MINNESOTA 2020 SYSTEM REFORM 1115 DEMONSTRATION
FACT SHEET

Name of Section 1115 Demonstration:	Minnesota 2020 System Reform
Waiver Number:	11-W-00286/5
Date Proposal Submitted:	March 12, 2018
Date Approved:	February 1, 2020
Date Expires:	January 31, 2025

SUMMARY

Minnesota's section 1115 demonstration was initially approved on October 18, 2013, with the goal of creating viable community alternatives for individuals receiving institutional care and reducing reliance on costly institutional care. The demonstration operated statewide and expanded eligibility to aged individuals and individuals with disabilities through the following programs:

1. The Alternative Care (AC) program provides a targeted set of home and community-based services (HCBS) to people ages 65 and older who are in need of a nursing facility level of care but not eligible for Medicaid coverage because their income and assets exceed eligibility limits. However, their excess income and/or assets are insufficient to pay for 135 days of nursing facility care.

2. The Activities of Daily Living (ADL) Needs program provides Medicaid funding to continue coverage of children under the age of 21 who met the state's March 2010 Medicaid state plan institutional level of care in the 1915(c) but did not meet the state's current Medicaid state plan institutional level of care in the 1915(c) that went into effect on January 1, 2015, and, therefore, would lose Medicaid eligibility without the demonstration.

On March 12, 2018 the state submitted a request to extend the demonstration for a five-year period beyond its scheduled expiration date of June 30, 2018. On January 31, 2020, the renewal request was approved, effective February 1, 2020 until January 31, 2025. Expenditure authority for the ADL population of children is effective until October 31, 2020, to allow time for the state to transition this group out of this demonstration.

ELIGIBILITY

Under this demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain as set forth under the state plan.

Applicants in the AC program must submit applications to lead agencies as identified by the state. Lead agencies must annually re-determine financial and service eligibility. Applicants may be required to provide all information necessary to determine eligibility for Alternative Care and potential eligibility under the Medicaid State Plan. Applicants for Alternative Care who appear to be categorically eligible under the Medicaid State Plan shall receive Alternative

Care for up to 60 days while State Plan eligibility is determined.

BENEFITS

AC program

The Alternative Care program provides an array of home and community-based services similar to the home and community-based services provided under the federally approved 1915(c) Elderly Waiver program (CMS control number 0025.91.R07.00), except that the following services are not covered: transitional support services, assisted living services, adult foster care services, and benefits that meet primary and acute health care needs. Alternative Care does additionally cover nutrition services and discretionary benefits that address special or unmet needs of a client or family caregiver that are not otherwise defined in the Alternative Care program service menu. The monthly cost of the Alternative Care services must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs participating in the Elderly Waiver program. The service definitions and standards for Alternative Care services are the same as the service definitions and standards specified in the federally approved 1915(c) Elderly Waiver. In summary, Alternative Care program benefits include but are not limited to:

a. Adult day service/adult day service bath;
b. Family caregiver training and education;
c. Case management and conversion case management;
d. Chore services;
e. Companion services;
f. Consumer-directed community supports;
g. Home health services;
h. Home-delivered meals;
i. Homemaker services;
j. Environmental accessibility adaptations;
k. Nutrition services;
l. Personal care;
m. Respite care;
n. Skilled nursing and home care nursing;
o. Specialized equipment and supplies including Personal Emergency Response System (PERS);
p. Non-medical Transportation;
q. Tele-home care; and,
r. Individual Community Living Supports (ICLS).

ADL program

Benefits for the ADL program are the same as what is provided under the Medicaid State Plan.

DELIVERY SYSTEM

AC program

These program services are provided on a fee-for-service basis and are administered by counties and tribal health agencies. The service definitions and standards for Alternative Care services are the same as the service definitions and standards specified in the federally approved 1915(c) Elderly Waiver plan. Approved services are prior authorized in the MMIS system. Services are provided by qualified providers who are enrolled Medicaid providers**.**

ADL program

These program services are provided on a fee-for-service basis in the same manner as authorized under the Medicaid State Plan.

COST SHARING

AC program

Individuals in the Alternative Care program pay cost-sharing fees up to 30 percent of the average monthly cost of the individual's Alternative Care services.

Determining Fees. Minnesota uses adjusted income and gross assets and the average monthly amount of services authorized for the beneficiary. Adjusted income for a married applicant who has a community spouse is calculated by subtracting the following amounts from gross income: the monthly spousal income allowance to the community spouse (which is calculated using the spousal impoverishment rules applicable under the 1915(c) Elderly Waiver); recurring and predictable medical expenses; and the federally indexed clothing and personal needs allowance. Adjusted income for all other applicants is calculated by subtracting the following amounts from gross income: recurring and predictable medical expenses and the federally indexed clothing and personal needs allowance.

Alternative Care Adjusted Income	**Gross Assets**	**Monthly Fee Charge (percentage of average monthly cost of services)**
Less than 100% of the FPL	Less than $10,000	No monthly fee
Between 100% and 149% of the FPL	Less than $10,000	5 percent
Between 150% and 199% of the FPL	Less than $10,000	15 percent
At or greater than 200% of the FPL	At or greater than $10,000	30 percent

a. Billing and Non-payment of Fees. Enrollee fees are billed the month after services begin. If enrollee fees are not paid within 60 days, the lead agency works with the enrollee to arrange a payment plan. The lead agency can extend the enrollee's eligibility as necessary while making arrangements to rectify nonpayment of past due amounts and facilitate future payments. If no arrangements can be made, a notice is issued 10 days prior to termination stating that the enrollee will be dis-enrolled from the program. The enrollee may appeal the disenrollment under the standard State Fair Hearing process. Following disenrollment due to nonpayment of a monthly fee, eligibility may not be reinstated for 30 days.

ADL program

Cost sharing for ADL program under the demonstration remains the same as what is included in the approved state plan.

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