALH:nlb

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**COURAGE
CENTER**

S.K.



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 CAD1 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

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.

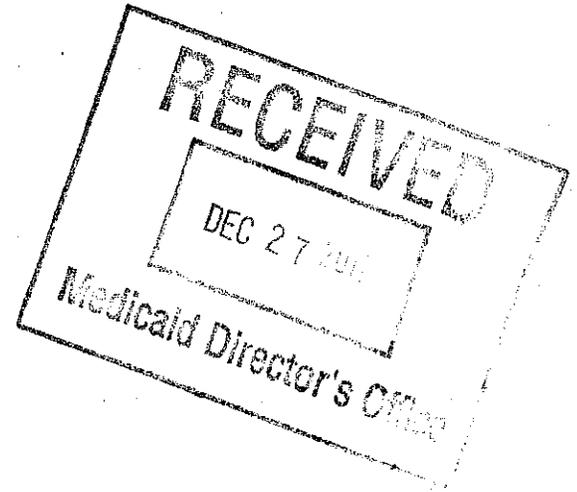
KANDIYOHI COUNTY FAMILY SERVICE DEPARTMENT

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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

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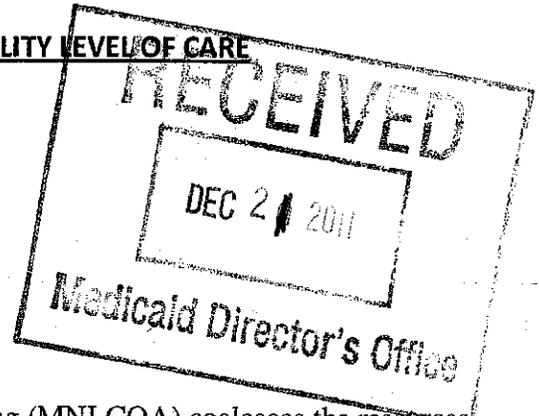
www.mnlcoa.org
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Minnesota Leadership Council On Aging
2635 N. McKnight Rd.
St. Paul, MN 55109

COMMENTS ON MODIFIED NURSING FACILITY LEVEL OF CARE

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 disenrolled?

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.



Dr. Edward Ratner
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MN Leadership Council on Aging
Ratne001@umn.edu



Patti Cullen
Co-Chair
MN Leadership Council on Aging
pcullen@careproviders.org

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 occasional 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
Douglas County Public Health
Waiver Program Coordinator
sue.kvasager@mail.co.douglas.mn.us
(320) 762-3022

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 waived 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 waived 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 waived 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.

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

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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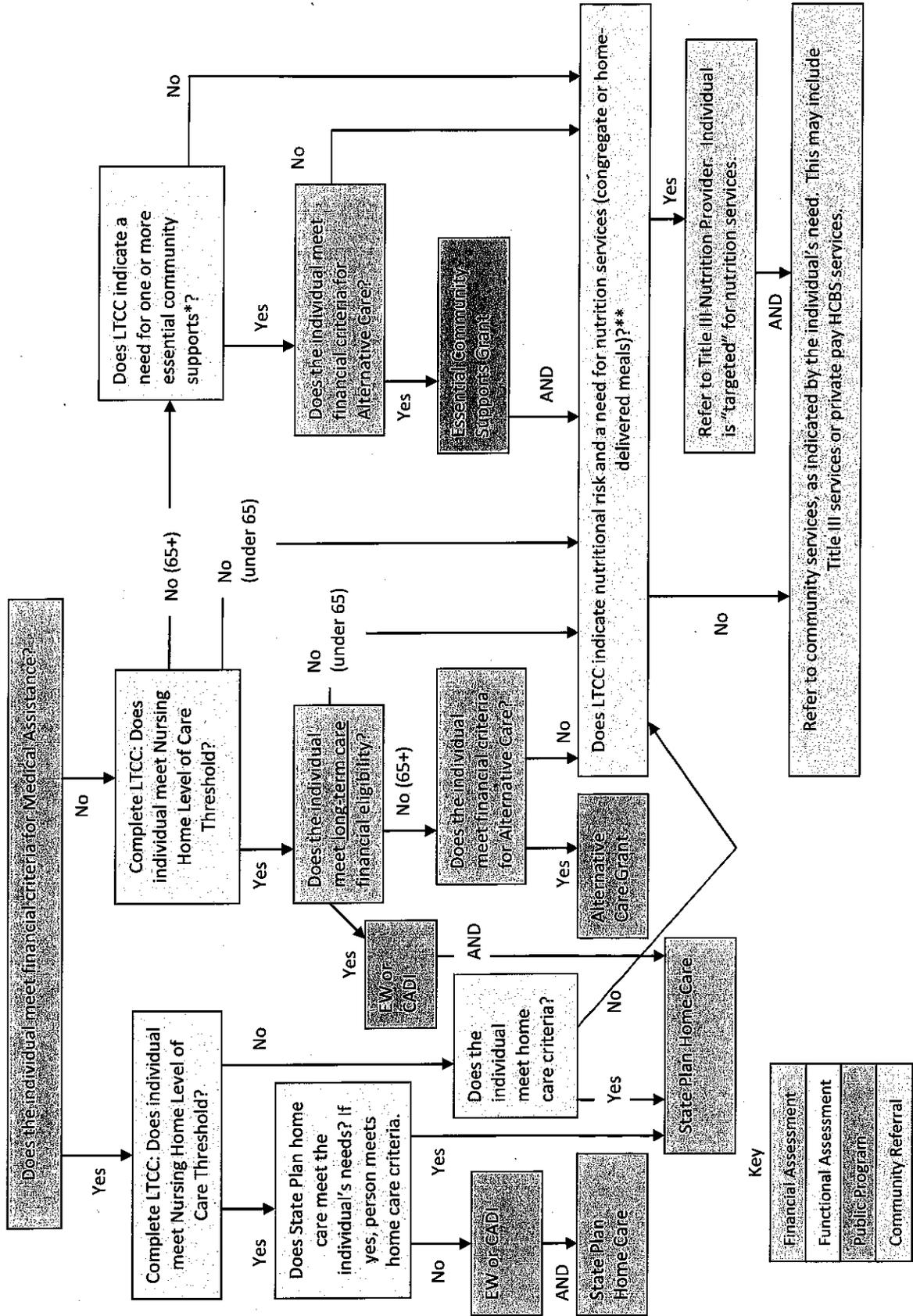
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Home and Community Based Service Options Public Program Criteria: Decision Tree – All Ages

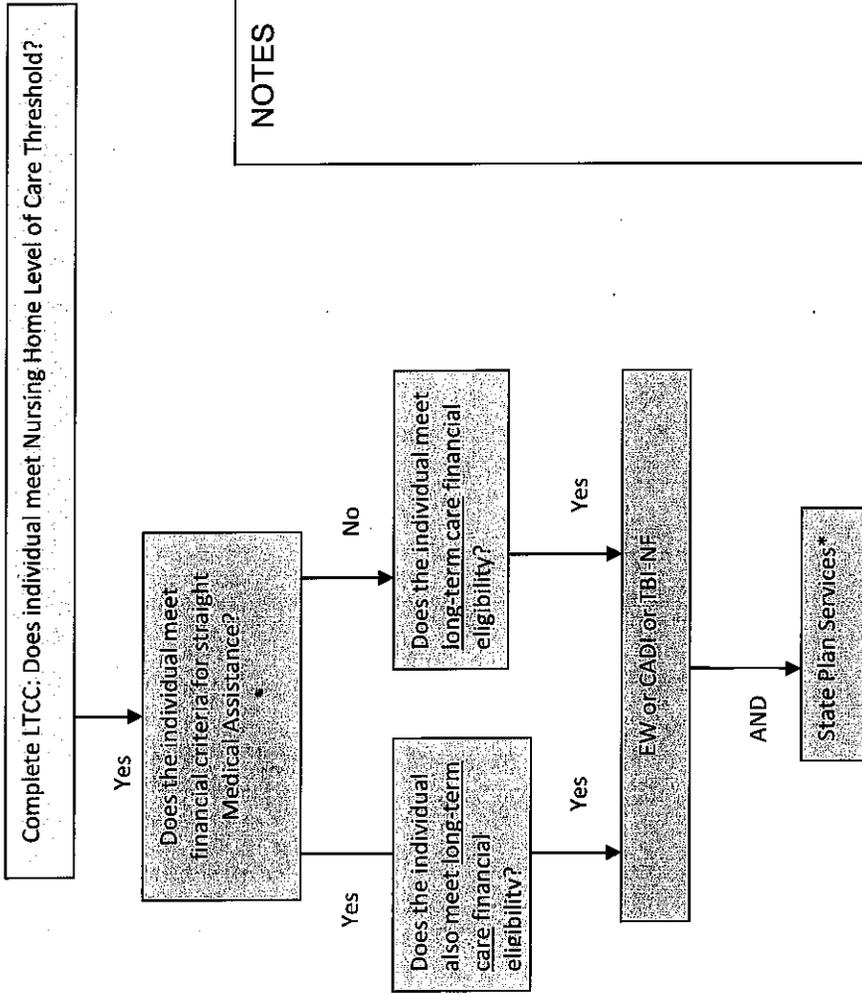


*Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system
 **Individuals under 60 are not eligible for Title III Nutrition services. If under 60, move to "Refer to community services as indicated by the individual's need."

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

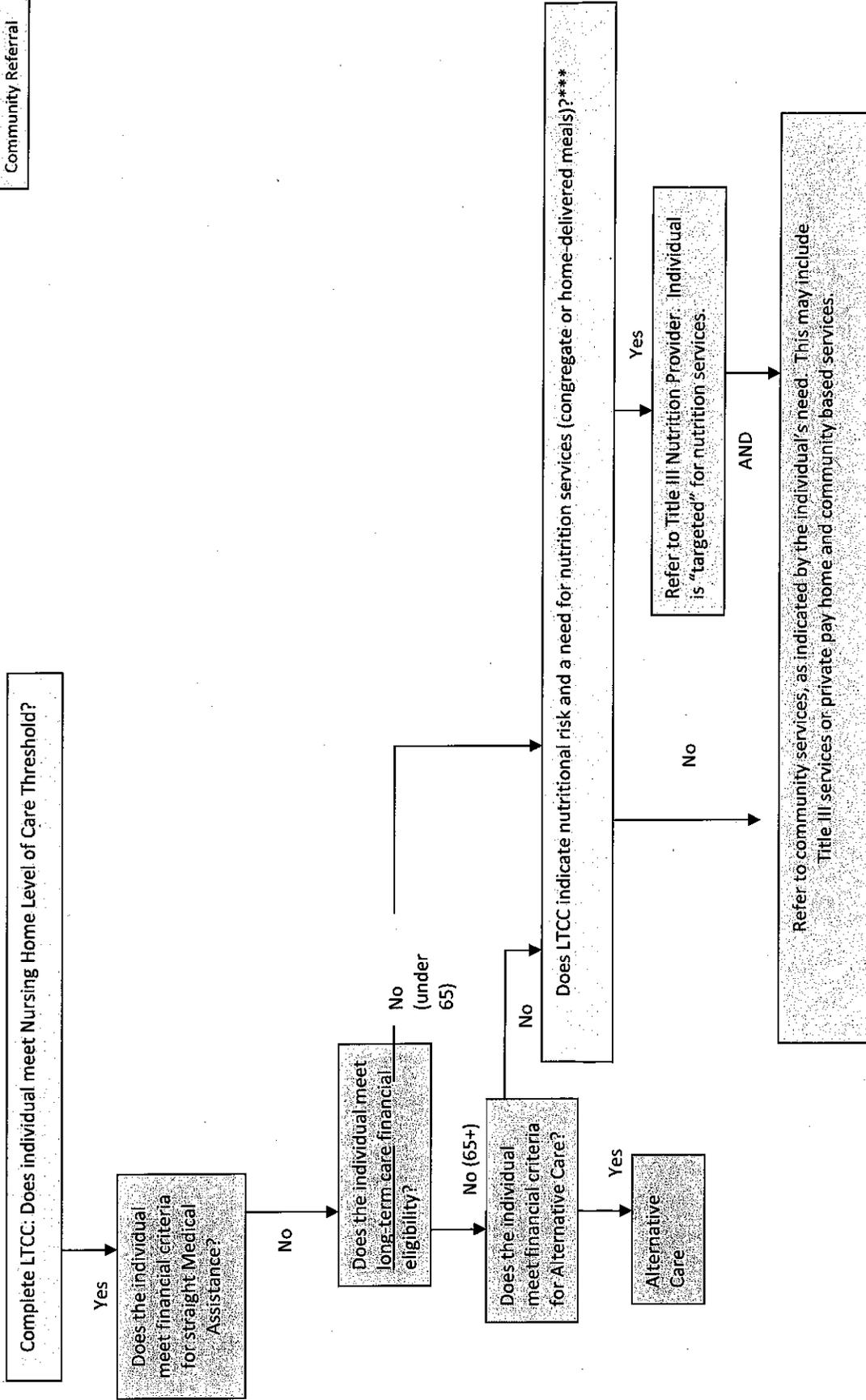


*Individual may or may not qualify for State Plan Home Care, based on whether the individual meets criteria for that program.
 **Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system
 ***Individuals under 60 are not eligible for 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?

**Home and Community Based Service Options
Public Program Criteria
Individual Does NOT Meet NF LOC AND DOES MEET MA Financial Eligibility Criteria**

Key

Financial Assessment
Functional Assessment
Public Program
Community Referral

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?

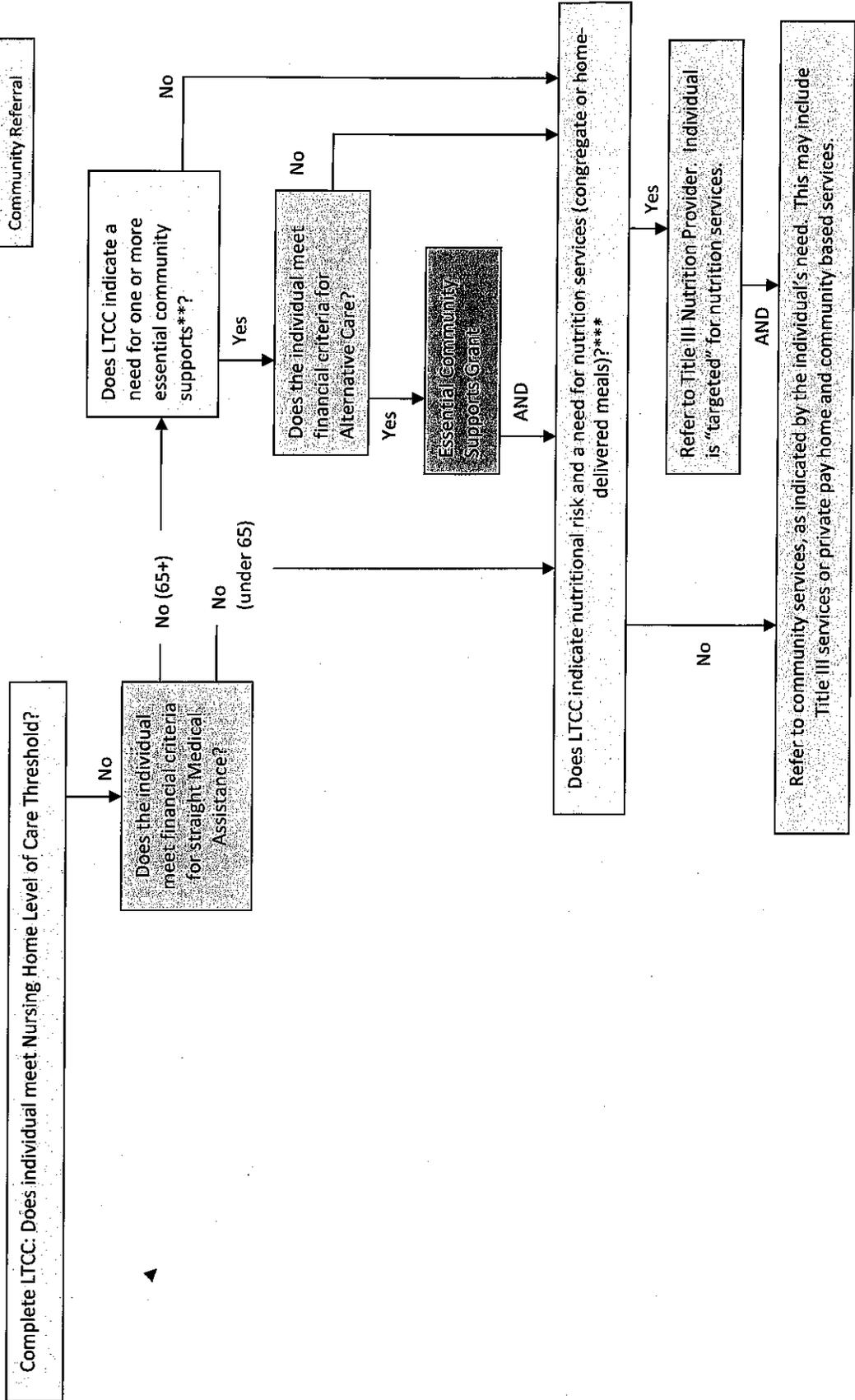
* Individual may or may not qualify for State Plan Home Care, based on whether the individual meets criteria for that program.
 ** Essential Community Supports are 1) caregiver support, 2) homemaker, 3) chore, 4) personal emergency response device or system
 *** Individuals under 60 are not eligible 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

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 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.

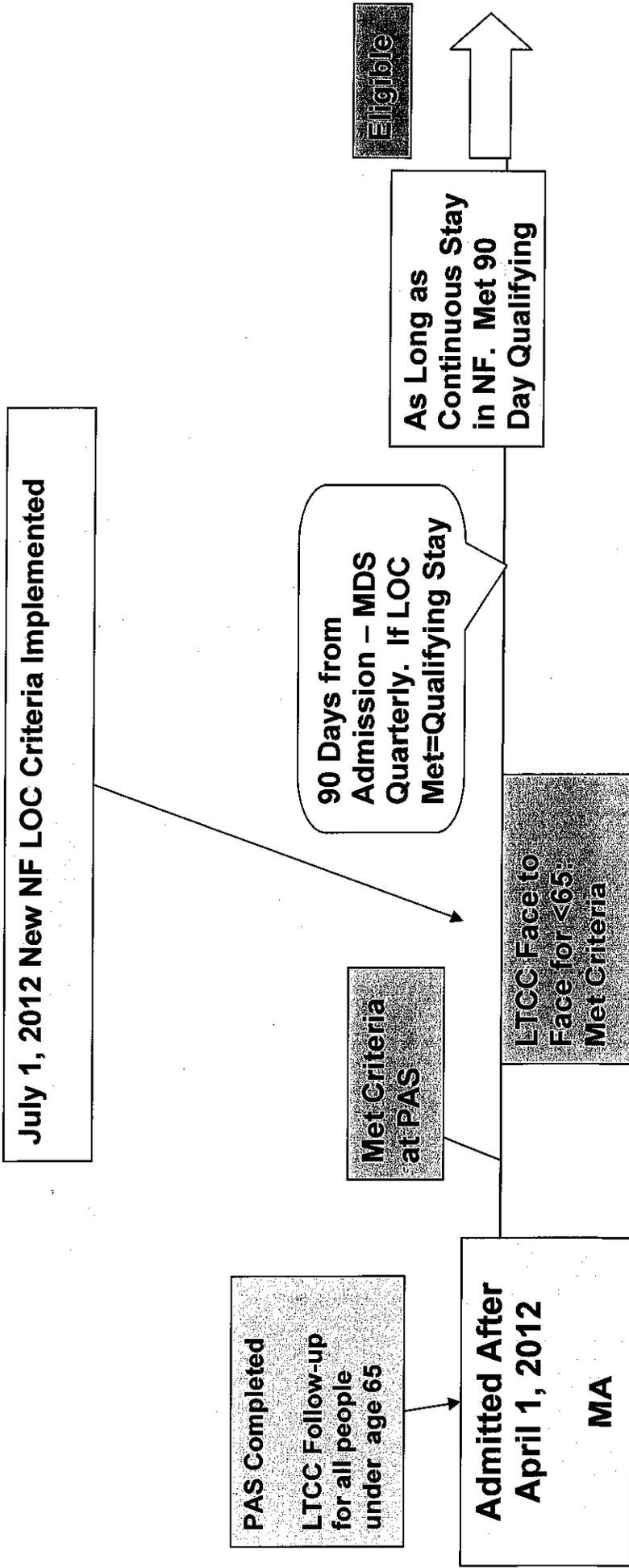
c.

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

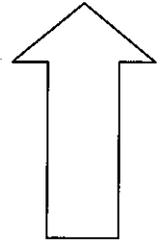
Potential July 1, 2012 Implementation

July 1, 2012 New NF LOC Criteria Implemented

90 Day Qualifying Stay Under Existing Criteria

Admitted More Than 90 Days Before Implementation (Before April 1, 2012) Private Pay or MA

Met 90 Day Qualifying Stay as Long as Continuous Stay in NF



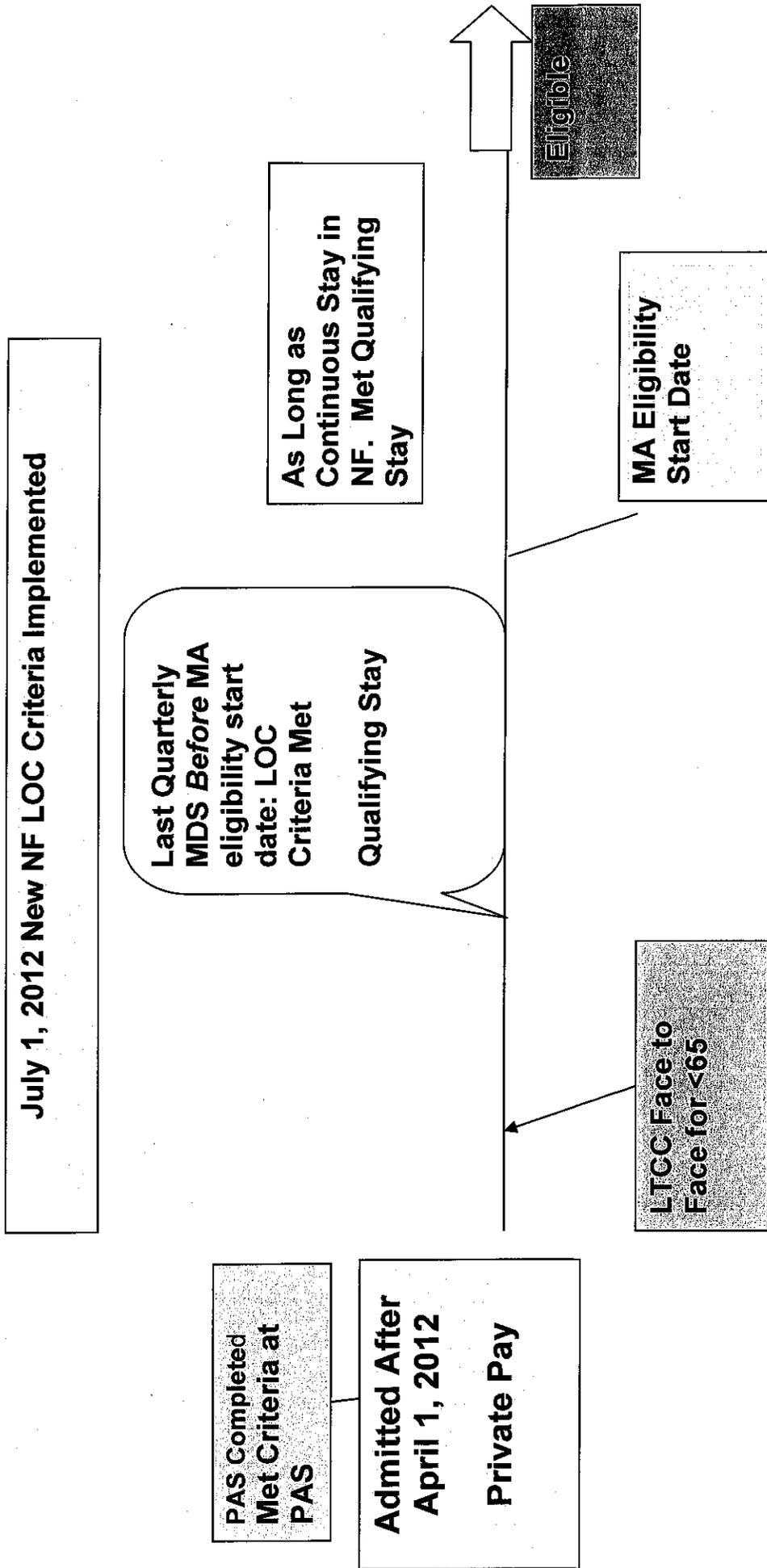
Eligible

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.

PAS Completed LTCC Follow-up completed for all 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%
* 33% offset for the 93% assumed to retain MA eligibility.				
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

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**

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%

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%

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%

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)

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 ineligible.

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).