State of Minnesota

Reform 2020: Pathways to Independence

Section 1115 Waiver Proposal

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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 been 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 seeks 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) requirements[10], 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:
    - <u>Home Care Case Management</u>: 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 Medicare 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 criteria[12], 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 hospital [13]
- 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 21and 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

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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 Utlization 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_CONVERSION&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 be 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

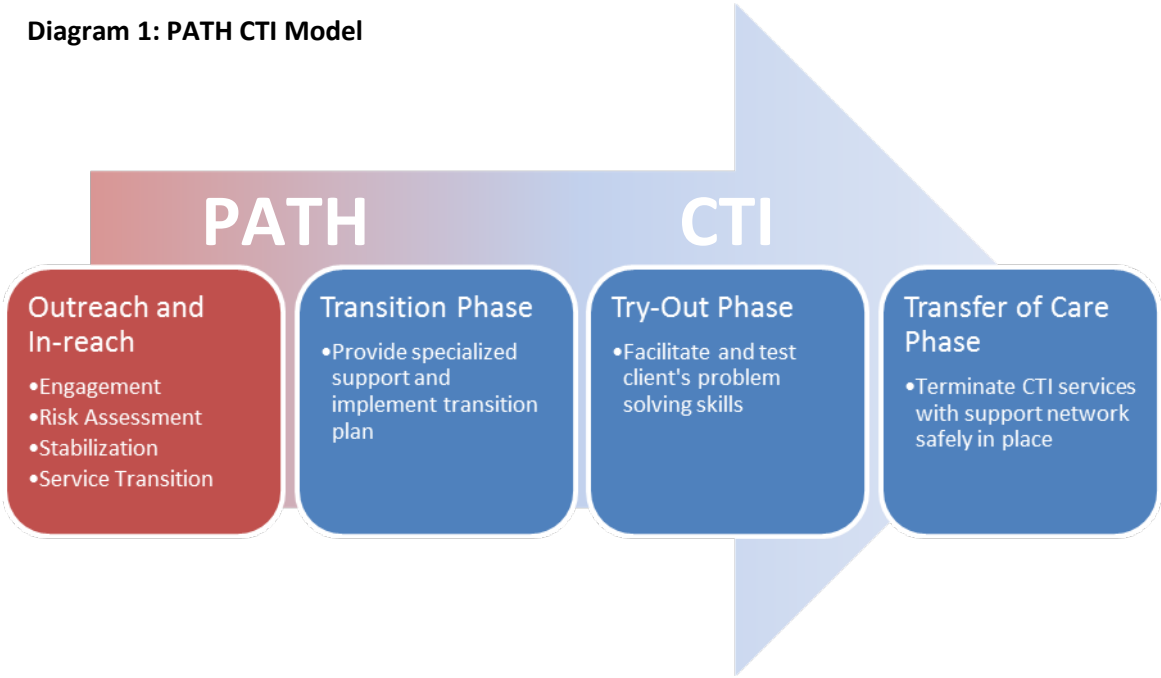
PATH eligible individuals are adults with a serious mental illness, or a serious mental illness and substance abuse, who are homeless or at imminent risk of becoming homeless and being served by a Minnesota PATH program. Eligible individuals include persons contacted via PATH outreach and in-reach services 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**
• Outreach • Case management	
• Screening and diagnostic treatment • Community mental health	• Psychiatric treatment and medication management
• Habilitation and rehabilitation	• Money management • Family interventions
• Alcohol or drug treatment	• Substance abuse treatment
• Housing services for stabilization • Supportive and supervisory services in residential settings	• Housing crisis management and prevention
• Referrals for primary health services, job training, education services, and relevant housing services	**Secondary Areas of CTI Intervention** • Life skills training • Vocational training • Education
• 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
VOM 1 Housing	1,715	909	*53%*
VOM 2 Benefits Income	1,438	808	*56%*
VOM 3 Earned Income	895	270	*30%*
VOM 4 Medical Insurance	1,096	1,031	*94%*
VOM 5 Primary Medical	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 housing[18]. 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 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 patent'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 Force[21], as well as the work of the Minnesota Autism/ASD Summit Committee[22], 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 disabilites, 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 recoupment 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 unlikeliness 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	Proper targeting of individuals for transition assistance Counseling, follow-up and referral of transitioned residents to community services Active participation of hospitals and nursing facilities in the community transition process Identification of risk factors and unmet need among transitioned individuals and caregivers	Medicaid savings HCBS costs significantly below what nursing home costs would have been for transitioned individuals Medicaid conversion delayed or avoided Nursing home utilization reduced No increase in hospitalizations and ED visits. Health and functioning maintained or improved
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.	Total LTC Costs HCBS costs Health Care Costs (Medicare and Medicaid) Nursing facility utilization rate Hospitalizations and ER visits

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

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	Target Population: nursing home admissions after program implementation. (Average acuity of all admissions, average length of stay) Comparison Group: nursing home admissions before program implementation. (Average acuity of all admissions, average length of stay)	Minimum Data Set (MDS) MDS	2014-2019 2009 - -2013
Essential Community Supports Program (ECS) serving	Target Populations: (Medicaid eligibles) Nursing facility applicants who fail to meet new NF LOC criteria prior to nursing facility admission Nursing facility residents who fail to meet new NF LOC criteria at their most recent assessment prior to Medicaid eligibility Persons in the community applying to or referred to ECS Comparison Groups: (Medicaid eligibles) Nursing facility applicants who would have failed to meet NF LOC criteria prior to nursing facility admission 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	NF Long-Term Care Consultation (LTCC) MDS Medicaid Claims	2014-2019 2009-2013

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

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 Miinnesota 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 Serves 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* Webiner 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 petitition 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 increases 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.

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[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.

- **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
    - 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

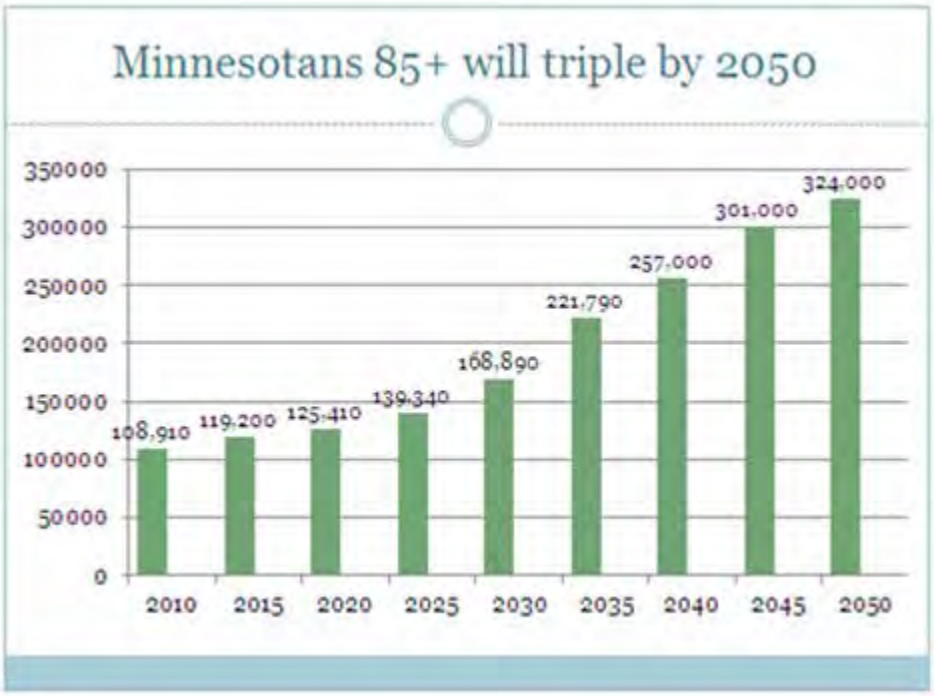
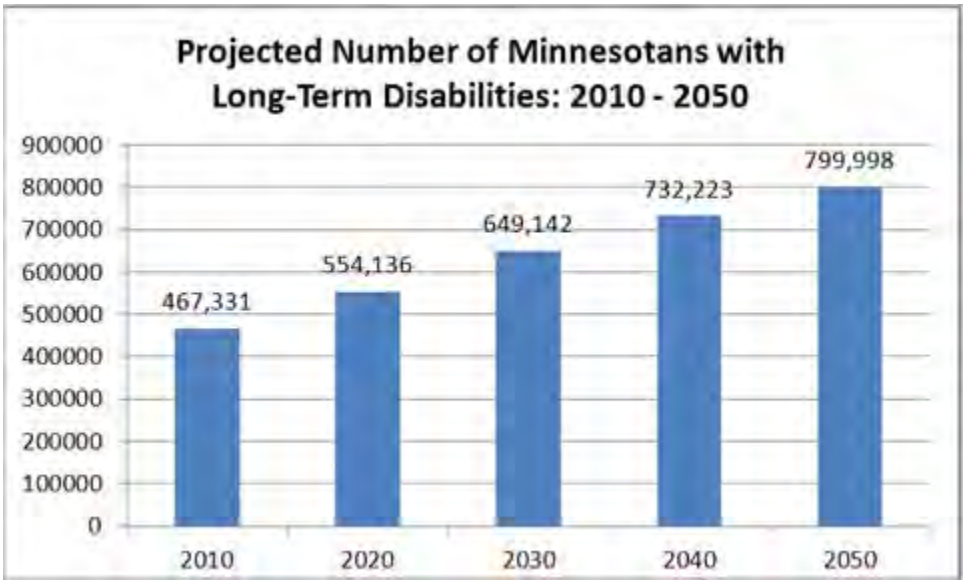
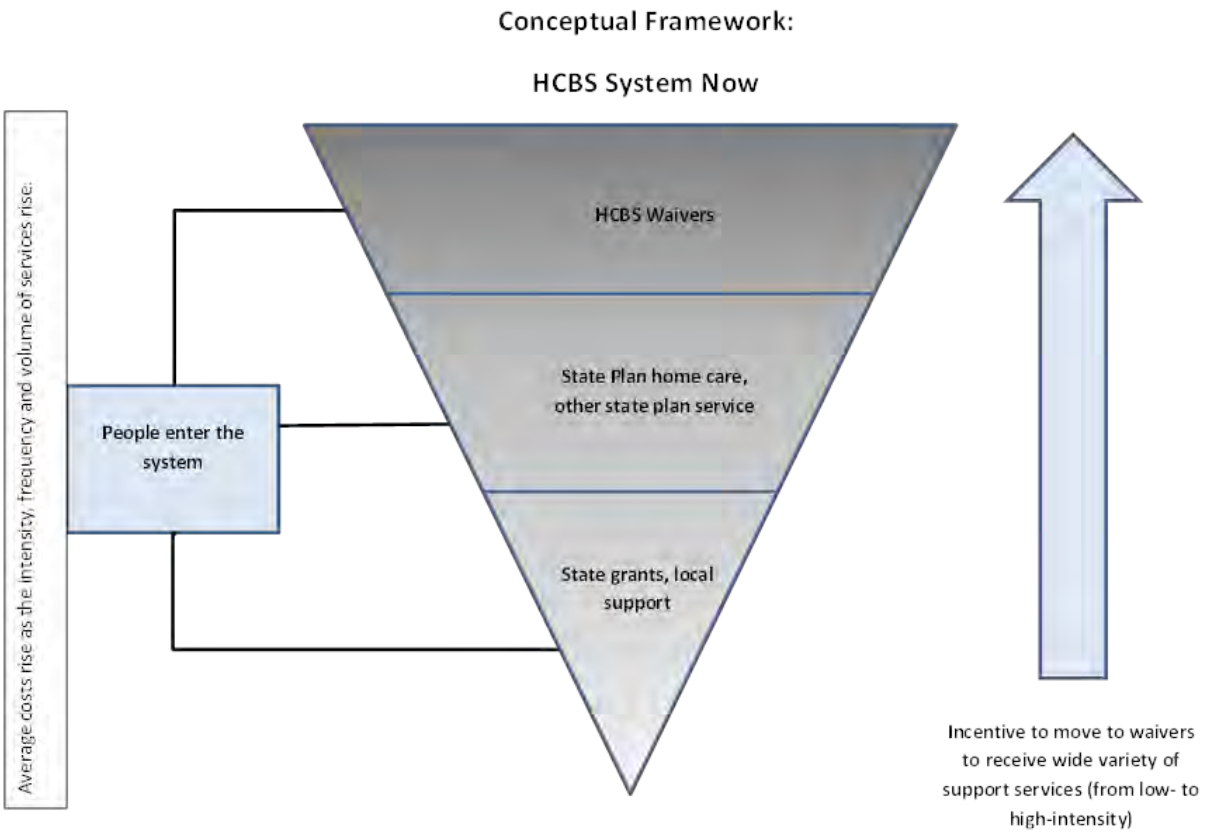


Chart 1: Projected number of Minnesotans with Long-Term Disabilities: 2010-2050

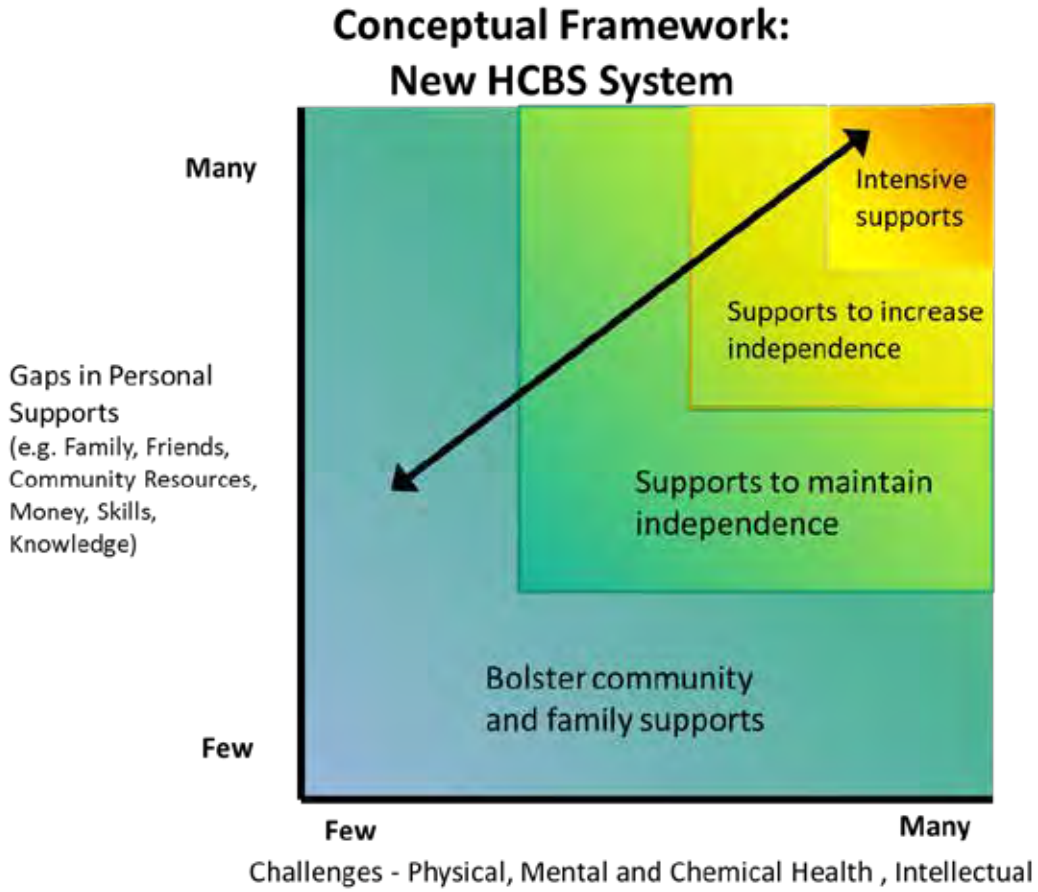


Attachment B: HCBS System "Now"



Current System Dynamic: There is pressure to move into waivered 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 *impaired cognition*: • Short term memory loss • Disorientation of person, place, time or location • Impaired decision-making ability **OR** *Frequent history of the following behavior* symptoms: • Wandering • Physical abuse of others • Resistive to care • Behavior problems requiring some supervision for safety of self or others • Severe communication problems		*Self neglect:* The person has not or may not obtain goods or service necessary to ensure reasonable care, hygiene, nutrition and safety, or to avoid physical or mental harm or disease; **OR** *Neglect, abuse, or exploitation:* The person's caregiver(s) or other persons cannot provide reasonable care to the person, or the person has been or may be physically and/or verbally abused, or the caregiver(s) or other persons have or may mismanage the person's funds and/or possessions; **OR** The person has experienced frequent or recent hospitalization, nursing facility *admissions*, falls, or overall frailty.
Proposed Operational Criteria: Functional Limitation	**OR**	**Proposed Operational Criteria: Clinical Need**	**OR**	**Proposed Operational Criteria: Cognition or Behavior**	**OR**	**Proposed Operational Criteria: Frailty or Vulnerability**
A high need for assistance in four or more ADLs; **OR** A high need for assistance in one ADL that requires 24 hour staff availability (toileting, positioning, transferring, mobility)		A need for clinical monitoring at least once a day		Significant difficulty with memory, using information, daily decision making, or behavioral needs that require at least occasional intervention.		A qualifying NF admission of at least 90 days **OR** Living alone AND risk factors are present (maltreatment, neglect, falls, or substantial sensory impairment)

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/lfserver/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 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 htttp://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 • 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

Coordinate and Streamline Services for people with complex needs • 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)	No Plan to seek state plan authority under 1915(i) following stakeholder process and legislative action. State will engage ASD Task Force and seek to align policy work with goals of the Task Force.
Redesign HCBS (Section 9.2)	No; necessary changes to 1915(c) HCBS waivers may be sought
Promote Personal Responsibility and Reward Health Outcomes (Section 9.3)	No; activities funded through a federal grant
Encourage Utilization of Cost-Effective Care (Section 9.4)	No
Intensive Residential Treatment Services (Section 9.5)	No
Children Under 21 in Residential IMD Facilities (Section 9.6)	No

Comments	DHS Response
2.2 Long Term Care Realignment Section 1115 Waiver 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.	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.
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.	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.
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.	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. 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. At this time, ECS services available for individuals on Medical Assistance are limited to those individuals who are part of the "transition" group: • 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

Comments	DHS Response
One commenter asked whether Essential Community Supports or ECS is intended to support MSHO/MSC+ seniors with less than four ADLS.	• have an assessed need for an ECS service as defined in statute. 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. To clarify, the LOC criteria based on ADL needs is *one* of three "critical" ADLSs (toileting, positioning or transferring), *or* 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. 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.
2.3 Redesigning Integrated Medicare and Medicaid Financing for People with Dual Eligibility 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	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.
3 Accountable Care Demonstration **Accountable Care Demonstration-** Demonstration Design Please consider the recommendations of the Governor's Health Reform Task Force Several commenters argued that it is essential to ensure that new models of	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

Comments	DHS Response
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	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.
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?	
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?	
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.	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.
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.	
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.	DHS is committed to thoughtful reform, and will continue to engage stakeholders.
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	

Comments	DHS Response
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. How will enrollment work? Assignment When can a person leave an ACO? Need more detail on consumer protections available under ACO model, including appeals What are the enrollment and opt-out options for consumers who choose not to enroll in an ACO Commenters urged DHS to establish robust consumer protections and accountability measures for the accountable-care demonstration. 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. **Accountable Care Demonstration -** Role of Health Plans • 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.	

Comments	DHS Response
• 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. **Accountable Care Demonstration -** ACO Financial Risk and Solvency Requirements • 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	
Accountable Care Demonstration- Freedom of Choice/ Adequacy of ACO networks • 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,	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.

Comments	DHS Response
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. **Accountable Care Demonstration –** Support Several commenters support the Accountable Care Demonstration • 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. **Accountable Care Demonstration -** Data Sharing Needs of ACOs • 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.	DHS appreciates stakeholder support as we move forward on these reform initiatives.
4 Demonstration to Reform Personal Assistance Services – CFSS ***Self-Direction/Individual Choice/Person-Centered Planning*** • 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	***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. DHS appreciates the support for the direction of case management system

Comments	DHS Response
• 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.	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: • Community membership • Health welfare, and safety • Own Home • Important Long Term Relationships • Choice over services and supports • Employment earnings and stable income. 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. 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.
General Strengths of Proposal • 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.	***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.

Comments	DHS Response
• 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	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.
Quality Assurance/Program Integrity • 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	***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. 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

Comments	DHS Response
needs • 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.	direct care worker training to assure that checks and balances are in place.
Communication/Transition • 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	***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.
Access Criteria for CFSS and the change in Nursing Facility Level of Care (NF LOC) Described in the Long Term Care Realignment waiver • 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	***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. 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. The proposed design of CFSS is to allow more flexibility than the current PCA

Comments	DHS Response
not qualify. • 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	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. 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. 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.
Details of Implementation • 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	***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. 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. 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.

Comments	DHS Response
service, waiver, managed care) ***Provider Standards/Training*** • 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".	***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, *in the right way*. It is imperative for providers to have appropriate skills in order to deliver the service *in the right way*. 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.
Stakeholder Input • 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.	***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. 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.
Simplification • 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	***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.

Comments	DHS Response

most complex (page 25)? What barriers, gaps, and redundancies does DHS believe prevent people from accessing the service they need?
 	
Service Models
• 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.
 	
Financial Management Entities (FME) responsibilities
• 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
  o Need for choice of service coordinators – competition important to maintaining quality of services
  § Recipients should be able to choose to have service
	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.
	
	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.
	
	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.
	
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Comments	DHS Response
coordination and financial management provided by the same entity	
County responsibilities • 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.	***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.
Managed Care role • 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	***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.
Interaction with HCBS Waivers • 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 § ILS therapies § Day Services § Personal supports § Respite	***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. 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

Comments	DHS Response
• 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? ***Need for data/fiscal analysis*** • 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.	areas related to activities of daily living. 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. 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. 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. ***Need for data/fiscal analysis***: The fiscal analysis is included at Attachment O. DHS will discuss the assumptions and the fiscal analysis with stakeholders.
4.2.3 Demonstration of Innovative Approaches to Service	***Changes made in proposal after public comment period:*** After reading public

Comments	DHS Response
Coordination (Children with CFSS)	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 and DHS will rely upon input from our stakeholders and our partners at the Department of Education to shape the final design.
Value in Better Service Coordination • A single coordinated plan will contribute to better outcomes for individuals • Great way to do something differently while working within current system • Coordinated care across environments and systematic coordination for transition from early intervention into school are both strengths of the proposal • Integrating/collaborating health care and education needs of children with disabilities is encouraging. • Med and Ed need to plow the same direction • Supports service coordination model demonstration for kids with CFSS • Critical for families to retain access to home care service coordination	***Value in Better Service Coordination:*** We appreciate the support for the concept that coordinating services and supports across home, community and school as well as having a method to assure appropriate transitions at key points in a child's life span are important can lead to better outcomes for children.
Concern about placing the service in schools • NAMI strongly supports better and more intensive care coordination models but doesn't believe they should be centered in the schools • Schools don't operate year-round, 24/7	***Concern about Placing the Service in Schools:*** Many responders raised concerns about the skill and training of school personnel. DHS would set provider standards for this service that would have to be met in order to participate in the demonstration. While we agree that it would be important to have knowledge about the needs of the children in the

Comments	DHS Response
• 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	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. • <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.

Comments	DHS Response
Partnership Needed • 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 ***More Information Needed*** • 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	***Partnership needed:*** DHS will include stakeholders in the planning, development, implementation and evaluation of the demonstration. The school-linked mental health grant program is a successful model that will be looked at in the design of this demonstration. ***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.
5 Demonstration to Expand Access to Transition Support • 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	***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. ***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: 1) Compare the characteristics and utilization patterns of NH admission cohorts before and after implementation of RTC to determine if: • 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:

Comments	DHS Response
to Medicaid; unsupportive of long-term care options counseling about community-based housing options as it is intrusive and unnecessary • 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	• 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. 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. 4) Examine the RTC initial CLS assessments in the NH and follow-up assessments to the community in order to: • 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 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. 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. 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. ***Support for extending Return to Community to younger adults with disabilities***: 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

Comments	DHS Response
	county or for those that are not on Medicaid, to the local Center for Independent Living for help with transition assistance and support. ***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. ***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. ***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. ***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.
6.1 Demonstration to Empower and Encourage Independence through Employment Supports	

Comments	DHS Response
Support for the proposal • 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	***Support for the proposal:*** DHS appreciates the support for this proposal.
Concern about design elements • 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	***Concern about design elements:*** • <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

Comments	DHS Response
the past year	to people who are currently unemployed.
• 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?	• Outreach efforts, participant engagement, program uptake and similarities to DMIE 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.
• Telephonic navigation not a good match for the needs of this group; need outreach approach	• Telephonic navigators embedded in the DLL, will not be effective 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 navigatio0n 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.
• Concern that services based on DMIE will not be effective	• Services based on DMIE will not be effective 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
• Concern that navigator functions don't include information about housing benefits	• Navigation services and housing benefits Information about housing benefits was included in the navigator function of

Comments	DHS Response
• Eligibility requirement concern that participants undergo a comprehensive mental health assessment	the DMIE project. The proposal has been changed to include this language.
Relationship with other entities	***Relationship with other entities:***
• Reform 2020 should honor the partnership with organizations that are operated as either Day Training and Habilitation programs or Community Rehabilitation programs by mentioning the positive outcomes they have produced	• DTH and Community Rehab The employment pilot detailed in the proposal is primarily targeted toward a population of people on Medicaid programs who are identified as having potentially disabling conditions, but who have not yet applied for disability benefits. DHS believes, and would like the opportunity to demonstrate, that providing this group of people with limited, telephonic navigation, benefits counseling and employment support services can help prevent destabilization and progression to need for more intensive services. While we recognize the good work being done by current vocational programs, people who will potentially receive these services will not be eligible for waivered services, Day Training and Habilitation programs or Community Rehabilitation programs. If this demonstration moves forward, we will evaluate potential efficacy of offering similar services to a wider array of Medicaid recipients including, potentially, people on waivers. At that time we will actively engage Day Training and Habilitation and Community Rehabilitation program providers.
• If the DLL is doing job placement, how will it supplement or complement Vocational Rehabilitation Services?	• VRS Demonstration navigation services provide health insurance benefits orientation and a wide network of community referrals that should supplement and complement people who are also eligible for VRS services. Job placement services are not included in the proposed benefit set.
• Waiver states that navigators will be part of Disability Linkage Line, what will be different about these services and those provided by Workforce Centers and Work Incentives Connection – services seem duplicative • What is the wraparound option that will be included in future health insurance exchanges? • What specific existing relationships will be leveraged with • Does not identify how services will be integrated with primary healthcare, mental health and workforce systems	• WorkForce Centers and WIC Services provided in the demonstration will be, primarily, for people who do not have a disability determination and who are not eligible to use the WIC. Demonstration Navigation services include benefits planning, health insurance benefits orientation, and referrals to community housing, employment, and legal resources which are not traditionally provided by WorkForce Centers or WIC. This demonstration is a lighter service than offered by the other mentioned entities, however, navigators will refer to one or both when appropriate. These less intensive services will be able to serve more people, and refer them to more intense services when needed.

Comments	DHS Response
• How will this section impact MCOs?	• Health Exchanges This demonstration is intended to inform design of a service which could potentially function in the future health insurance exchange. • DEED, DOC, MDE These agencies were engaged in the development process for the proposed demonstration and they will be engaged as partners in future development. • Primary healthcare, MH and workforce 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. • MCOs 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
More information requested • Provide reasoning for selecting particular groups	***More information requested:*** • Why these groups? 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)
• Will the navigators be trained in person centered planning?	• Person Centered Planning 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.
• 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?	• Anticipated cost reductions and tax revenue These are discussed in the revised budget section of the final waiver request • Has DLL providing employment and job placement services been tested? 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

Comments	DHS Response
• Competitive employment isn't stressed enough • No reference to the ongoing problem of people with mental illness + intellectual/developmental disability languishing in sheltered workshops and the need for meaningful employment • Requests employment taskforce to study interagency policies practices and financial models	– this has been clarified in the proposal. • Competitive employment isn't stressed enough Thank you for this comment. Additional language stressing competitive employment has been added. In addition, employment services will be included in the iniative described at 9.1.4 Intensive Mental Health Recovery. Services.
Research • Describe, in detail, policies and initiatives that were developed through the Pathways to Employment • Provide data about people using DB101 and Return on Investment • What are medical providers going to be doing with employment, what research will they be conducting and what is the purpose of the research?	***Research:*** • PTE info Links to websites with extensive information about initiatives that influenced the design of the employment demonstration were provided in the waiver proposal. • DB101 and ROI In the first half of 2012, DB101 had 17,373 visitors. MN is participating in a DB101 evaluation which will further identify value. At this time, we have testimonials bout the value from providers – helps people set high work goals, choose competitive work, earn more, and take control of their benefits. • Role of medical providers in research Medical providers are not participants in this design. • Projected numbers Potential numbers of participants for all subgroups were not yet available when the waiver was made available for public comment. All numbers are now included in this waiver request. ***IPS:*** DHS supports and is aware of the value of IPS services. The groups proposed in this demonstration may be well served by a lighter, less expensive set of services and supports. DMIE had success with navigation which we seek to build upon with this demonstration. These services may help delay or prevent participants from needing more intensive services in the future. MN has IPS demonstrations and will continue to pursue funding mechanisms to advance these initiatives. In addition, employment services will be included in the iniative described at 9.1.4 Intensive Mental Health Recovery. Services.

Comments	DHS Response
6.2 Housing Stabilization Services Demonstration	
• 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)	We are revising this section and eliminating the need for a functional assessment.
• Target population should be expanded (several comments received)	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.
• MnCHOICES is not applicable to people who are homeless (several comments received)	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.
• 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)	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.
• 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)	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.
• 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)	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.
• Limiting the Housing Stabilization Services to people who are 18 and older (several comments received)	In our revised section we have eliminated the requirement that the target population is18 or older.
• Do not limit the program or have a cap to the number of people to be served (several comments received)	If financing allows, we will eliminate the cap on number of people to be served.
• Limit the population not the specific benefit set of services. Maintain a	

Comments	DHS Response
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)	DHS appreciates the comments of support and looks forward to continuing to work with stakeholders to refine the program.
• HealthPartners would like additional information about funding streams for providing housing services for individuals that are being discharged from hospital settings	DHS agrees with this comment and is structuring the proposal accordingly. 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.
Comments of support 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. • 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	DHS appreciates all the comments and letters of support.

Comments	DHS Response
correctional facilities, residential chemical dependency treatment and inpatient facilities as well as nursing facilities • 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 *Blueprint for Reform* 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	
6.3 PATH Critical Time Intervention Demonstration • 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	DHS continues to strongly support access to healthcare and the use of evidence-based practices for persons with SMI. 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. 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. 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

Comments	DHS Response
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.
7 Anoka Metro Regional Treatment Center (AMRTC) Demonstration • 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.	***Comments expressing support*** DHS appreciates the support for this proposal. ***Are health Plans required to pay for services if this waiver is approved?*** Health Plans would be required to pay for all medically necessary services rendered for MA-eligible patients who meet criteria for treatment at AMRTC. ***What is the goal of the IMD exclusion waiver?*** 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.) ***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?*** 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. ***Would an IMD exclusion waiver allow people at AMRTC to become eligible for MA and become eligible for "Money Follows the Person"?*** 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. ***What is the relationship between the proposed 1915(i) and waivers/services under the CFSS proposal and those with complex co-morbidities?*** People

Comments	DHS Response
• 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?	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 co-morbidities 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. 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 brings 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. ***Does the IMD exclusion keep all people from moving to the community?*** 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.
8 Eligibility for Adults without Children Several commenters opposed the proposed changes to eligibility for adults without children.	DHS thanks commenters for their input, and will take these comments into consideration. State law requires federal approval for these changes to be sought.

Comments	DHS Response
Commenters questioned whether this approach was allowable under the maintenance of effort requirements under the Affordable Care Act. 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.	
9.1.2 1915(i) for kids with ASD [Summary of more than 35 comments submitted by consumers, family members, and relatives of someone with ASD not commenting on behalf of an organization] • 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)	***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: ***Concerns that the intent of the proposal is to cut off autism services at age 7 and shift responsibility for services to the schools:*** 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. ***Support for development and inclusion of medically-necessary services across a range of ages:*** 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>

Comments	DHS Response
• 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 [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] • 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	services will be developed through a formal stakeholder process set to begin this fall. ***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. ***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. ***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. 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. The State agencies are represented on the Minnesota ASD Task Force and are already working on projects and strategies to facilitate enhanced coordination

Comments	DHS Response
• 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	among activities across the life span of an individual with ASD.

Comments	DHS Response
integrating or collaborating around the health care and education needs of these children is encouraging • 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	

Comments	DHS Response
• 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	

Comments	DHS Response
services is pending? • 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	
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 • 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	***NOTE:*** DHS does not 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: ***Focus on institutional level of care to qualify for service excludes too many people with mental illness.*** 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.

Comments	DHS Response
to provide services to persons before they end up in psychiatric hospitals, prisons, jails or nursing facilities • 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	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. 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. ***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. ***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. ***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. ***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.
9.1.5 1915(i) for adults with co-occurring DD, SMI and sexual disorder, called Targeted Clinical and Community Services	***Initiative should focus on intervention with lower needs people rather than this group.*** This is a high need group that crosses disabilities and service

Comments	DHS Response
• 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.	needs. Their services are not always coordinated and some services are not provided or provided without reimbursement. 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.
9.2 Redesign Home and Community-Based Services • 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.	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. 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. 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
9.2.2 MnCHOICES	DHS has worked in collaboration with stakeholders and those who use services

Comments	DHS Response
• 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	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. 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 *diagnostic* 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 *functional* 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. 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. 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. 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. 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. 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

Comments	DHS Response
	except that information may be able to be shared with those settings to inform them of the services that an individual is receiving. 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.
9.2.3 Home and Community-Based Services Report Card • 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?	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. 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: • 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. 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.
9.2.4 Strategies for Integration of Long Term Services and Supports	

Comments	DHS Response
with Other Initiatives ***Alzheimer's Health Care Home Demonstration*** • 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	DHS is in agreement and plans to consider all parameters in the development of an Alzheimer's Health Care Home Demonstration.
9.2.4 Health Home Demonstration • 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.	DHS welcomes the support of stakeholders as it explores development of one or more health homes under Section 2703 of the ACA
9.2.4 Evidence-Based Health Promotion • Supportive, and welcome future opportunities to collaborate	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.
9.2.5 Planning and Service Development ***Critical access study for HCBS*** • Consider both current and future workforce issues, particularly in rural areas.	DHS is in agreement and will incorporate current and future workforce issues into the scope of the study.
9.2.5 Redirect residential and nursing facility services • 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	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. 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.

Comments	DHS Response
9.2.6 Enhancements to 1915(c) Waivers • 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.	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.
Service Menus • 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 it 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	***Provider standards*** 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. 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. 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. 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. 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.
CDCS Changes • Page 39….Changing from 15 Fiscal Support Entities (FSE) to 2 Fiscal	The Consumer Directed Task Force recommended changing from the service of Fiscal Support Entities to administrative entities providing Fiscal

Comments	DHS Response
Management Entities (FME) will reduce individual's choice. • 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.	Management services across all of Minnesota's self-directed programs. National research also supports this direction to provide the strongest integrity of fiscal management. Stakeholders will be involved in the future discussions of when providers can provide multiple services under self-directed services.
9.2.6 New budget methodology to serve medically complex seniors who are vent dependent • 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	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.
9.2.6 Threshold for accessing residential services • Consider how to assist private pay residents who have lived in a housing-with-services setting for a long time prior to waiver eligibility	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. 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: • 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,

Comments	DHS Response
	discharges, and non-renewal of leases • 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
9.2.6 Provider Standards • 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?	***Provider standards*** 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. ***Licensing and Quality Outcomes:*** 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. ***Rule 40:*** 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.
9.2.7 Rate Methodologies • 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.	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.

Comments	DHS Response
9.2.8 Redesign Case Management • 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	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. 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. 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.
9.2.9 Crisis Intervention and Protection of Vulnerable Adults • 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	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. 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).
9.2.9 Statewide, centralized system for Reports of Vulnerable Adult Maltreatment • 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	DHS appreciates the comments in support of the Centralization of the Common Entry Point. DHS has been working collaboratively with the Vulnerable Adult Justice Project (VAJP) on centralization of the Common Entry Point since 2008. 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

Comments	DHS Response
• Supportive; will reduce variability and enhance effective responses • Supportive of centralized CEP and increased training for professionals	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. 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.
9.2.10 Money Follows the Person • Adult Day Services are a key service for people returning home from a nursing home	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.
9.5 Intensive Residential Treatment Services • 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	DHS welcomes the support of stakeholders as it explores development of integrated models of care in these intensive settings for people with complex needs.
9.6 Children Under 21 in Residential "IMD" Facilities • 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	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. 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,

Comments	DHS Response
	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.
10 Evaluation • 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? Evaluation design focuses on process without addressing how to measure client outcomes	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. 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. 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.
Waiver Process – Over-arching Comments • 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	Attachment O includes the fiscal analysis for those items requiring waiver approval under this document. Many of the comments in this section have been addressed elsewhere in this document. Most changes to the Medicaid program require federal authority, but requests

Comments	DHS Response
developed; role of counties and other entities in unclear • Two commenters urge DHS to ensure budget neutrality not just with state budget but *across the system* • 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	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.

• Previous changes to MA have been significantly detrimental to people with mental illness, specifically:
  o NFLOC will result in thousands of people with mental illness no longer able to receive CADI services
  o PCA changes meant that many people, esp. children, were no longer eligible or drastically cut hours
  o CADI reduced funding for people with "low needs" and that hurt many people with mental illness whose needs are not well understood/assessed (NAMI)
	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.

• 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	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.
• 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	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.
• 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?	DHS is not seeking authority to limit or prohibit using managed care organizations and/or county-based purchasing for Medicaid.

Comments	DHS Response

• 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:
  o Technology and assistive technology (terms seem to be used interchangeably)
  o Person-centered planning/plans; other types of plans are also mentioned—be specific and consistent
  o DD, intellectual disability and mental retardation (page 79) are all used. Pick on consistent term (not MR)
  o No definition of "most integrated setting"
  o 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
  o 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	

Comments	DHS Response
comment and sent a re-write of the submittal summary in a tone that is about people) • 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	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.

Comments	DHS Response
Consumer Concern Regarding Medicaid Eligibility • 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	DHS responded directly to this consumer.

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 *(no changes)*	• 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).	• 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 *(no change in access to service; change on an administrative level)*	• State plan service (you don't need to be on a waiver to access) • People on waivers can access PCA	• 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 CFSS[3]

Services allowed
(more flexibility in how services can be used, more things covered)
	• 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).	• Same services as currently available under PCA, ***plus,***
		• Individuals can access
		  o Skills acquisition
		  o Assistive technology
		  o Environmental modifications
		  o Transition supports

Needs determination *(no change)*	• Needs are assessed and participant is assigned a home care rating • NOT based on institutional level of care	• Needs are assessed and participant is assigned a home care rating • NOT based on institutional level of care
Daily minutes of coverage *(minimum level of minutes raised)*	Determined by current PCA home care ratings • 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: • 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 *(changes)*	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.	• 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) *(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)*	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). Other self-direction options for personal support services are: • 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	Individuals will have a choice of models. The specific service models will be developed in collaboration with the Development and Implementation Council. Broadly, there will be three options: • 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 model[4] – Participant has complete control over whom the 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.

[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.

Attachment N

Current HCBS System:

Interaction of Nursing Facility Level of Care, HCBS Waivers, and PCA

Meets NF LOC

Alternative Care

- 65+
- Not eligible for MA

People on AC can access PCA

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 PCA

Personal Care Assistance (PCA)

- Any age
- Eligibility: Need assistance with at least one ADL, OR a Level One Behavior.
- Services: Assistance with activities of daily living or instrumental activities of daily living.
- Lowest daily amount of coverage is 30 minutes.

Current Nursing Facility Level of Care (NF LOC) criteria - professional judgment used to determine whether a person meets one of several bases for NF LOC determination.

Does not meet NF LOC

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

- PCA

Attachment N

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

7.31.12

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	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	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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%
	Subsitution 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
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
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%
	Subsitution 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
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
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
With Waiver
With 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	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	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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

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
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%
	Subsitution 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

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
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%
	Subsitution 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 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
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
0	$380	$380	$380	$380	$380	$380
Total Costs	$6,844,008	$5,299,874	$4,337,880	$3,558,486	$2,926,153	$2,412,351
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

SOS - Anoka Adult MH
Estimated Revenue if IMD Status Waived

Asssumptions:
- 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

With Waiver

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

Without Waiver

Metro Hospitals Contract Beds	Year 1	Year 2	Year 3	Year 4	Year 5
Net MA Days Payable	28,607	30,514	32,421	34,328	36,235
Per Diem Rate (inflated 3.5% per year)	$ 1,083	$ 1,121	$ 1,160	$ 1,201	$ 1,243
Total MA Revenue	$ 30,981,246	$ 34,203,295	$ 37,612,936	$ 41,219,353	$ 45,032,143
50% Fed Share	$ 15,490,623	$ 17,101,648	$ 18,806,468	$ 20,609,676	$ 22,516,072
Savings if AMRTC is provider	**$ 901,117**	**$ 994,833**	**$ 1,094,005**	**$ 1,198,901**	**$ 1,309,799**

Waiver Difference

Total MA	$ (1,802,233)	$ (1,989,665)	$ (2,188,010)	$ (2,397,802)	$ (2,619,598)
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
State share	-$901,117	-$994,833	-$1,094,005	-$1,198,901	-$1,309,799

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

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:

	SNBC Monthly Payment / Non-Medicare	MA Adults / No Kids Monthly Payment	Difference	Rate trends: SNBC	Rate trends: 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,

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 fromthis 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 groupmore 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

(Cash Basis Costs and Revenues)

	Medical Payments	Revenue from Enrollee Payments	Federal Share Under Waiver	Net Cost
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

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 Asssumptions:
- 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

Historical - Notes:
*MA patient days not tracked separately prior to SFY2010
**Based on percent for all payors

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

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 P: Historical Financial Data

If Paid at Metro Hospitals Contract Bed Rates	Year 1	Year 2	Year 3	Year 4	Year 5
Net MA Days Payable	28,607	30,514	32,421	34,328	36,235
Per Diem Rate (inflated 3.5% per year)	$ 1,083	$ 1,121	$ 1,160	$ 1,201	$ 1,243
Total MA Revenue	$ 30,981,246	$ 34,203,295	$ 37,612,936	$ 41,219,353	$ 45,032,143
50% Fed Share	$ 15,490,623	$ 17,101,648	$ 18,806,468	$ 20,609,676	$ 22,516,072
Savings if AMRTC is provider	**$ 901,117**	**$ 994,833**	**$ 1,094,005**	**$ 1,198,901**	**$ 1,309,799**

If Paid at Metro Hospitals Contract Bed Rates	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012
Net MA Days Payable	58,521	47,771	41,713	40,143	39,595
Per Diem Rate	$ 1,000	$ 1,029	$ 1,070	$ 1,083	$ 1,089
Total MA Revenue	$ 58,521,000	$49,156,359	$ 44,632,910	$ 43,474,869	$ 43,118,955
50% Fed Share	$ 29,260,500	$24,578,180	$ 22,316,455	$ 21,737,435	$ 21,559,478
Savings if AMRTC is provider			**$ 13,723,943**	**$ 10,316,897**	**$ 9,468,983**

Metro Hospitals Contract Beds	Year 1	Year 2	Year 3	Year 4	Year 5

Historical Metro Hospitals Contract Beds Usag	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012
Patient Days	7,908	7,386	9,264	8,508	5,786
Per Diem Rate	$ 1,000	$ 1,029	$ 1,070	$ 1,083	$ 1,089
Total MA Revenue	$ 7,910,175	$ 7,602,461	$ 9,910,160	$ 9,216,666	$ 6,299,943
50% Fed Share	$ 3,955,088	$ 3,801,231	$ 4,955,080	$ 4,608,333	$ 3,149,972

*May have delayed billing at end of state fiscal year

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 concerned 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 difficultly of care and high needs of my son and people with disabilities similar to his.

Sincerely,

[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 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 regarding the issues these kids face. He stated he was asked by a group of community leaders, "why the facility near the 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". , who oversees the 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 then 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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Phone: 651-523-0823 ext. 112
Fax: 651-523-0829
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. <u>Essential Community Supports (ECS) Program for "Transition Group"</u>

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.

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

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